

Electronically delivered August 25, 2020

Administrator Franklin Rehabilitation & Healthcare Center 900 3rd Street South Franklin, MN 55333

RE: CCN: 245273 Cycle Start Date: August 11, 2020

Dear Administrator:

On August 11, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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 remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 9, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 9, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 9, 2020.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 \$10,483; 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 September 9, 2020., the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Franklin Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 9, 2020. 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" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor Marshall District Office Health Regulation Division Licensing and Certification 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Cell: 218-340-3083

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 February 11, 2021 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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

> Nursing Home Informal Dispute Process Minnesota Department of Health

> Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 25, 2020

Administrator Franklin Rehabilitation & Healthcare Center 900 3rd Street South Franklin, MN 55333

Re: State Nursing Home Licensing Orders Event ID: KRUR11

Dear Administrator:

The above facility was surveyed on August 3, 2020 through August 11, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, Unit Supervisor Marshall District Office Health Regulation Division Licensing and Certification 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Cell: 218-340-3083

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

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	receive nursing ca custodial care, and individual needs at the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	n general. A residen re and treatment, p d supervision based nd preferences as in e resident assessm scribed in parts 469 sing home resident possible unless that the attending physic ain in bed or the resident n bed.	ersonal and l on dentified in ent and 58.0400 and must be out lere is a cian that the				
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		ment is not met as evidence	d			
	by: Based on observa	ation, interview and documer	at	corrected		
	review, facility fail	ed to ensure the safety of 1		Conceled		
		ailing to follow the care plan	f			
		This resulted in actual harm sulted in a fractured left hip.				
	facility had implen	nented corrective action to				
	non-compliance.	nce by 3/27/20, resulting in	past			
	Findings include:					
	hemiplegia (paral following stroke a sclerosis, bipolar	ecord included diagnoses of ysis of one side of the body) ffecting her left side, multiple disorder, adjustment disorde erline personality disorder an ire.	e er,			
	identified R3 was impairment on on walk. R3 required	ssion Minimum Data Set (M cognitively impaired, had e side of the body and did no extensive assist of two staff was fully dependent on two	ot f for			
	R3 had improved impairment, but si extensive assist o	ficant Change MDS identifie mental cognition to no cogn till could not walk, required of two staff for bed mobility, a ent on two staff for transfers.	itive and			
	fall, identified R3 i Activities of Daily and multiple scler	e plan, active at the time of F required assistance with Living (ADL's) related to stro osis. R3 required assist of tw lity and total assistance of tw	oke wo			
	staff for transfers	using a mechanical lift.				
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	resulting in a fractuidentified the nurse nursing assistant (assistant (TMA). T left side on floor nor ready to be transfe bed was removed the bed. R3 had id reach for somethin room and had turn R3's wheelchair. T toe assessment on any redness, swel side. R3 rated her nurse applied Biof pain. R3 continued and swelling was I non-emergent and that day for further received phone ca a left hip fracture a surgery.	R3 had a fallen that day ured left hip. The report e was called into R3's room by (NA) and a trained medication The nurse found R3 laying on ext to bed. R3 was getting erred so the floor mat next to . R3 was sitting up at the side of lentified she stood up trying to ng and fell. The NA was in the ned with her back to R3 to grab The nurse completed a head to n R3 after the fall, not noting ling, or bruising to R3's left pain at 9 on scale of 1-10. The reeze to R3's left hip area for d to complain of severe pain ater noted. R3 was sent by bulance at around 3:30 p.m. r follow-up. Facility staff and had been transferred for				
	identified R3 was a mobility, and mech Nursing assistant in bed, turned her wheelchair. R3 att and fell. NA-A ider place as NA-A was and was waiting for person as she had	lity investigation of the fall a two person assist with bed nanical hoyer lift for transfers. (NA)-A identified she sat R3 up back to her and grabbed the empted to stand up by herself ntified the fall mat was not in s planning on transferring R3 or assistance from another d planned to transfer R3 with a taff. Through staff interviews,				
	the facility determi to use the lift. Action reoccurrence to R	ned R3 would at times refuse on taken to prevent 3 included R3's transfer and eassessed and confirmed R3				

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		staff for bed mobility and t					
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		nce to other residents incl					
		sing (DON) or designee, a d review each resident's c					
		rent and update as neede					
		hat on-going attendance					
		ily meeting will be manda					
		ges for residents. Nursing					
		will be educated to the pro					
	Through facility int	erviews it was identified N	NA-A				
	was unaware R3 r	equired a mechanical lift	or				
		NA Kardex care plan for					
		eds. NA-A identified she k					
		B by "word of mouth." Rev					
		mation found NA-A receiv	ed				
		-education related to not					
	following the care	pian.					
	Review of R3's pro	ogress note dated 3/27/20) at				
		ed the nurse was called in					
		R3 on floor on her left side					
		e that R3 was sat up by N					
		ed her back to her and R3					
	talking to her wher	n she became distracted a	and				
		R3 reported to nurse she					
		Note identified nurse asse					
		staff that R3 is a two pers					
		d not have been sitting at					
		ified nurse had educated					
		nt also. Progress note date					
		as late entry for 12:15 p.m rgency room (ER) was ca					
		red hip from fall. Resident					
		ain and would like to be s					
		not identified any swelling					
		ie. ER nurse directed the					
		call back if swelling or					
		ted. Progress note dated					
		n., identified R3 left for El					
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	to have swelling an Progress note on 3 hospital nurse call	-ray of left hip as R3 was noted nd severe pain in left hip. 3/27/20 at 6:31 p.m., identified ed and reported R3 had a nd would be admitted.				
	observed to be tra mechanical lift by	4/20 at 8:44 a.m., R3 was nsferred correctly with a two staff from her wheelchair were no concerns identified				
	director of nursing not follow R3's car a fall with a fractur was re-training pro importance of follo R3 had no further	at 2:41 p.m., with assistant (ADON) confirmed NA-A did e plan. As a result, R3 suffered e. Following R3's fall, there wided to all staff on the wing each resident's care plan. falls since 3/27/20. All residents en reviewed for accuracy				
	nurse (RN)-A ident on duty at time of I after R3 fell to ass R3 up on edge of I wheelchair when F mechanical lift with also reported she transferring R3 alo for the second stat update a care plan NA Kardex on the assistants complet skills while training The ADON manag shown the Kardex.	20 at 9:56 a.m., with registered tified she was the charge nurse R3's fall. NA-A came to get her ess R3. NA-A reported she sat bed and turned to get the R3 fell. R3 required a total in two staff assistance. NA-A never had intentions of one and was just getting ready if to arrive. When the nurses b, it automatically goes to the computer. All nursing the a return demonstration of on the floor with other staff. ed education and NA's were . It was each nurses sure staff were monitored and e followed.				

	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
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2 830	Continued From p	age 6	2 830			
	identified staff hav NA Kardex they can needs. The DON we care plan and impli- identified when pro- refuse care or inter- staff to update the the resident the re- facility had multiple plan for each reside of the care plan. The facility at time of the retraining of staff are ensured present far and followed to pre-	20 at 12:40 p.m., with the DON e "cheat sheets" along with the an reference for residents care would expect staff to follow the lement interventions as oviding care. If a resident would rventions, she would expect charge nurse and explain to ason for the intervention. The e departments review the care lent and ensure implementation he DON was not employed at he fall, investigation, or at the time R3 had fallen, but acility processes were ongoing event falls. 20 at 10:24 a.m., with medical				
	director (MD) idem quarterly basis unl been notified of R3 at the facility to im that was put in pla	tified he is notified of falls on a ess there was injury. MD had 3's fall. MD would expect staff plement the identified care plan ce for each resident.				
	administrator (A) v found staff had no resulted in her hip staff to followed ea interventions to en has routinely sche	20 at 12:16 p.m., with rerified the facility investigation t followed R3's care plan which fracture. The A expected all ach resident's care plan and isure safe transfers. The facility duled meetings to discuss falls aff as needed as well as audit	,			
	Causes policy ider was to identify the had a fall, staff we signs and check for	ated, Assessing Falls and Their ntified the purpose of the policy cause of a fall. If a resident re to assess the resident's vital or injury, providing first-aid as were to perform a post-fall				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
_D	FNDI	00934	B. WING	/I EDGE	C 08/11/202	20
NAME OF I	PROVIDER OR SUPPLIEF		ADDRESS, CITY, S			
RANKL	IN REHABILITATION		D STREET SOL LIN, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COM	X5) IPLETI ATE
2 830	Continued From p	age 7	2 830			
	implement interve	ify complications from the fall, entions to prevent further falls, tion, and notify all appropriate				
	conducted a root of specific corrective the NA involved, a	ciency, the facility had cause analysis of R3's fall, action training was provided to Il other residents' care plans accuracy, and all remaining ated by 3/27/20.)			
	Because the defic	THOD OF CORRECTION: ency was cited at PAST CE, no method of correction is				
21525	MN Rule 4658.130 Consultation	05 A.B.C Pharmacist Service	21525		9/2/2	20
	services of a phar Board of Pharmac A. provides co	nust employ or obtain the macist currently licensed by the y who: onsultation on all aspects of the nacy services in the nursing				
	and disposition of detail to enable an C. determines	a system of records of receip all controlled drugs in sufficien accurate reconciliation; and that drug records are ned and that an account of all maintained.				
	by: Based on docume facility failed to en	nent is not met as evidenced nt review and interview, the sure medications were obtaine as ordered for 2 of 7 residents		corrected		

STATE FORM

If continuation sheet 8 of 20

Minneso	ta Department of H	ealth			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				/ FDOF	c
	FNIJI	00934	B. WING	//-/=///-	08/11/202 <u>0</u>
NAM <mark>E</mark> OF I	PROVIDER OR SUPPLIEF			STATE, ZIP CODE	
FRANKL	IN REHABILITATION		STREET SOUN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETE
21525	Continued From p	age 8	21525		
	(R5 and R14) iden reports.	tified in medication error			
	Findings include:				
	1/1/20 through 8/5	nedication error reports from /20, identified 2 reports of on related to no supply.			
	identified R5 recei the morning of 2/2 and an order was but was not delive According to the re identified an Advai Breath inhaler, 100 dose. Staff were to two times a day, re pulmonary disease	20, Medication Error Report ved the last dose of Advair on 7/20. R5's medication was out placed through the pharmacy, red until 3/2/20, 3 days later. eport, R5's medication order r Discus Aerosol Powder 0-50 micrograms (mcg) per o administer 1 puff inhale orally, elated to chronic obstructive e (COPD), and rinse R5's use. There were 8 doses			
	identified R14 was nightmares while t receive 25 milligra starting 4/6/20 thro given Benadryl as 4/11/20, and 4/12/2 available. A call way who identified they Benadryl from nur- facility had had sto always have pharr available. Resoluti stock Benadryl su	5/20, Medication Error Report ordered Benadryl for aking an antibiotic. R14 was to ms (mg) at hour of sleep (hs) ough 4/12/20. R14 was not ordered on 4/9/20, 4/10/20, 20, as there was no medication as placed to R14's pharmacy, had not received the order for sing staff. In the past, the ock Benadryl and would not nacy fill the order if stock was on to the error was to order a oply which was to be delivered s a total of 4 doses missed for he report.			

Minnesc	ta Department of H	ealth				10125
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURV COMPLETE	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRANKL	IN REHABILITATION		STREET SOU N, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE CO	(X5) MPLETE DATE
21525	Continued From pa	age 9	21525			
	director of nursing pharmacy deliverer week. Staff were re- medication (PRN) The person workin to notify the charger medication. The ch the medication from has an after-hours call if there was a p confirmed there was concerns. The fact 8/19/20, identifying medication supply. currently in place to related to shortager Interview on 8/10/2 pharmacist consul medications ordered the pharmacy is wan not received the or pharmacy is unabler reason, facility state update, then, if app or change the medication interview on 8/10/2 director of nursing expect if staff did re sent right away. The staff to give medication	2 at 12:36 p.m., with assistant (ADON) identified the d scheduled medications each esponsible to order as needed when low, prior to running out. g on the medication cart was e nurse of the need for more harge nurse was to then order in the pharmacy. The facility number for pharmacy they can botential to run out. The ADON as medication administration lity had set up training for g they would also be reviewing There had been no system o prevent medication errors e of supply and ordering. 20 at 11:46 a.m., with the tant (PC) identified if ed were not delivered it may be aiting on authorization, or had rder. The facility should call the ations were not received, as n-call 24 hours a day. If the e get medications for some if were to call the provider to propriate, get an order to hold dication if authorized. 20 at 12:21 p.m., with the (DON) identified she would not have medication available ould check the emergency kit e pharmacy for a dose to be ne DON's expectation was for ations as directed by the doctor ropriate person (s) right away if				

	ta Department of H		T		1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY
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		00934	B. WING			_ 1/2020
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RANKL	IN REHABILITATION	RANKL	IN, MN 55333	ł		
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PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
				DEFICIENC	Y)	
21525	Continued From p	bage 10	21525			
		20 at 10:24 a.m., with the				
		MD) identified he would expect				
		t the pharmacy if they did not				
		n available as ordered. If staff et the ordered medication from				
		would expect the nurse to				
		ler who ordered the medication				
	for guidance.					
	Interview on 8/11/	20 at 12:16 p.m., with the				
		agreed there are some				
		dication errors and felt some				
		needed to take place. He would				
		rror occurred, the DON at that				
		net with the staff and completed Administrator identified he was				
		ocess if a medication is not				
	available or did no	ot come in from the pharmacy.				
		that the pharmacy be contacted				
		discovered if unable to obtain				
		e charge nurse should call the and speak to the on-call MD for				
		also expect the pharmacist				
		nvolved with the medication				
		ntify ways to prevent errors from				
	occurring.					
	Review of undate	d, Medication Therapy Policy				
		sultant pharmacist was to review	1			
	medication related	d issues as part of its Quality				
		mance Improvement activities				
	and collaborate w address issues.	it the medical director to				
	2001000 100000.					
	SUGGESTED ME	ETHOD OF CORRECTION:				
		rsing (DON) or designee could				
		policies and procedures related				
		ors. The DON or designee could nsure medications are correctly				
		ch may include but is not limited				
nesota De	epartment of Health	-,	l			1
E FOR			6899 K	BUB11	If continuation	on sheet 11

Minneso	ta Department of H	ealth				/ 110125
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:			E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRANKL	IN REHABILITATION		STREET SOL N, MN 55333			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21525	Continued From p	age 11	21525			
	transcribing. The I processes to ensu- maintains appropri- administration pro- could have a meth compliance, such administration and amount of days x_ monthly x, to g ensure staff have of further education v any actions and/or QAPI committee to need for continued	ifying orders and accurately DON or designee should review re the pharmacist begins or iate oversight of the medication cess. The DON or designee odical system to verify as auditing medication or medical records for specific , then weekly x, then ather appropriate data to corrected the concern or if vould be required. Results of audits should be taken to the o determine compliance or the I monitoring. R CORRECTION: Twenty One				
21545	A nursing home m A. Its medicati percent as describ Guidelines for Coo 42, section 483.25 the State Operatio Surveyors for Long incorporated by re purposes of this pa (1) a discrepa prescribed and wh administered to re (2) the admin medications. B. It is free of error. A significant (1) an error	20 A.B.C Medication Errors ust ensure that: on error rate is less than five ed in the Interpretive le of Federal Regulations, title (m), found in Appendix P of ns Manual, Guidance to g-Term Care Facilities, which is ference in part 4658.1315. For art, a medication error means: ancy between what was at medications are actually sidents in the nursing home; or istration of expired any significant medication t medication error is: which causes the resident ardizes the resident's health or	21545			9/2/20

Minneso	ta Department of H	ealth					
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION		(X2) MULTIPL A. BUILDING:		(X3) DATE COMP	SURVEY LETED
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			900 3RD :	STREET SO	UTH		
FRANKL	IN REHABILITATION	& HEALTHCARE		N, MN 5533			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
					DEFICIENCY)		
21545	requires the medic be titrated to a spe- medication error of precipitate a reocc toxicity. All medica prescribed. An im- error report must be that occurs. Any s resident reactions physician or the phr resident or the resi- designated represe must be made in th C. All medicat prescribed. An incor report must be file occurs. Any signif resident reactions physician or the phr resident reactions physician or the phr resident or the resi- designated represe must be made in th This MN Requirem by: Based on interview facility failed to ensi-	ion from a category cation in the resider actific blood level an ould alter that level currence of sympton tions are administer cident report or me be filed for any medication must be reported t hysician's designee ident's legal guardi entative and an exp he resident's clinication icant medication er must be reported t hysician's designee ident's legal guardi entative and an exp he resident's clinication icant medication er must be reported t hysician's designee ident's legal guardi entative and an exp he resident's clinication icant medication er must be reported t hysician's designee ident's legal guardi entative and an exp he resident's clinication icant medication er must be reported t hysician's designee ident's legal guardi entative and an exp he resident's clinication in the resident's clinication	nt's blood to d a single and ms or ered as edication lication error on errors or o the and the an or blanation al record. red as dication error on error that rors or o the and the an or blanation al record. red as dication error o the and the an or blanation al record. red as dication error o the and the an or blanation al record.		corrected		
	significant adverse	R5 had potential to reaction after rece therapy medication	o sustain a eiving extra				
Minnacata		imum Data Set (MI	DS) dated				
iviinnesota D	epartment of Health						

Minnesc	ota Department of H	ealth			FORM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIEF	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
FRANKL	IN REHABILITATION		STREET SOL		
			N, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
21545	Continued From p	age 13	21545		
	impairment but wa after set up assist medication, antips chemotherapy me Review of the 1/11 identified R5 poss received four extra identified there we Xeloda medication when the medication when the medication interviewed and de day. R5 was asses found. A call was p doctor recommend drawing laboratory medication treatm evaluated by the p called back recom hospital due to pos call was placed to to call Poison Con they would not nee called oncology ba labs that day and or results. R5 had not fine". The investig- licensed staff were administration polio orders on 1/16/20 was no indication staff or the resider would occur.	R5 had severe cognitive as independent with his cares ance. R5 took schedule pain ychotic medication, and dication. /20, State Agency (SA) report ably had medication error and a doses of Xeloda. Report re four missing doses of a. The report lists it was unclear on was given. Staff were enied giving more than twice a ssed for side effects with none blaced to oncology and R5's ded holding the Xeloda and r testing. Staff would resume ent after labs had been hysician (MD). The MD later mending sending R5 to ssible toxicity of medication. A ER and ER staff recommended trol and informed the facility ed to see R5. Facility staff ack and were instructed to draw update the doctor with those adverse reaction and "felt ation was completed and e re-educated on the medication cy and processing of doctor and again on 1/22/20. There how the facility would monitor it to ensure no future errors			
	Xeloda (chemothe	eived four extra doses of rapy medication).			
Minnesota D STATE FOR	epartment of Health M		6899 K	RUR11	If continuation sheet 14 of 20

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
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RANKL	IN REHABILITATION		STREET SOU IN, MN 55333	ТН		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From p	age 14	21545			
	due to no supply. 3) 3/10/20 R5 rece chemotherapy dru taken was to chan process to discont than place on holo and stop dates on record (MAR). The oncology physician what the follow-up training to staff on medication errors. Review of R5's ora identified Xeloda 5 two tablets to equa order was on a thr 1) Week 1: day 1 L intravenous (IV) cl home, start oral Xe day 1. Day 2 throu 2) Week 2: day 8 L chemotherapy, no of Xeloda until he Xeloda twice a day 3) Week 3: day 15 chemotherapy, da completed the mo 28 doses R5 recei evening of day 15 Cycle repeats for a Review of R5's MA	al chemotherapy drug order 500 milligram (mg) tablets, give al 1000 mg twice a day. The ee week cycle as follows: have labs, see doctor, nemotherapy, return to nursing eloda, gets evening dose on 1gh 7 takes Xeloda twice a day. have labs, complete IV need to hold the morning dose returns home, day 8-14 takes y every day this week. 5 have labs, complete IV y 15 Xeloda should be rning of day 15. This completes ves each cycle. No Xeloda				
	mouth two times a a week and restar 3/13/20. There wa medication on hole	a, soo MG Give Tooo Ing by a day For 14 days then stop for t. Hold from 3/9/20 through s no indication placing a d would prompt staff to not dication in the MAR electronic				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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		900.3BD	STREET SOU			
RANKL	IN REHABILITATION		IN, MN 55333			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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21545	Continued From p	age 15	21545			
	documentation.					
	2) 3/20/20, an ord	der was placed with the same				
	instructions as ab	ove, but the dates identified the				
		nd a discontinue date of 3/18/20				
		order was received) had been				
		here was no indication staff				
		order before entering it in the				
	transcribing orders	had checks of 2 staff when				
		cate order was entered that				
		le same instructions as above,				
		4/1/20, 12 days after it began.				
		indication staff had checked				
		re entering the order into the				
	electronic MAR.	-				
	R5's care plan ide	ntified on 12/31/20, R5 was				
		nerapy related to cancer of the				
		and was to be an oral				
		ng was to monitor for				
		e effects and give medication				
		ordered, and maintain				
		th the oncology clinic. Staff				
	were also to inter	vene as necessary.				
	Interview on 8/4/2	0 at 10:45 a.m., with assistant				
	director of nursing	(ADON) identified the previous	6			
		(DON) did the investigation for	-			
		by drug error on identified on				
		er found the 4 pills and treated				
		was given the medication.				
		ility changed their procedure to erapy drug in the lock box on the				
		nd started to count them in				
		nore closely. When we get				
		the nurse enters into the				
		n another nurse has to verify				
		it would be double checked.				
	The facility gets get	et a 14 day supply each time,				
	pharmacy delivers	around 6:00 p.m., and the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
		900 3RD	STREET SOU	тн	
RANKLI	IN REHABILITATION	FRANKI	_IN, MN 55333		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	(X5)
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21545	Continued From n	2220 16	21545		
21545	Continued From p	age 16	21545		
		medications in. All medications			
		card which identifies the day to			
		Id be easy to see if you did not			
		pply. The ADON was unaware			
		DON found or did with her			
		mation after R5 was given four			
	additional doses.				
	Eurthor intorviow	on 8/6/20 at 12:36 p.m., with the			
		the second medication error	5		
		8/10/20, identified R5 received 5	5		
		his Xeloda. There was some			
		8/25/20, but she was unaware o	f		
		irred. The ADON confirmed	•		
		needed to be addressed right			
		of the data surrounding the			
		provide consistent and			
		o prevent further potential			
	errors.				
	Interview on 8/10/	20 at 11:46 a.m., with the			
		ant (PC) identified she was			
		notherapy drug error from			
		of R5 documentation's during a	a		
		not for the 3/10/20 error. PC			
		ent Xeloda order for accuracy.			
		she had not been given any			
		eports during her monthly			
		for input on possible resolutions			
		s identified. She used to review			
		a "long time ago" during the eetings but could not remember	r		
		ad seen an error report. PC			
		loda medication is a specialty			
		macy has to order in before			
		facility. The PC identified			
		on like Xeloda should be			
		related to all the side effects			
		. She would review a resident's			
	medication orders				1

	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
RANKL	IN REHABILITATION		STREET SOU IN, MN 55333	ГН		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21545	Continued From p	age 17	21545			
		y review each and every order at the time of her monthly				
	identified she or A medication errors resolved it by re-tr staff following an i identified if a staff medication errors person re-take the training course. SI medications as or	20 at 12:21 p.m., with DON DON would review any to identify root cause and aining staff. She would council dentified medication error and would continued to have she would have that staff e medication administration he expected staff to administer dered and if unsure of the charge nurse to assist.				
	director (MD) iden medication errors expect staff to be training was comp administration erro again he would ex provided immedia	20 at 10:24 a.m., with medical tified he was notified of on a quarterly basis. MD would re-trained following an error. If oleted on medication ors, and the error occurred spect further training to be tely to all staff. The MD agreed were a concern and had the nificant.				
	administrator (A) a concerns with mea appropriate educa when an error occ with all staff and ro the process when but would expect s manner, and mon contact pharmacy dose to alert them dispensation. The	20 at 12:16 p.m., with agreed there were ongoing dication errors and identified ation was needed. He expected curred, the DON would meet e-educate. He was not aware of medications were not available staff to order ahead in a timely itor for delivery. Staff were to prior to the next scheduled medication had not arrived for A agreed staff needed training ministration and order	,			

STATEMEN	It of Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIEF	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	_	
FRANKL	IN REHABILITATION		STREET SOUT N, MN 55333	ГН		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From p	age 18	21545			
	critical to identify we errors and should	pharmacist consultant was vays to prevent medication have been involved in oversight administration process.				
	Performance Impr minutes identified listed as discussed what the error was medication errors in incident reports 3/16/20) were revi corrective action r	5/20, Quality Assurance rovement (QAPI) meeting there was one medication error d. The minutes failed to identify s, the total number of reported (3 were documented from January 1, 2020 through ewed to identify causes, needed, potential or actual staff API planned to monitor the compliance.				
	and 1/23/20, ident medication orders enter orders in con Always call and as not understandabl double checked by TMA's (medication for clarification if s There was no indi	meeting agenda for 1/22/20 ified staff were to review . The education noted: "Do not mputer that are incomplete. sk for clarification if the order is e. All new orders must be y another nurse for accuracy. n aides) always seek your nurse omething does not feel right." cation follow-up audits occurred cation provided had corrected				
	Superior Healthca Region policy, ide medication related meetings. The ME and address conc review resident me requested. There the policy how or v	ated, Medication Therapy re Management Minnesota ntified the facility was to review d issues as part of their QAPI o and PC were to collaborate erns identified. The PC was to edications monthly, and as was no specific plan outlined in when the MD and PC were to dication errors, nor the PC was				

Minnesota Department of H	lealth				ATTIOVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
PENDI	00934	B. WING		C 08/1	; 1/202 <u>0</u>
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		STREET SO N, MN 5533			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
to ensure staff foll orders and pharm SUGGESTED ME The director of nur review and revise to medication error educate staff to en administered which to the need for ve transcribing. The processes to ensur maintains appropria administration pro- could have a meth compliance, such administration and amount of days x monthly x, to g ensure staff have further education any actions and/o QAPI committee to need for continue	edication administration process owed best practice, physician acy polices appropriately. ETHOD OF CORRECTION: rsing (DON) or designee could policies and procedures related ors. The DON or designee could nsure medications are correctly the may include but is not limited rifying orders and accurately DON or designee should review ure the pharmacist begins or riate oversight of the medication cess. The DON or designee nodical system to verify as auditing medication d or medical records for specific , then weekly x, then gather appropriate data to corrected the concern or if would be required. Results of r audits should be taken to the o determine compliance or the	21545			
(21) days					
Minnesota Department of Health		c200		lf a sublime th	h+ 00 - (00

		AND HUMAN SERVICES			FORM	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	245273 & HEALTHCARE CENTER	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH FRANKLIN, MN 55333	(08/1	C 11/202 <u>0</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	survey was comple complaint(s) invest NOT to be in comp Requirements for I The following com SUBSTANTIATED cited at F755 and I deficiencies cited a Additionally, the fo to be SUBSTANTI. H5273061C, H527 H5273066C, H527 H5273066C, H527 However, no defici The following com UNSUBSTANTIAT H5273057C, H527 H5273065C. The facility's plan of as your allegation Department's acce Because you are es signature is not rec page of the CMS-2	 a 8/11/20, an abbreviated eted at your facility to conduct a tigation. Your facility was found bliance with 42 CFR Part 483, Long Term Care Facilities. plaints were found to be : H5273059C with deficiencies F760 and H5273061C, with at F689. llowing complaints were found ATED: H5273060C, '3062C, H5273064C, '3067C and H5273068C. encies were cited. plaints were found to be ED: H5273055C, H5273056C, '3058C, H5273063C, and of correction (POC) will serve of compliance upon the eptance. enrolled in ePOC, your quired at the bottom of the first 2567 form. Your electronic POC will be used as 	F 00			
	on-site revisit of your validate that substances are gulations has be your verification.	acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with		TITLE		(X6) DATE
	ically Signed			IIILE		09/03/2020

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.

		I AND HUMAN SERVICES E & MEDICAID SERVICES		FORM	0: 09/11/2020 APPROVED 0: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		TE SURVEY MPLETED
		245273	B. WING		C / 11/2020
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	/11/2020
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER	-	00 3RD STREET SOUTH RANKLIN, MN 55333	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 609 SS=D	Reporting of Allege CFR(s): 483.12(c)(F 609		9/9/20
		onse to allegations of abuse, n, or mistreatment, the facility			
	involving abuse, ne mistreatment, inclu source and misapp are reported imme hours after the alle that cause the alle serious bodily injur the events that cau abuse and do not r the administrator o officials (including adult protective set for jurisdiction in lo	are that all alleged violations eglect, exploitation or iding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ng-term care facilities) in tate law through established			
	designated represe accordance with S Survey Agency, wit incident, and if the appropriate correct This REQUIREME by: Based on interview facility failed to ens physical abuse was and State agency (ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State hin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced w and document review, the sure allegations of potential s reported to the administrator SA) within two hours, as residents (R2 and R12).		Franklin Rehabilitation & Healthcare OHFC 609: Preparation, submission, and implementation of this plan of correction do not constitute an admission of or	
	Findings include:			agreement with the facts and conclusions	

Facility ID: 00934

If continuation sheet Page 2 of 22

TATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
	r oormeorion		A. BUILDING			
						С
_		245273	B. WING			11/202 <u>0</u>
NAME OF F	PROVIDER OR SUPPLIE	ER	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDANKI		N & HEALTHCARE CENTER	9	00 3RD STREET SOUTH		
			F	RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 609	Continued From	page 2	F 609			
			1 000	set forth on the survey report.	Our plan of	
	R2's 6/2/20 aug	rterly Minimum Data Set (MDS)		correction is prepared and exe		
		<i>impairment, verbal behaviors</i>		means to continuously improve		
		s, and was independent with all		of care and to comply with all a		
		agnoses of a personality disorder		state and federal regulatory rec		
	and schizoaffecti			The facility has updated it's Re		
	Poviow of the 6/	15/20 at 8:20 a m State Agenov		Abuse policy to incldue a break		
		15/20 at 8:39 a.m., State Agency ified on 6/14/20 at 11:25 a.m., R2		reporting timelines. All staff we		
		g at R12 who was standing in		educated on 8/19/20 at an all-s		
		aff immediately intervened and		meeting and were educated on		
		sh R12, who fell to his knees.		alleged violations in accordance		
		and directed R12 back to his		timelines set forth in 483.12		
		ed staff to R12's room and		Staff were also educated that r	enardless	
		's door threatening to "knock him		of a resident's diagnosis or any		
		able to redirect R2. The facility		involved, all alleged violations i		
		umentation included in the report		abuse, neglect, exploitation or		
		verheard R2 saying "he was in my		mistreatment, including injuries	of	
		rritorial tendencies and was		unknown source and misappro		
		secured unit to minimize intrusive		resident property, are reported		
	wandering of oth	ers into his room.		immediately, but not later than	2 hours	
	-			after the allegation is made if the	ne events	
	Review of R2's c	are plan identified R2 was at risk		that cause the allegation involv	e abuse or	
	and had potentia	I for abuse related to decreased		result in serious bodily injury. T	he policy	
		wandering, and history of		also identifies that the Administ	rator and	
	altercations with	peers. Staff were to explain to		Director of Nursing are to be no		
		e doing prior to providing cares,		incidents immediately to help u		
		r others that disturb him, have a		which incidents would require a	a state	
		ay to prevent others from		agency report.		
		is room, and re-direct R2 if he				
		yone else's room or area that		Administrator will audit all incid		
		him. R2's behaviors included		daily for 2 weeks then x1 mont		
		cal aggression when others were		months with the IDT team to de		
		pace, related to his diagnosis of		any incidents requiring a state		
		njury (TBI). Staff were to		report will be done in accordan		
		eds, intervene if he shows		timelines set forth in 483.12. R		
		ement thirty minute checks at		those audits will be taken to the		
		irect when they noticed he was anxious or agitated, and eat in		meeting to determine complian need for further monitoring.	ce or the	

Facility ID: 00934

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	09/11/2020 APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER		00 3RD STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	Continued From pa	age 3	F 609			
		ze interactions with peers		Compliance Date: 9/9/20		
	severe cognitive im three days, walks in staff assistant for o diagnosis of demen disorder, diabetic, a Review of R12's ca for potential abuse with behavioral dist communication, an R12 has a history of to remove from dat redirect. Care plan history of suicide ic injury. Staff are to a R12 has psychiatry Interview on 8/5/20 member (FM)-A co behaviors and feels facility can do with	IDS dated 5/5/20, identified npairment, wandering one to ndependently, requires one cares. Further identified ntia with Lewy bodies, anxiety and COPD. are plan identified R12 is at risk related to Lewy body dementia turbances, impaired ad mental health diagnosis. of intrusive wandering. Staff are ngerous situations and identified behaviors related to leation's with attempt of self anticipate and meet his needs. <i>v</i> consult as needed. 0 at 9:32 a.m., with R2's family unfirmed R2 had these types of s there is only so much the him. FM-A identified the facility come up with solutions to				
	prevent R2 from ha with his peers. FM- care for himself or is this way. FM-A ic to her suggestions inappropriate intera so rude. FM-A iden with him when he r even though he jus over.	Aving inappropriate interactions A identified R2 was unable to his lifestyle and that is why he dentified that the facility listens and they try to keep R2 from actions even though he can be ntified what she can do is talk needs me or is feeling anxious at says the same thing over and 0 at 1:00 p.m., with the rmed the SA report had been				

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245273	B. WING	EIN	C 08/11/2020	
	PROVIDER OR SUPPLI	ER DN & HEALTHCARE CENTER	9	STREET ADDRESS, CITY, STATE, ZIP CODE 000 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 609 F 689 SS=G	started at the fac confusion about frame. Staff here reporting time fra thought that if the interaction betwe and no harm it d the two hour time hours. Requested abus undated, Report Management Su Minnesota Regio identified employ and/or physician incident or suspen neglect, includin resident property to the facility ma as the willful inflii intimidation, or p or mental anguis reporting to the S Free of Accident CFR(s): 483.25(d) Accident S483.25(d)(1) The as free of accident S483.25(d)(2)Eas supervision and accidents.	A ministrator identified when he cility there was still some reporting within the two hour time a thought that the two hour ame was for serious injury. Staff ere was a resident to resident een two residents with dementia id not need to be reported within e frame but did within twenty four e reporting policy, received ing Abuse to Facility operior Healthcare Management on policy. Review of policy yee, consultants, family, visitors, s are to report promptly any ected incident of abuse or g theft, misappropriation of y, or injuries of unknown source nagement. Policy identifies abuse ction of injury, confinement, ounishment resulting in harm, pain sh. The policy had no mention of SA and timelines of reporting. Hazards/Supervision/Devices d)(1)(2)	F 609			8/31/20

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C		
		245273	B. WING		08/11/202 <u>0</u>	
	PROVIDER OR SUPPLIE	N & HEALTHCARE CENTER	90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 3RD STREET SOUTH RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 689	Based on observ review, facility fai resident (R3) by f during a transfer. R3, whose fall re- facility had implet prevent reoccurre- non-compliance. Findings include: R3's admission re- hemiplegia (para following stroke a sclerosis, bipolar depression, bord high blood pressi R3's 2/4/20, adm identified R3 was impairment on or walk. R3 required bed mobility, and for transfers. R3's 4/6/20, Sign R3 had improved impairment, but s extensive assist of was fully depender R3's 1/30/20, car fall, identified R3 Activities of Daily and multiple scle staff for bed mobility	vation, interview and document led to ensure the safety of 1 of 1 failing to follow the care plan This resulted in actual harm for sulted in a fractured left hip. The mented corrective action to ence by 3/27/20, resulting in past ecord included diagnoses of lysis of one side of the body) affecting her left side, multiple disorder, adjustment disorder, erline personality disorder and		Past noncompliance: no plan o correction required.	f	

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		AND HUMAN SERVICES			FORM	09/11/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER	-	00 3RD STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	resulting in a fracture identified the nurser nursing assistant (I assistant (TMA). The left side on floor ner- ready to be transfe bed was removed. the bed. R3 had ider reach for somethin room and had turne R3's wheelchair. The toe assessment on any redness, swelling side. R3 rated her nurse applied Biofr pain. R3 continued and swelling was la non-emergent amb that day for further received phone call a left hip fracture a surgery. Review of the facilit identified R3 was a mobility, and mech Nursing assistant (in bed, turned her facility and fell. NA-A iden place as NA-A was and was waiting for person as she had gait belt and two st the facility determine to use the lift. Action reoccurrence to R3	R3 had a fallen that day ired left hip. The report was called into R3's room by NA) and a trained medication he nurse found R3 laying on ext to bed. R3 was getting rred so the floor mat next to R3 was sitting up at the side of entified she stood up trying to g and fell. The NA was in the ed with her back to R3 to grab he nurse completed a head to a R3 after the fall, not noting ing, or bruising to R3's left pain at 9 on scale of 1-10. The eeze to R3's left hip area for to complain of severe pain ater noted. R3 was sent by bulance at around 3:30 p.m. follow-up. Facility staff I from hospital stating R3 had nd had been transferred for ty investigation of the fall two person assist with bed anical hoyer lift for transfers. NA)-A identified she sat R3 up pack to her and grabbed the empted to stand up by herself tified the fall mat was not in planning on transferring R3 r assistance from another planned to transfer R3 with a aff. Through staff interviews, ned R3 would at times refuse	F 689			

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CENTER	RS FOR MEDICA	TH AND HUMAN SERVICES			FORM OMB NO.	09/11/202 APPROVE 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245273 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED C 08/11/2020		
		B. WING				
		^{-R} N & HEALTHCARE CENTER	90	REET ADDRESS, CITY, STATE, ZIP CODE 0 3RD STREET SOUTH RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 689	Continued From	page 7 staff for bed mobility and total	F 689			
	assistant with a r prevent reoccurr the director of nu with therapy wou plan to ensure cu Further identified therapy staff at d address any cha and therapy staff Through facility i was unaware R3 where to find the resident's care n how to care for F investigation info	mechanical lift. Action taken to ence to other residents included ursing (DON) or designee, along Id review each resident's care urrent and update as needed. I that on-going attendance by aily meeting will be mandatory to nges for residents. Nursing staff will be educated to the process. Interviews it was identified NA-A required a mechanical lift or NA Kardex care plan for eeds. NA-A identified she knew 3 by "word of mouth." Review of rmation found NA-A received e-education related to not				
	1:39 p.m., identif R3's room to find informed the nur and then she turn talking to her why stood up and fell head and left hip R3 and educated transfer and sho of bed. Note iden staff about reside 3/27/20 identified identified the em for possible fract	rogress note dated 3/27/20 at ied the nurse was called into I R3 on floor on her left side. R3 se that R3 was sat up by NA-A ned her back to her and R3 was en she became distracted and . R3 reported to nurse she hit her . Note identified nurse assessed d staff that R3 is a two person uld not have been sitting at edge ntified nurse had educated other ent also. Progress note dated d as late entry for 12:15 p.m., ergency room (ER) was called ured hip from fall. Resident had pain and would like to be seen.				
	Facility nurse had redness at this ti to watch area an	d not identified any swelling or me. ER nurse directed the facility d call back if swelling or oted. Progress note dated				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 09/11/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER	-	00 3RD STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	3:05 p.m., for an x- to have swelling an Progress note on 3 hospital nurse calle fractured left hip ar Observation on 8/4 observed to be tran mechanical lift by t into her bed. There during the transfer. Interview on 8/6/20 director of nursing not follow R3's care a fall with a fracture was re-training pro- importance of follow R3 had no further f care plans had bee Interview on 8/10/2 nurse (RN)-A ident on duty at time of F after R3 fell to asse R3 up on edge of b wheelchair when R mechanical lift with also reported she r transferring R3 alou for the second staf- update a care plan NA Kardex on the c assistants complet skills while training The ADON manage shown the Kardex.	n., identified R3 left for ER at ray of left hip as R3 was noted ad severe pain in left hip. /27/20 at 6:31 p.m., identified ed and reported R3 had a nd would be admitted. /20 at 8:44 a.m., R3 was nsferred correctly with a two staff from her wheelchair e were no concerns identified	F 689			

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CENTER	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				FORM OMB NO.	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			E SURVEY PLETED
		245273	B. WING			1/2020
NAME OF I	PROVIDER OR SUPPLIEF	1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	I & HEALTHCARE CENTER		00 3RD STREET SOUTH		
		ATEMENT OF DEFICIENCIES	l	RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	Continued From p	age 9	F 689			
	the care plans we	-				
	identified staff hav NA Kardex they ca needs. The DON care plan and imp identified when pro- refuse care or inter- staff to update the the resident the re- facility had multipl plan for each reside of the care plan. T facility at time of the retraining of staff a	20 at 12:40 p.m., with the DON re "cheat sheets" along with the an reference for residents care would expect staff to follow the lement interventions as oviding care. If a resident would erventions, she would expect charge nurse and explain to ason for the intervention. The e departments review the care dent and ensure implementation the fall, investigation, or at the time R3 had fallen, but acility processes were ongoing event falls.				
	director (MD) iden quarterly basis un been notified of R at the facility to im	20 at 10:24 a.m., with medical tified he is notified of falls on a less there was injury. MD had 3's fall. MD would expect staff plement the identified care plan ce for each resident.				
	administrator (A) v found staff had no resulted in her hip staff to followed ea interventions to er has routinely sche and re-educate sta care provided.	20 at 12:16 p.m., with verified the facility investigation t followed R3's care plan which fracture. The A expected all ach resident's care plan and isure safe transfers. The facility duled meetings to discuss falls aff as needed as well as audit				
	Causes policy ide	ated, Assessing Falls and Their ntified the purpose of the policy cause of a fall. If a resident				

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ATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		3 NO. 0938-039 3) DATE SURVEY COMPLETED
		245273	B. WING		C 08/11/202 <u>0</u>
NAME OF I	PROVIDER OR SUPPLI	R		REET ADDRESS, CITY, STATE, ZIP CODE	
RANKL	IN REHABILITATIO	N & HEALTHCARE CENTER		3RD STREET SOUTH ANKLIN, MN 55333	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 689	Continued From	page 10	F 689		
	signs and check appropriate. Stat assessment, ide implement inter	vere to assess the resident's vital for injury, providing first-aid as f were to perform a post-fall ntify complications from the fall, ventions to prevent further falls, nation, and notify all appropriate			
F 755 SS=E	conducted a roo specific correctiv the NA involved, were reviewed for staff were re-edu Pharmacy Srvcs	ficiency, the facility had t cause analysis of R3's fall, re action training was provided to all other residents' care plans or accuracy, and all remaining icated by 3/27/20. /Procedures/Pharmacist/Records a)(b)(1)-(3)	F 755		9/9/20
	drugs and biolog them under an a §483.70(g). The personnel to adr	provide routine and emergency icals to its residents, or obtain greement described in facility may permit unlicensed ninister drugs if State law under the general supervision of			
	pharmaceutical s that assure the a dispensing, and	edures. A facility must provide services (including procedures accurate acquiring, receiving, administering of all drugs and eet the needs of each resident.			
		ce Consultation. The facility obtain the services of a licensed			
		ovides consultation on all ovision of pharmacy services in			

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CENTER	MENT OF HEALTH AND HUMAN SERVICES	[FORI OMB NO	D: 09/11/2020 MAPPROVED D. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		TE SURVEY
	245273	B. WING	Of	3/11/2020
NAME OF F	PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , 202 <u>0</u>
FRANKI	IN REHABILITATION & HEALTHCARE CENTER	9	00 3RD STREET SOUTH	
		F	RANKLIN, 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
F 755	Continued From page 11 the facility.	F 755		
	§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			
	§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 document review and interview, the facility failed to ensure medications were obtained and administered as ordered for 2 of 7 residents (R5 and R14) identified in medication error reports.		Franklin Rehabilitation & Healthcare OHFC 755: Preparation, submission, and implementation of this plan of correction do not constitute an admission of or	
	Findings include: Review of facility medication error reports from		agreement with the facts and conclusions set forth on the survey report. Our plan o correction is prepared and executed as a	of
	1/1/20 through 8/5/20, identified 2 reports of medication omission related to no supply.		means to continuously improve the qualit of care and to comply with all applicable	у
	Review of the 3/2/20, Medication Error Report identified R5 received the last dose of Advair on the morning of 2/27/20. R5's medication was out and an order was placed through the pharmacy, but was not delivered until 3/2/20, 3 days later. According to the report, R5's medication order identified an Advair Discus Aerosol Powder Breath inhaler, 100-50 micrograms (mcg) per dose. Staff were to administer 1 puff inhale orally, two times a day, related to chronic obstructive pulmonary disease (COPD), and rinse R5's mouth after each use. There were 8 doses missed. Review of the 4/15/20, Medication Error Report		state and federal regulatory requirements F755 "R5 and R14 are residents at Franklin Rehabilitation & Healthcare. "All Residents at Franklin Rehabilitation & Healthcare who are receiving medication management have the potential to be affected. "Licensed nursing staff are educated upo hire/annually/PRN on the Medication Orders and Medication Administration policy. Licensed nursing staff have been educated following the incident by DON/Designee. A revision has been made to the Medication Orders policy to	k

Facility ID: 00934

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STATEMENT	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		3 NO. 0938-039 3) DATE SURVEY COMPLETED
		245273	B. WING		C 08/11/2020
	PROVIDER OR SUPPLIE	R & HEALTHCARE CENTER	90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 3RD STREET SOUTH RANKLIN, MN 55333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 755	identified R14 wa nightmares while receive 25 milligr starting 4/6/20 th given Benadryl a 4/11/20, and 4/12 available. A call w who identified the Benadryl from nu facility had had s always have pha available. Resolu stock Benadryl si 4/16/20. There w R14, identified in Interview on 8/6/2 director of nursin pharmacy deliver week. Staff were medication (PRN The person work to notify the char medication. The the medication fr has an after-hou call if there was a confirmed there w concerns. The fa 8/19/20, identifyin medication suppl currently in place related to shortage Interview on 8/10 pharmacist const medications order the pharmacy is to	as ordered Benadryl for taking an antibiotic. R14 was to rams (mg) at hour of sleep (hs) rough 4/12/20. R14 was not s ordered on 4/9/20, 4/10/20, 2/20, as there was no medication vas placed to R14's pharmacy, ey had not received the order for irsing staff. In the past, the tock Benadryl and would not rmacy fill the order if stock was ition to the error was to order a upply which was to be delivered as a total of 4 doses missed for	F 755	reflect information on reordering and hour pharmacy services. "DON/Designee will audit medication orders to ensure compliance with fac policy on Medication Orders and Medication Administration daily on ea shift for one month and then x1 audit weekly for two additional months. "The facility conducted a meeting on 8/20/20 with the consulting pharmaci and Thrifty White Pharmacy to discus delivery expectations and concerns." consulting pharmacist noted that the pharmacy does have a 24 hr. line in emergent cases of needing medication and will deliver promptly. The consult pharmacist also conducts medication regimen reviews monthly and guarterly O meetings to discuss pharmacy service The facility will review medication erro on a monthly basis with the consultin pharmacist to identify and address concerns. "Audit results will be reviewed at mor QAPI meetings x3 months to ensure consistent implementation of the faci Medication Orders and Medication Administration policy. Results of thos audits will be taken to the QAPI meet to determine compliance or the need further monitoring. "Completion date: 9.9.20	ility ich st ss The ons ing ed to DAPI es. ors g ithly lities e ing

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		1/2020
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER	-	00 3RD STREET SOUTH RANKLIN, MN 55333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETION DATE
F 755	Continued From pa	age 13	F 755			
	the pharmacy is on pharmacy is unable reason, facility staf update, then, if app	ations were not received, as i-call 24 hours a day. If the e get medications for some f were to call the provider to propriate, get an order to hold				
	-	ication if authorized.				
	director of nursing expect if staff did n as ordered, they we or get a hold of the sent right away. Th staff to give medica	to at 12:21 p.m., with the (DON) identified she would ot have medication available ould check the emergency kit pharmacy for a dose to be the DON's expectation was for ations as directed by the doctor ropriate person (s) right away if				
	medical director (M the staff to contact have a medication were unable to get the pharmacy he w	0 at 10:24 a.m., with the ID) identified he would expect the pharmacy if they did not available as ordered. If staff the ordered medication from rould expect the nurse to er who ordered the medication				
	administrator (A) a concerns with med strong education n expect when an err time would have m a coaching form. A unaware of the pro available or did not He would expect th as soon as it was c and potentially the	0 at 12:16 p.m., with the greed there are some ication errors and felt some eeded to take place. He would ror occurred, the DON at that et with the staff and completed dministrator identified he was cess if a medication is not come in from the pharmacy. the pharmacy be contacted discovered if unable to obtain charge nurse should call the nd speak to the on-call MD for				

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	<u> SFOR MEDICAI</u> OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILDIN			PLETED
					C	2
	/ []] [245273	B. WING			1/202 <u>0</u>
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CC 900 3RD STREET SOUTH	DDE	
FRANKL	IN REHABILITATIO	N & HEALTHCARE CENTER		FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From	page 14	F 75	5		
	guidance. Would	also expect the pharmacist	_	-		
		involved with the medication ntify ways to prevent errors from				
	identified the con medication relate Assurance Perfo	ed, Medication Therapy Policy sultant pharmacist was to review ed issues as part of its Quality rmance Improvement activities vit the medical director to				
F 760 SS=E	address issues.	ee of Significant Med Errors	F 76	o		9/9/20
	medication errors	sidents are free of any significant				
	Based on intervi facility failed to e	ew and document review, the nsure 1 of 7 residents (R5) tions and were free of significant		Franklin Rehabilitation & He OHFC 760:	althcare	
	medication errors	s. R5 had potential to sustain a se reaction after receiving extra otherapy medication (Xeloda) on		Preparation, submission, and implementation of this plan of do not constitute an admission agreement with the facts and set forth on the survey report	of correction on of or d conclusions	
	Findings include:			correction is prepared and e means to continuously impro		
	5/5/20, identified	nimum Data Set (MDS) dated R5 had severe cognitive vas independent with his cares		of care and to comply with all state and federal regulatory	l applicable	
	after set up assis medication, antip chemotherapy m	stance. R5 took schedule pain sychotic medication, and edication.		F760 "R5 is a current resident at F Rehabilitation & Healthcare "All Residents at Franklin Re	habilitation &	
		1/20, State Agency (SA) report sibly had medication error and		Healthcare who are receiving management have the poter		

Facility ID: 00934

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TATEMENT	OF DEFICIENCIES	XE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
					C	2
		245273	B. WING			11/202 <u>0</u>
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
FRANKL	IN REHABILITATIO	N & HEALTHCARE CENTER		000 3RD STREET SOUTH FRANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From	page 15	F 760			
	identified there w Xeloda medicatio when the medica interviewed and o day. R5 was asse found. A call was doctor recommen drawing laborator medication treatm evaluated by the called back recor hospital due to po call was placed to to call Poison Co they would not ne called oncology b labs that day and results. R5 had n fine". The investig licensed staff we administration po orders on 1/16/20 was no indication staff or the reside would occur.	ra doses of Xeloda. Report ere four missing doses of in. The report lists it was unclear tion was given. Staff were denied giving more than twice a essed for side effects with none placed to oncology and R5's inded holding the Xeloda and ry testing. Staff would resume nent after labs had been physician (MD). The MD later inmending sending R5 to ossible toxicity of medication. A o ER and ER staff recommended introl and informed the facility eed to see R5. Facility staff pack and were instructed to draw update the doctor with those o adverse reaction and "felt gation was completed and re re-educated on the medication licy and processing of doctor 0 and again on 1/22/20. There how the facility would monitor ent to ensure no future errors		affected. "Licensed nursing staff are hire/annually/PRN on the M Orders and Medication Adm policy. Licensed nursing sta educated following the ever September 9th, 2020 by DC "DON/Designee will audit m orders to ensure compliance policy on Medication Orders Medication Administration of shift for one month and the weekly for two additional m "Audit results will be review QAPI meetings x3 months consistent implementation of Medication Orders and Medication orders and	ledication ninistration aff have been nt on DN/Designee. nedication we with facility s and daily on each n x1 audit onths. ed at monthly to ensure of the facility s dication sults of those DAPI meeting	
	errors. On: 1) 1/11/20, R5 red Xeloda (chemoth 2) 3/2/20, R5 did due to no supply. 3) 3/10/20 R5 red chemotherapy dr taken was to cha	entified the following medication ceived four extra doses of erapy medication). not receive Advair for three days eeived five days of additional ug. Immediate action action nge the medication order ntinue (DC) medications, rather				

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	11/2020
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER		00 3RD STREET SOUTH		
	_		F	RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	Continued From pa	age 16	F 760			
	and stop dates on record (MAR). The oncology physiciar what the follow-up	the medication administration facility contacted R5's (MD). There was no indication from the MD identified, nor any the potential significance of	1 700			
	identified Xeloda 5 two tablets to equa order was on a thr 1) Week 1: day 1 h intravenous (IV) ch home, start oral Xe day 1. Day 2 throu 2) Week 2: day 8 h chemotherapy, no of Xeloda until he n Xeloda twice a day 3) Week 3: day 15 chemotherapy, day completed the moi 28 doses R5 receir evening of day 15	al chemotherapy drug order 00 milligram (mg) tablets, give al 1000 mg twice a day. The ee week cycle as follows: have labs, see doctor, hemotherapy, return to nursing eloda, gets evening dose on gh 7 takes Xeloda twice a day. have labs, complete IV need to hold the morning dose returns home, day 8-14 takes v every day this week. have labs, complete IV y 15 Xeloda should be rning of day 15. This completes ves each cycle. No Xeloda through 21. another three weeks.				
	 1/23/20, Xeloda mouth two times a a week and restart 3/13/20. There was medication on hold administer the med documentation. 3/20/20, an ord instructions as abo start as 3/20/20 an (2 days before the 	AR identified orders on: a, 500 MG Give 1000 mg by day For 14 days then stop for Hold from 3/9/20 through s no indication placing a d would prompt staff to not dication in the MAR electronic er was placed with the same ove, but the dates identified the id a discontinue date of 3/18/20 order was received) had been here was no indication staff				

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING			C I 1/2020
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	11/2020
FRANKI	IN REHABILITATION	& HEALTHCARE CENTER	9	00 3RD STREET SOUTH		
			F	RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 760	Continued From pa	age 17	F 760			
F 760	had validated the or system, or if they h transcribing orders 3) 3/20/20, a duplic same day, with the to be discontinued There was also no for accuracy before electronic MAR. R5's care plan ider receiving chemoth liver and bile duct a medication. Nursin chemotherapy side and treatments as communication wit were also to interv Interview on 8/4/20 director of nursing director of nursing R5's chemotherapy 1/11/20. They never the error as if R5 w Ultimately, the faci lock the chemothe medication cart, ar order to monitor m medication orders computer and ther the order, this way The facility gets get	order before entering it in the nad checks of 2 staff when cate order was entered that e same instructions as above, 4/1/20, 12 days after it began. indication staff had checked e entering the order into the ntified on 12/31/20, R5 was erapy related to cancer of the and was to be an oral g was to monitor for e effects and give medication ordered, and maintain h the oncology clinic. Staff rene as necessary. 0 at 10:45 a.m., with assistant (ADON) identified the previous (DON) did the investigation for y drug error on identified on er found the 4 pills and treated vas given the medication. lity changed their procedure to rapy drug in the lock box on the nd started to count them in ore closely. When we get the nurse enters into the another nurse has to verify it would be double checked. t a 14 day supply each time,	F 760			
	nurse checks the r come in a punch c be given so it woul have an ample sup	around 6:00 p.m., and the nedications in. All medications ard which identifies the day to d be easy to see if you did not oply. The ADON was unaware DON found or did with her				

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245273	B. WING		(08/1	C 11/2020
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER		00 3RD STREET SOUTH RANKLIN, MN 55333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760	additional doses. Further interview of ADON confirmed t that occurred on 3/ additional days of H training done on 3/ what training occur medication errors of away with review of error reviewed, to p accurate training to errors. Interview on 8/10/2 pharmacy consulta aware of the chem 1/11/20 by review of reviewed the curre The PC identified s medication error reviews or asked for when an error was medication errors a quarterly QAPI me the last time she having identified R5's Xelo drug that the pharm dispensing to the fa- specialty medication monitored closely of that could happen.	nation after R5 was given four n 8/6/20 at 12:36 p.m., with the he second medication error 10/20, identified R5 received 5 his Xeloda. There was some 25/20, but she was unaware of red. The ADON confirmed heeded to be addressed right f the data surrounding the provide consistent and prevent further potential 20 at 11:46 a.m., with the ent (PC) identified she was otherapy drug error from of R5 documentation's during a not for the 3/10/20 error. PC Int Xeloda order for accuracy. the had not been given any ports during her monthly prinput on possible resolutions identified. She used to review a "long time ago" during the etings but could not remember ad seen an error report. PC bda medication is a specialty nacy has to order in before acility. The PC identified on like Xeloda should be related to all the side effects She would review a resident's	F 760	DEFICIENCY)		
	would not routinely	during her monthly audit but review each and every order at the time of her monthly				

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING		(08/ ⁻	C 11/2020
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER	-	00 3RD STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 760	identified she or AI medication errors to resolved it by re-tra- staff following an id identified if a staff medication errors as person re-take the training course. She medications as orce something to ask to Interview on 8/11/2 director (MD) ident medication errors of expect staff to be re- training was comple administration errors of potential to be sign Interview on 8/11/2 administrator (A) as concerns with medication appropriate education when an error occe with all staff and re- the process when but would expect s- manner, and monific contact pharmacy dose to alert them dispensation. The po- critical to identify we	20 at 12:21 p.m., with DON DON would review any to identify root cause and aining staff. She would council dentified medication error and would continued to have she would have that staff medication administration the expected staff to administer dered and if unsure of he charge nurse to assist. 20 at 10:24 a.m., with medical iffied he was notified of on a quarterly basis. MD would e-trained following an error. If leted on medication ors, and the error occurred bect further training to be ely to all staff. The MD agreed were a concern and had the	F 760			

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM	09/11/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245273	B. WING			C 11/2020
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKL	IN REHABILITATION	& HEALTHCARE CENTER		00 3RD STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 760	Continued From pa	-	F 760			
	of the medication a	administration process.				
	Performance Impro minutes identified to listed as discussed what the error was medication errors to in incident reports 3/16/20) were revise corrective action no	/20, Quality Assurance ovement (QAPI) meeting there was one medication error I. The minutes failed to identify , the total number of reported (3 were documented from January 1, 2020 through ewed to identify causes, eeded, potential or actual staff API planned to monitor the compliance.				
	and 1/23/20, identi medication orders. enter orders in con Always call and as not understandable double checked by TMA's (medication for clarification if so There was no indic	meeting agenda for 1/22/20 fied staff were to review The education noted: "Do not nputer that are incomplete. k for clarification if the order is e. All new orders must be another nurse for accuracy. aides) always seek your nurse omething does not feel right." ation follow-up audits occurred ation provided had corrected				
	Superior Healthcar Region policy, ider medication related meetings. The MD and address conce review resident me requested. There w the policy how or w collaborate on meet to oversee the meet	ated, Medication Therapy e Management Minnesota tified the facility was to review issues as part of their QAPI and PC were to collaborate erns identified. The PC was to edications monthly, and as vas no specific plan outlined in when the MD and PC were to dication errors, nor the PC was dication administration process owed best practice, physician				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 09/11/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245273			B. WING		C 08/11/2020
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
FRANKLIN REHABILITATION & HEALTHCARE CENTER				00 3RD STREET SOUTH	
	I		I	RANKLIN, MN 55333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLÉTION
F 760	Continued From p	bage 21 Nacy polices appropriately.	F 760		
	orders and pharm	lacy polices appropriately.			

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