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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

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 only a suggestion 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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 8/3/20 through 8/11/20, an abbreviated survey complaint investigation was conducted to determine compliance with State Licensure. Your facility was found NOT to be in compliance with the MN State Licensure. The following complaints were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	B. WING _____ A. BUILDING: _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H5273059C and H5273061C, with licensing orders issued. Additionally, the following complaints were found to be SUBSTANTIATED: H5273060C, H5273061C, H5273062C, H5273064C, H5273066C, H5273067C and H5273068C. However, no licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5273055C, H5273056C, H5273057C, H5273058C, H5273063C, and H5273065C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		9/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure the safety of 1 of 1 resident (R3) by failing to follow the care plan during a transfer. This resulted in actual harm for R3, whose fall resulted in a fractured left hip. The facility had implemented corrective action to prevent reoccurrence by 3/27/20, resulting in past non-compliance. Findings include: R3's admission record included diagnoses of hemiplegia (paralysis of one side of the body) following stroke affecting her left side, multiple sclerosis, bipolar disorder, adjustment disorder, depression, borderline personality disorder and high blood pressure. R3's 2/4/20, admission Minimum Data Set (MDS) identified R3 was cognitively impaired, had impairment on one side of the body and did not walk. R3 required extensive assist of two staff for bed mobility, and was fully dependent on two staff for transfers. R3's 4/6/20, Significant Change MDS identified R3 had improved mental cognition to no cognitive impairment, but still could not walk, required extensive assist of two staff for bed mobility, and was fully dependent on two staff for transfers. R3's 1/30/20, care plan, active at the time of R3's fall, identified R3 required assistance with Activities of Daily Living (ADL's) related to stroke and multiple sclerosis. R3 required assist of two staff for bed mobility and total assistance of two staff for transfers using a mechanical lift.	2 830	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 Review of the State Agency (SA) report filed 3/27/20, identified R3 had a fallen that day resulting in a fractured left hip. The report identified the nurse was called into R3's room by nursing assistant (NA) and a trained medication assistant (TMA). The nurse found R3 laying on left side on floor next to bed. R3 was getting ready to be transferred so the floor mat next to bed was removed. R3 was sitting up at the side of the bed. R3 had identified she stood up trying to reach for something and fell. The NA was in the room and had turned with her back to R3 to grab R3's wheelchair. The nurse completed a head to toe assessment on R3 after the fall, not noting any redness, swelling, or bruising to R3's left side. R3 rated her pain at 9 on scale of 1-10. The nurse applied Biofreeze to R3's left hip area for pain. R3 continued to complain of severe pain and swelling was later noted. R3 was sent by non-emergent ambulance at around 3:30 p.m. that day for further follow-up. Facility staff received phone call from hospital stating R3 had a left hip fracture and had been transferred for surgery. Review of the facility investigation of the fall identified R3 was a two person assist with bed mobility, and mechanical hoyer lift for transfers. Nursing assistant (NA)-A identified she sat R3 up in bed, turned her back to her and grabbed the wheelchair. R3 attempted to stand up by herself and fell. NA-A identified the fall mat was not in place as NA-A was planning on transferring R3 and was waiting for assistance from another person as she had planned to transfer R3 with a gait belt and two staff. Through staff interviews, the facility determined R3 would at times refuse to use the lift. Action taken to prevent reoccurrence to R3 included R3's transfer and bed mobility was reassessed and confirmed R3	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 had required two staff for bed mobility and total assistant with a mechanical lift. Action taken to prevent reoccurrence to other residents included the director of nursing (DON) or designee, along with therapy would review each resident's care plan to ensure current and update as needed. Further identified that on-going attendance by therapy staff at daily meeting will be mandatory to address any changes for residents. Nursing staff and therapy staff will be educated to the process. Through facility interviews it was identified NA-A was unaware R3 required a mechanical lift or where to find the NA Kardex care plan for resident's care needs. NA-A identified she knew how to care for R3 by "word of mouth." Review of investigation information found NA-A received counseling and re-education related to not following the care plan. Review of R3's progress note dated 3/27/20 at 1:39 p.m., identified the nurse was called into R3's room to find R3 on floor on her left side. R3 informed the nurse that R3 was sat up by NA-A and then she turned her back to her and R3 was talking to her when she became distracted and stood up and fell. R3 reported to nurse she hit her head and left hip. Note identified nurse assessed R3 and educated staff that R3 is a two person transfer and should not have been sitting at edge of bed. Note identified nurse had educated other staff about resident also. Progress note dated 3/27/20 identified as late entry for 12:15 p.m., identified the emergency room (ER) was called for possible fractured hip from fall. Resident had reported a lot of pain and would like to be seen. Facility nurse had not identified any swelling or redness at this time. ER nurse directed the facility to watch area and call back if swelling or increased pain noted. Progress note dated 3/27/20 at 3:38 p.m., identified R3 left for ER at	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 3:05 p.m., for an x-ray of left hip as R3 was noted to have swelling and severe pain in left hip. Progress note on 3/27/20 at 6:31 p.m., identified hospital nurse called and reported R3 had a fractured left hip and would be admitted. Observation on 8/4/20 at 8:44 a.m., R3 was observed to be transferred correctly with a mechanical lift by two staff from her wheelchair into her bed. There were no concerns identified during the transfer. Interview on 8/6/20 at 2:41 p.m., with assistant director of nursing (ADON) confirmed NA-A did not follow R3's care plan. As a result, R3 suffered a fall with a fracture. Following R3's fall, there was re-training provided to all staff on the importance of following each resident's care plan. R3 had no further falls since 3/27/20. All residents care plans had been reviewed for accuracy Interview on 8/10/20 at 9:56 a.m., with registered nurse (RN)-A identified she was the charge nurse on duty at time of R3's fall. NA-A came to get her after R3 fell to assess R3. NA-A reported she sat R3 up on edge of bed and turned to get the wheelchair when R3 fell. R3 required a total mechanical lift with two staff assistance. NA-A also reported she never had intentions of transferring R3 alone and was just getting ready for the second staff to arrive. When the nurses update a care plan, it automatically goes to the NA Kardex on the computer. All nursing assistants complete a return demonstration of skills while training on the floor with other staff. The ADON managed education and NA's were shown the Kardex. It was each nurses responsibility to ensure staff were monitored and the care plans were followed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 Interview on 8/10/20 at 12:40 p.m., with the DON identified staff have "cheat sheets" along with the NA Kardex they can reference for residents care needs. The DON would expect staff to follow the care plan and implement interventions as identified when providing care. If a resident would refuse care or interventions, she would expect staff to update the charge nurse and explain to the resident the reason for the intervention. The facility had multiple departments review the care plan for each resident and ensure implementation of the care plan. The DON was not employed at facility at time of the fall, investigation, or retraining of staff at the time R3 had fallen, but ensured present facility processes were ongoing and followed to prevent falls. Interview on 8/11/20 at 10:24 a.m., with medical director (MD) identified he is notified of falls on a quarterly basis unless there was injury. MD had been notified of R3's fall. MD would expect staff at the facility to implement the identified care plan that was put in place for each resident. Interview on 8/11/20 at 12:16 p.m., with administrator (A) verified the facility investigation found staff had not followed R3's care plan which resulted in her hip fracture. The A expected all staff to followed each resident's care plan and interventions to ensure safe transfers. The facility has routinely scheduled meetings to discuss falls and re-educate staff as needed as well as audit care provided. Review of the undated, Assessing Falls and Their Causes policy identified the purpose of the policy was to identify the cause of a fall. If a resident had a fall, staff were to assess the resident's vital signs and check for injury, providing first-aid as appropriate. Staff were to perform a post-fall	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 assessment, identify complications from the fall, implement interventions to prevent further falls, document information, and notify all appropriate personal. To correct the deficiency, the facility had conducted a root cause analysis of R3's fall, specific corrective action training was provided to the NA involved, all other residents' care plans were reviewed for accuracy, and all remaining staff were re-educated by 3/27/20. SUGGESTED METHOD OF CORRECTION: Because the deficiency was cited at PAST NON-COMPLIANCE, no method of correction is necessary.	2 830		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN 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	21525	corrected	9/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 8 (R5 and R14) identified in medication error reports. Findings include: Review of facility medication error reports from 1/1/20 through 8/5/20, identified 2 reports of medication omission related to no supply. 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 identified R14 was ordered Benadryl for nightmares while taking an antibiotic. R14 was to receive 25 milligrams (mg) at hour of sleep (hs) starting 4/6/20 through 4/12/20. R14 was not given Benadryl as ordered on 4/9/20, 4/10/20, 4/11/20, and 4/12/20, as there was no medication available. A call was placed to R14's pharmacy, who identified they had not received the order for Benadryl from nursing staff. In the past, the facility had had stock Benadryl and would not always have pharmacy fill the order if stock was available. Resolution to the error was to order a stock Benadryl supply which was to be delivered 4/16/20. There was a total of 4 doses missed for R14, identified in the report.	21525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 9 Interview on 8/6/20 at 12:36 p.m., with assistant director of nursing (ADON) identified the pharmacy delivered scheduled medications each week. Staff were responsible to order as needed medication (PRN) when low, prior to running out. The person working on the medication cart was to notify the charge nurse of the need for more medication. The charge nurse was to then order the medication from the pharmacy. The facility has an after-hours number for pharmacy they can call if there was a potential to run out. The ADON confirmed there was medication administration concerns. The facility had set up training for 8/19/20, identifying they would also be reviewing medication supply. There had been no system currently in place to prevent medication errors related to shortage of supply and ordering. Interview on 8/10/20 at 11:46 a.m., with the pharmacist consultant (PC) identified if medications ordered were not delivered it may be the pharmacy is waiting on authorization, or had not received the order. The facility should call the pharmacy if medications were not received, as the pharmacy is on-call 24 hours a day. If the pharmacy is unable get medications for some reason, facility staff were to call the provider to update, then, if appropriate, get an order to hold or change the medication if authorized. Interview on 8/10/20 at 12:21 p.m., with the director of nursing (DON) identified she would expect if staff did not have medication available as ordered, they would check the emergency kit or get a hold of the pharmacy for a dose to be sent right away. The DON's expectation was for staff to give medications as directed by the doctor and notify any appropriate person (s) right away if unable to do so.	21525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 10 Interview on 8/11/20 at 10:24 a.m., with the medical director (MD) identified he would expect the staff to contact the pharmacy if they did not have a medication available as ordered. If staff were unable to get the ordered medication from the pharmacy he would expect the nurse to contact the provider who ordered the medication for guidance. Interview on 8/11/20 at 12:16 p.m., with the administrator (A) agreed there are some concerns with medication errors and felt some strong education needed to take place. He would expect when an error occurred, the DON at that time would have met with the staff and completed a coaching form. Administrator identified he was unaware of the process if a medication is not available or did not come in from the pharmacy. He would expect that the pharmacy be contacted as soon as it was discovered if unable to obtain and potentially the charge nurse should call the local hospital ER and speak to the on-call MD for guidance. Would also expect the pharmacist consultant to be involved with the medication errors also to identify ways to prevent errors from occurring. Review of undated, Medication Therapy Policy identified the consultant pharmacist was to review medication related issues as part of its Quality Assurance Performance Improvement activities and collaborate wit the medical director to address issues. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited	21525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 11 to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could have a methodical system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21525		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or	21545		9/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 12 safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 7 residents (R5) received medications and were free of significant medication errors. R5 had potential to sustain a significant adverse reaction after receiving extra doses of a chemotherapy medication (Xeloda) on two separate occasions. Findings include: R5's quarterly Minimum Data Set (MDS) dated	21545	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 13 5/5/20, identified R5 had severe cognitive impairment but was independent with his cares after set up assistance. R5 took schedule pain medication, antipsychotic medication, and chemotherapy medication. Review of the 1/11/20, State Agency (SA) report identified R5 possibly had medication error and received four extra doses of Xeloda. Report identified there were four missing doses of Xeloda medication. The report lists it was unclear when the medication was given. Staff were interviewed and denied giving more than twice a day. R5 was assessed for side effects with none found. A call was placed to oncology and R5's doctor recommended holding the Xeloda and drawing laboratory testing. Staff would resume medication treatment after labs had been evaluated by the physician (MD). The MD later called back recommending sending R5 to hospital due to possible toxicity of medication. A call was placed to ER and ER staff recommended to call Poison Control and informed the facility they would not need to see R5. Facility staff called oncology back and were instructed to draw labs that day and update the doctor with those results. R5 had no adverse reaction and "felt fine". The investigation was completed and licensed staff were re-educated on the medication administration policy and processing of doctor orders on 1/16/20 and again on 1/22/20. There was no indication how the facility would monitor staff or the resident to ensure no future errors would occur. Review of all medication error reports for 1/1/20 through 8/5/20 identified the following medication errors. On: 1) 1/11/20, R5 received four extra doses of Xeloda (chemotherapy medication).	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 14 2) 3/2/20, R5 did not receive Advair for three days due to no supply. 3) 3/10/20 R5 received five days of additional chemotherapy drug. Immediate action action taken was to change the medication order process to discontinue (DC) medications, rather than place on hold. Staff were to put specific start and stop dates on the medication administration record (MAR). The facility contacted R5's oncology physician (MD). There was no indication what the follow-up from the MD identified, nor any training to staff on the potential significance of medication errors. Review of R5's oral chemotherapy drug order identified Xeloda 500 milligram (mg) tablets, give two tablets to equal 1000 mg twice a day. The order was on a three week cycle as follows: 1) Week 1: day 1 have labs, see doctor, intravenous (IV) chemotherapy, return to nursing home, start oral Xeloda, gets evening dose on day 1. Day 2 through 7 takes Xeloda twice a day. 2) Week 2: day 8 have labs, complete IV chemotherapy, no need to hold the morning dose of Xeloda until he returns home, day 8-14 takes Xeloda twice a day every day this week. 3) Week 3: day 15 have labs, complete IV chemotherapy, day 15 Xeloda should be completed the morning of day 15. This completes 28 doses R5 receives each cycle. No Xeloda evening of day 15 through 21. Cycle repeats for another three weeks. Review of R5's MAR identified orders on: 1) 1/23/20, Xeloda, 500 MG Give 1000 mg by mouth two times a day For 14 days then stop for a week and restart. Hold from 3/9/20 through 3/13/20. There was no indication placing a medication on hold would prompt staff to not administer the medication in the MAR electronic	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 15 documentation. 2) 3/20/20, an order was placed with the same instructions as above, but the dates identified the start as 3/20/20 and a discontinue date of 3/18/20 (2 days before the order was received) had been entered by staff. There was no indication staff had validated the order before entering it in the system, or if they had checks of 2 staff when transcribing orders. 3) 3/20/20, a duplicate order was entered that same day, with the same instructions as above, to be discontinued 4/1/20, 12 days after it began. There was also no indication staff had checked for accuracy before entering the order into the electronic MAR. R5's care plan identified on 12/31/20, R5 was receiving chemotherapy related to cancer of the liver and bile duct and was to be an oral medication. Nursing was to monitor for chemotherapy side effects and give medication and treatments as ordered, and maintain communication with the oncology clinic. Staff were also to intervene as necessary. Interview on 8/4/20 at 10:45 a.m., with assistant director of nursing (ADON) identified the previous director of nursing (DON) did the investigation for R5's chemotherapy drug error on identified on 1/11/20. They never found the 4 pills and treated the error as if R5 was given the medication. Ultimately, the facility changed their procedure to lock the chemotherapy drug in the lock box on the medication cart, and started to count them in order to monitor more closely. When we get medication orders the nurse enters into the computer and then another nurse has to verify the order, this way it would be double checked. The facility gets get a 14 day supply each time, pharmacy delivers around 6:00 p.m., and the	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	B. WING _____ A. BUILDING: _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 16 nurse checks the medications in. All medications come in a punch card which identifies the day to be given so it would be easy to see if you did not have an ample supply. The ADON was unaware what the previous DON found or did with her investigation information after R5 was given four additional doses. Further interview on 8/6/20 at 12:36 p.m., with the ADON confirmed the second medication error that occurred on 3/10/20, identified R5 received 5 additional days of his Xeloda. There was some training done on 3/25/20, but she was unaware of what training occurred. The ADON confirmed medication errors needed to be addressed right away with review of the data surrounding the error reviewed, to provide consistent and accurate training to prevent further potential errors. Interview on 8/10/20 at 11:46 a.m., with the pharmacy consultant (PC) identified she was aware of the chemotherapy drug error from 1/11/20 by review of R5 documentation's during a routine review but not for the 3/10/20 error. PC reviewed the current Xeloda order for accuracy. The PC identified she had not been given any medication error reports during her monthly reviews or asked for input on possible resolutions when an error was identified. She used to review medication errors a "long time ago" during the quarterly QAPI meetings but could not remember the last time she had seen an error report. PC identified R5's Xeloda medication is a specialty drug that the pharmacy has to order in before dispensing to the facility. The PC identified specialty medication like Xeloda should be monitored closely related to all the side effects that could happen. She would review a resident's medication orders during her monthly audit but	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 17 would not routinely review each and every order for every resident at the time of her monthly review. Interview on 8/10/20 at 12:21 p.m., with DON identified she or ADON would review any medication errors to identify root cause and resolved it by re-training staff. She would council staff following an identified medication error and identified if a staff would continued to have medication errors she would have that staff person re-take the medication administration training course. She expected staff to administer medications as ordered and if unsure of something to ask the charge nurse to assist. Interview on 8/11/20 at 10:24 a.m., with medical director (MD) identified he was notified of medication errors on a quarterly basis. MD would expect staff to be re-trained following an error. If training was completed on medication administration errors, and the error occurred again he would expect further training to be provided immediately to all staff. The MD agreed medication errors were a concern and had the potential to be significant. Interview on 8/11/20 at 12:16 p.m., with administrator (A) agreed there were ongoing concerns with medication errors and identified appropriate education was needed. He expected when an error occurred, the DON would meet with all staff and re-educate. He was not aware of the process when medications were not available, but would expect staff to order ahead in a timely manner, and monitor for delivery. Staff were to contact pharmacy prior to the next scheduled dose to alert them medication had not arrived for dispensation. The A agreed staff needed training on medication administration and order	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 18	21545		

transcription. The pharmacist consultant was critical to identify ways to prevent medication errors and should have been involved in oversight of the medication administration process.

Review of the 3/16/20, Quality Assurance Performance Improvement (QAPI) meeting minutes identified there was one medication error listed as discussed. The minutes failed to identify what the error was, the total number of medication errors reported (3 were documented in incident reports from January 1, 2020 through 3/16/20) were reviewed to identify causes, corrective action needed, potential or actual staff training, or how QAPI planned to monitor the concern to ensure compliance.

Review of nursing meeting agenda for 1/22/20 and 1/23/20, identified staff were to review medication orders. The education noted: "Do not enter orders in computer that are incomplete. Always call and ask for clarification if the order is not understandable. All new orders must be double checked by another nurse for accuracy. TMA's (medication aides) always seek your nurse for clarification if something does not feel right." There was no indication follow-up audits occurred to ensure the education provided had corrected the concern.

Review of the undated, Medication Therapy Superior Healthcare Management Minnesota Region policy, identified the facility was to review medication related issues as part of their QAPI meetings. The MD and PC were to collaborate and address concerns identified. The PC was to review resident medications monthly, and as requested. There was no specific plan outlined in the policy how or when the MD and PC were to collaborate on medication errors, nor the PC was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	900 3RD STREET SOUTH FRANKLIN, MN 55333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 19 to oversee the medication administration process to ensure staff followed best practice, physician orders and pharmacy polices appropriately. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could have a methodical system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/3/20 through 8/11/20, an abbreviated survey was completed at your facility to conduct a complaint(s) investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5273059C with deficiencies cited at F755 and F760 and H5273061C, with deficiencies cited at F689. Additionally, the following complaints were found to be SUBSTANTIATED: H5273060C, H5273061C, H5273062C, H5273064C, H5273066C, H5273067C and H5273068C. However, no deficiencies were cited. The following complaints were found to be UNSUBSTANTIATED: H5273055C, H5273056C, H5273057C, H5273058C, H5273063C, and H5273065C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential physical abuse was reported to the administrator and State agency (SA) within two hours, as required, for 2 of 2 residents (R2 and R12). Findings include:	F 609	Franklin Rehabilitation & Healthcare OHFC 609: Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions	9/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 R2's 6/2/20, quarterly Minimum Data Set (MDS) identified cognitive impairment, verbal behaviors one to three days, and was independent with all cares. R2 had diagnoses of a personality disorder and schizoaffective disorder. Review of the 6/15/20 at 8:39 a.m., State Agency (SA) report identified on 6/14/20 at 11:25 a.m., R2 was heard yelling at R12 who was standing in R2's doorway. Staff immediately intervened and observed R2 push R12, who fell to his knees. Staff separated and directed R12 back to his room. R2 followed staff to R12's room and pounded on R12's door threatening to "knock him out". Staff were able to redirect R2. The facility investigation documentation included in the report identified staff overheard R2 saying "he was in my stuff". R2 had territorial tendencies and was moved to the unsecured unit to minimize intrusive wandering of others into his room. Review of R2's care plan identified R2 was at risk and had potential for abuse related to decreased cognitive ability, wandering, and history of altercations with peers. Staff were to explain to R2 what they are doing prior to providing cares, not have R2 near others that disturb him, have a gate in his doorway to prevent others from wandering into his room, and re-direct R2 if he wandered into anyone else's room or area that was not safe for him. R2's behaviors included verbal and physical aggression when others were in his personal space, related to his diagnosis of traumatic brain injury (TBI). Staff were to anticipate his needs, intervene if he shows aggression, implement thirty minute checks at those times, redirect when they noticed he was becoming more anxious or agitated, and eat in	F 609	set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility has updated it's Reporting Abuse policy to incldue a break down of reporting timelines. All staff were educated on 8/19/20 at an all-staff meeting and were educated on reporting alleged violations in accordance with the timelines set forth in 483.12 Staff were also educated that regardless of a resident's diagnosis or any parties involved, all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. The policy also identifies that the Administrator and Director of Nursing are to be notified of all incidents immediately to help us identify which incidents would require a state agency report. Administrator will audit all incident reports daily for 2 weeks then x1 monthly for 2 months with the IDT team to determine any incidents requiring a state agency report will be done in accordance to the timelines set forth in 483.12. Results of those audits will be taken to the QAPI meeting to determine compliance or the need for further monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 his room to minimize interactions with peers related to his verbal aggression. R12's admission MDS dated 5/5/20, identified severe cognitive impairment, wandering one to three days, walks independently, requires one staff assistant for cares. Further identified diagnosis of dementia with Lewy bodies, anxiety disorder, diabetic, and COPD. Review of R12's care plan identified R12 is at risk for potential abuse related to Lewy body dementia with behavioral disturbances, impaired communication, and mental health diagnosis. R12 has a history of intrusive wandering. Staff are to remove from dangerous situations and redirect. Care plan identified behaviors related to history of suicide ideation's with attempt of self injury. Staff are to anticipate and meet his needs. R12 has psychiatry consult as needed. Interview on 8/5/20 at 9:32 a.m., with R2's family member (FM)-A confirmed R2 had these types of behaviors and feels there is only so much the facility can do with him. FM-A identified the facility is actively trying to come up with solutions to prevent R2 from having inappropriate interactions with his peers. FM-A identified R2 was unable to care for himself or his lifestyle and that is why he is this way. FM-A identified that the facility listens to her suggestions and they try to keep R2 from inappropriate interactions even though he can be so rude. FM-A identified what she can do is talk with him when he needs me or is feeling anxious even though he just says the same thing over and over. Interview on 8/11/20 at 1:00 p.m., with the administrator confirmed the SA report had been	F 609	Compliance Date: 9/9/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4 filed late. The Administrator identified when he started at the facility there was still some confusion about reporting within the two hour time frame. Staff here thought that the two hour reporting time frame was for serious injury. Staff thought that if there was a resident to resident interaction between two residents with dementia and no harm it did not need to be reported within the two hour time frame but did within twenty four hours. Requested abuse reporting policy, received undated, Reporting Abuse to Facility Management Superior Healthcare Management Minnesota Region policy. Review of policy identified employee, consultants, family, visitors, and/or physicians are to report promptly any incident or suspected incident of abuse or neglect, including theft, misappropriation of resident property, or injuries of unknown source to the facility management. Policy identifies abuse as the willful infliction of injury, confinement, intimidation, or punishment resulting in harm, pain or mental anguish. The policy had no mention of reporting to the SA and timelines of reporting.	F 609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		8/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 Based on observation, interview and document review, facility failed to ensure the safety of 1 of 1 resident (R3) by failing to follow the care plan during a transfer. This resulted in actual harm for R3, whose fall resulted in a fractured left hip. The facility had implemented corrective action to prevent reoccurrence by 3/27/20, resulting in past non-compliance. Findings include: R3's admission record included diagnoses of hemiplegia (paralysis of one side of the body) following stroke affecting her left side, multiple sclerosis, bipolar disorder, adjustment disorder, depression, borderline personality disorder and high blood pressure. R3's 2/4/20, admission Minimum Data Set (MDS) identified R3 was cognitively impaired, had impairment on one side of the body and did not walk. R3 required extensive assist of two staff for bed mobility, and was fully dependent on two staff for transfers. R3's 4/6/20, Significant Change MDS identified R3 had improved mental cognition to no cognitive impairment, but still could not walk, required extensive assist of two staff for bed mobility, and was fully dependent on two staff for transfers. R3's 1/30/20, care plan, active at the time of R3's fall, identified R3 required assistance with Activities of Daily Living (ADL's) related to stroke and multiple sclerosis. R3 required assist of two staff for bed mobility and total assistance of two staff for transfers using a mechanical lift. Review of the State Agency (SA) report filed	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 3/27/20, identified R3 had a fallen that day resulting in a fractured left hip. The report identified the nurse was called into R3's room by nursing assistant (NA) and a trained medication assistant (TMA). The nurse found R3 laying on left side on floor next to bed. R3 was getting ready to be transferred so the floor mat next to bed was removed. R3 was sitting up at the side of the bed. R3 had identified she stood up trying to reach for something and fell. The NA was in the room and had turned with her back to R3 to grab R3's wheelchair. The nurse completed a head to toe assessment on R3 after the fall, not noting any redness, swelling, or bruising to R3's left side. R3 rated her pain at 9 on scale of 1-10. The nurse applied Biofreeze to R3's left hip area for pain. R3 continued to complain of severe pain and swelling was later noted. R3 was sent by non-emergent ambulance at around 3:30 p.m. that day for further follow-up. Facility staff received phone call from hospital stating R3 had a left hip fracture and had been transferred for surgery. Review of the facility investigation of the fall identified R3 was a two person assist with bed mobility, and mechanical hoyer lift for transfers. Nursing assistant (NA)-A identified she sat R3 up in bed, turned her back to her and grabbed the wheelchair. R3 attempted to stand up by herself and fell. NA-A identified the fall mat was not in place as NA-A was planning on transferring R3 and was waiting for assistance from another person as she had planned to transfer R3 with a gait belt and two staff. Through staff interviews, the facility determined R3 would at times refuse to use the lift. Action taken to prevent reoccurrence to R3 included R3's transfer and bed mobility was reassessed and confirmed R3	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 had required two staff for bed mobility and total assistant with a mechanical lift. Action taken to prevent reoccurrence to other residents included the director of nursing (DON) or designee, along with therapy would review each resident's care plan to ensure current and update as needed. Further identified that on-going attendance by therapy staff at daily meeting will be mandatory to address any changes for residents. Nursing staff and therapy staff will be educated to the process. Through facility interviews it was identified NA-A was unaware R3 required a mechanical lift or where to find the NA Kardex care plan for resident's care needs. NA-A identified she knew how to care for R3 by "word of mouth." Review of investigation information found NA-A received counseling and re-education related to not following the care plan. Review of R3's progress note dated 3/27/20 at 1:39 p.m., identified the nurse was called into R3's room to find R3 on floor on her left side. R3 informed the nurse that R3 was sat up by NA-A and then she turned her back to her and R3 was talking to her when she became distracted and stood up and fell. R3 reported to nurse she hit her head and left hip. Note identified nurse assessed R3 and educated staff that R3 is a two person transfer and should not have been sitting at edge of bed. Note identified nurse had educated other staff about resident also. Progress note dated 3/27/20 identified as late entry for 12:15 p.m., identified the emergency room (ER) was called for possible fractured hip from fall. Resident had reported a lot of pain and would like to be seen. Facility nurse had not identified any swelling or redness at this time. ER nurse directed the facility to watch area and call back if swelling or increased pain noted. Progress note dated	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 3/27/20 at 3:38 p.m., identified R3 left for ER at 3:05 p.m., for an x-ray of left hip as R3 was noted to have swelling and severe pain in left hip. Progress note on 3/27/20 at 6:31 p.m., identified hospital nurse called and reported R3 had a fractured left hip and would be admitted. Observation on 8/4/20 at 8:44 a.m., R3 was observed to be transferred correctly with a mechanical lift by two staff from her wheelchair into her bed. There were no concerns identified during the transfer. Interview on 8/6/20 at 2:41 p.m., with assistant director of nursing (ADON) confirmed NA-A did not follow R3's care plan. As a result, R3 suffered a fall with a fracture. Following R3's fall, there was re-training provided to all staff on the importance of following each resident's care plan. R3 had no further falls since 3/27/20. All residents care plans had been reviewed for accuracy Interview on 8/10/20 at 9:56 a.m., with registered nurse (RN)-A identified she was the charge nurse on duty at time of R3's fall. NA-A came to get her after R3 fell to assess R3. NA-A reported she sat R3 up on edge of bed and turned to get the wheelchair when R3 fell. R3 required a total mechanical lift with two staff assistance. NA-A also reported she never had intentions of transferring R3 alone and was just getting ready for the second staff to arrive. When the nurses update a care plan, it automatically goes to the NA Kardex on the computer. All nursing assistants complete a return demonstration of skills while training on the floor with other staff. The ADON managed education and NA's were shown the Kardex. It was each nurses responsibility to ensure staff were monitored and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 the care plans were followed. Interview on 8/10/20 at 12:40 p.m., with the DON identified staff have "cheat sheets" along with the NA Kardex they can reference for residents care needs. The DON would expect staff to follow the care plan and implement interventions as identified when providing care. If a resident would refuse care or interventions, she would expect staff to update the charge nurse and explain to the resident the reason for the intervention. The facility had multiple departments review the care plan for each resident and ensure implementation of the care plan. The DON was not employed at facility at time of the fall, investigation, or retraining of staff at the time R3 had fallen, but ensured present facility processes were ongoing and followed to prevent falls. Interview on 8/11/20 at 10:24 a.m., with medical director (MD) identified he is notified of falls on a quarterly basis unless there was injury. MD had been notified of R3's fall. MD would expect staff at the facility to implement the identified care plan that was put in place for each resident. Interview on 8/11/20 at 12:16 p.m., with administrator (A) verified the facility investigation found staff had not followed R3's care plan which resulted in her hip fracture. The A expected all staff to followed each resident's care plan and interventions to ensure safe transfers. The facility has routinely scheduled meetings to discuss falls and re-educate staff as needed as well as audit care provided. Review of the undated, Assessing Falls and Their Causes policy identified the purpose of the policy was to identify the cause of a fall. If a resident	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 had a fall, staff were to assess the resident's vital signs and check for injury, providing first-aid as appropriate. Staff were to perform a post-fall assessment, identify complications from the fall, implement interventions to prevent further falls, document information, and notify all appropriate personal. To correct the deficiency, the facility had conducted a root cause analysis of R3's fall, specific corrective action training was provided to the NA involved, all other residents' care plans were reviewed for accuracy, and all remaining staff were re-educated by 3/27/20.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		9/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §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. Findings include: Review of facility medication error reports from 1/1/20 through 8/5/20, identified 2 reports of medication omission related to no supply. 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	F 755	Franklin Rehabilitation & Healthcare OHFC 755: Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable 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 upon 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 identified R14 was ordered Benadryl for nightmares while taking an antibiotic. R14 was to receive 25 milligrams (mg) at hour of sleep (hs) starting 4/6/20 through 4/12/20. R14 was not given Benadryl as ordered on 4/9/20, 4/10/20, 4/11/20, and 4/12/20, as there was no medication available. A call was placed to R14's pharmacy, who identified they had not received the order for Benadryl from nursing staff. In the past, the facility had had stock Benadryl and would not always have pharmacy fill the order if stock was available. Resolution to the error was to order a stock Benadryl supply which was to be delivered 4/16/20. There was a total of 4 doses missed for R14, identified in the report. Interview on 8/6/20 at 12:36 p.m., with assistant director of nursing (ADON) identified the pharmacy delivered scheduled medications each week. Staff were responsible to order as needed medication (PRN) when low, prior to running out. The person working on the medication cart was to notify the charge nurse of the need for more medication. The charge nurse was to then order the medication from the pharmacy. The facility has an after-hours number for pharmacy they can call if there was a potential to run out. The ADON confirmed there was medication administration concerns. The facility had set up training for 8/19/20, identifying they would also be reviewing medication supply. There had been no system currently in place to prevent medication errors related to shortage of supply and ordering. Interview on 8/10/20 at 11:46 a.m., with the pharmacist consultant (PC) identified if medications ordered were not delivered it may be the pharmacy is waiting on authorization, or had not received the order. The facility should call the	F 755	reflect information on reordering and after hour pharmacy services. "DON/Designee will audit medication orders to ensure compliance with facility policy on Medication Orders and Medication Administration daily on each 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 pharmacist and Thrifty White Pharmacy to discuss delivery expectations and concerns. The consulting pharmacist noted that the pharmacy does have a 24 hr. line in emergent cases of needing medications and will deliver promptly. The consulting pharmacist also conducts medication regimen reviews monthly and is invited to participate in monthly and quarterly QAPI meetings to discuss pharmacy services. The facility will review medication errors on a monthly basis with the consulting pharmacist to identify and address concerns. "Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of the facilities Medication Orders and Medication Administration policy. Results of those audits will be taken to the QAPI meeting to determine compliance or the need for further monitoring. "Completion date: 9.9.20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13 pharmacy if medications were not received, as the pharmacy is on-call 24 hours a day. If the pharmacy is unable get medications for some reason, facility staff were to call the provider to update, then, if appropriate, get an order to hold or change the medication if authorized. Interview on 8/10/20 at 12:21 p.m., with the director of nursing (DON) identified she would expect if staff did not have medication available as ordered, they would check the emergency kit or get a hold of the pharmacy for a dose to be sent right away. The DON's expectation was for staff to give medications as directed by the doctor and notify any appropriate person (s) right away if unable to do so. Interview on 8/11/20 at 10:24 a.m., with the medical director (MD) identified he would expect the staff to contact the pharmacy if they did not have a medication available as ordered. If staff were unable to get the ordered medication from the pharmacy he would expect the nurse to contact the provider who ordered the medication for guidance. Interview on 8/11/20 at 12:16 p.m., with the administrator (A) agreed there are some concerns with medication errors and felt some strong education needed to take place. He would expect when an error occurred, the DON at that time would have met with the staff and completed a coaching form. Administrator identified he was unaware of the process if a medication is not available or did not come in from the pharmacy. He would expect that the pharmacy be contacted as soon as it was discovered if unable to obtain and potentially the charge nurse should call the local hospital ER and speak to the on-call MD for	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14 guidance. Would also expect the pharmacist consultant to be involved with the medication errors also to identify ways to prevent errors from occurring. Review of undated, Medication Therapy Policy identified the consultant pharmacist was to review medication related issues as part of its Quality Assurance Performance Improvement activities and collaborate wit the medical director to address issues.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 7 residents (R5) received medications and were free of significant medication errors. R5 had potential to sustain a significant adverse reaction after receiving extra doses of a chemotherapy medication (Xeloda) on two separate occasions. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/5/20, identified R5 had severe cognitive impairment but was independent with his cares after set up assistance. R5 took schedule pain medication, antipsychotic medication, and chemotherapy medication. Review of the 1/11/20, State Agency (SA) report identified R5 possibly had medication error and	F 760	Franklin Rehabilitation & Healthcare OHFC 760: Preparation, submission, and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F760 "R5 is a current resident at Franklin Rehabilitation & Healthcare "All Residents at Franklin Rehabilitation & Healthcare who are receiving medication management have the potential to be	9/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 15 received four extra doses of Xeloda. Report identified there were four missing doses of Xeloda medication. The report lists it was unclear when the medication was given. Staff were interviewed and denied giving more than twice a day. R5 was assessed for side effects with none found. A call was placed to oncology and R5's doctor recommended holding the Xeloda and drawing laboratory testing. Staff would resume medication treatment after labs had been evaluated by the physician (MD). The MD later called back recommending sending R5 to hospital due to possible toxicity of medication. A call was placed to ER and ER staff recommended to call Poison Control and informed the facility they would not need to see R5. Facility staff called oncology back and were instructed to draw labs that day and update the doctor with those results. R5 had no adverse reaction and "felt fine". The investigation was completed and licensed staff were re-educated on the medication administration policy and processing of doctor orders on 1/16/20 and again on 1/22/20. There was no indication how the facility would monitor staff or the resident to ensure no future errors would occur. Review of all medication error reports for 1/1/20 through 8/5/20 identified the following medication errors. On: 1) 1/11/20, R5 received four extra doses of Xeloda (chemotherapy medication). 2) 3/2/20, R5 did not receive Advair for three days due to no supply. 3) 3/10/20 R5 received five days of additional chemotherapy drug. Immediate action action taken was to change the medication order process to discontinue (DC) medications, rather than place on hold. Staff were to put specific start	F 760	affected. "Licensed nursing staff are educated upon hire/annually/PRN on the Medication Orders and Medication Administration policy. Licensed nursing staff have been educated following the event on September 9th, 2020 by DON/Designee. "DON/Designee will audit medication orders to ensure compliance with facility policy on Medication Orders and Medication Administration daily on each shift for one month and then x1 audit weekly for two additional months. "Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of the facility□s Medication Orders and Medication Administration policies. Results of those audits will be taken to the QAPI meeting to determine compliance or the need for further monitoring. "Completion date: 9.9.20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 16	F 760		

and stop dates on the medication administration record (MAR). The facility contacted R5's oncology physician (MD). There was no indication what the follow-up from the MD identified, nor any training to staff on the potential significance of medication errors.

Review of R5's oral chemotherapy drug order identified Xeloda 500 milligram (mg) tablets, give two tablets to equal 1000 mg twice a day. The order was on a three week cycle as follows:
1) Week 1: day 1 have labs, see doctor, intravenous (IV) chemotherapy, return to nursing home, start oral Xeloda, gets evening dose on day 1. Day 2 through 7 takes Xeloda twice a day.
2) Week 2: day 8 have labs, complete IV chemotherapy, no need to hold the morning dose of Xeloda until he returns home, day 8-14 takes Xeloda twice a day every day this week.
3) Week 3: day 15 have labs, complete IV chemotherapy, day 15 Xeloda should be completed the morning of day 15. This completes 28 doses R5 receives each cycle. No Xeloda evening of day 15 through 21.
Cycle repeats for another three weeks.

Review of R5's MAR identified orders on:
1) 1/23/20, Xeloda, 500 MG Give 1000 mg by mouth two times a day For 14 days then stop for a week and restart. Hold from 3/9/20 through 3/13/20. There was no indication placing a medication on hold would prompt staff to not administer the medication in the MAR electronic documentation.
2) 3/20/20, an order was placed with the same instructions as above, but the dates identified the start as 3/20/20 and a discontinue date of 3/18/20 (2 days before the order was received) had been entered by staff. There was no indication staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 17 had validated the order before entering it in the system, or if they had checks of 2 staff when transcribing orders. 3) 3/20/20, a duplicate order was entered that same day, with the same instructions as above, to be discontinued 4/1/20, 12 days after it began. There was also no indication staff had checked for accuracy before entering the order into the electronic MAR. R5's care plan identified on 12/31/20, R5 was receiving chemotherapy related to cancer of the liver and bile duct and was to be an oral medication. Nursing was to monitor for chemotherapy side effects and give medication and treatments as ordered, and maintain communication with the oncology clinic. Staff were also to intervene as necessary. Interview on 8/4/20 at 10:45 a.m., with assistant director of nursing (ADON) identified the previous director of nursing (DON) did the investigation for R5's chemotherapy drug error on identified on 1/11/20. They never found the 4 pills and treated the error as if R5 was given the medication. Ultimately, the facility changed their procedure to lock the chemotherapy drug in the lock box on the medication cart, and started to count them in order to monitor more closely. When we get medication orders the nurse enters into the computer and then another nurse has to verify the order, this way it would be double checked. The facility gets get a 14 day supply each time, pharmacy delivers around 6:00 p.m., and the nurse checks the medications in. All medications come in a punch card which identifies the day to be given so it would be easy to see if you did not have an ample supply. The ADON was unaware what the previous DON found or did with her	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 18 investigation information after R5 was given four additional doses. Further interview on 8/6/20 at 12:36 p.m., with the ADON confirmed the second medication error that occurred on 3/10/20, identified R5 received 5 additional days of his Xeloda. There was some training done on 3/25/20, but she was unaware of what training occurred. The ADON confirmed medication errors needed to be addressed right away with review of the data surrounding the error reviewed, to provide consistent and accurate training to prevent further potential errors. Interview on 8/10/20 at 11:46 a.m., with the pharmacy consultant (PC) identified she was aware of the chemotherapy drug error from 1/11/20 by review of R5 documentation's during a routine review but not for the 3/10/20 error. PC reviewed the current Xeloda order for accuracy. The PC identified she had not been given any medication error reports during her monthly reviews or asked for input on possible resolutions when an error was identified. She used to review medication errors a "long time ago" during the quarterly QAPI meetings but could not remember the last time she had seen an error report. PC identified R5's Xeloda medication is a specialty drug that the pharmacy has to order in before dispensing to the facility. The PC identified specialty medication like Xeloda should be monitored closely related to all the side effects that could happen. She would review a resident's medication orders during her monthly audit but would not routinely review each and every order for every resident at the time of her monthly review.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 19 Interview on 8/10/20 at 12:21 p.m., with DON identified she or ADON would review any medication errors to identify root cause and resolved it by re-training staff. She would council staff following an identified medication error and identified if a staff would continued to have medication errors she would have that staff person re-take the medication administration training course. She expected staff to administer medications as ordered and if unsure of something to ask the charge nurse to assist. Interview on 8/11/20 at 10:24 a.m., with medical director (MD) identified he was notified of medication errors on a quarterly basis. MD would expect staff to be re-trained following an error. If training was completed on medication administration errors, and the error occurred again he would expect further training to be provided immediately to all staff. The MD agreed medication errors were a concern and had the potential to be significant. Interview on 8/11/20 at 12:16 p.m., with administrator (A) agreed there were ongoing concerns with medication errors and identified appropriate education was needed. He expected when an error occurred, the DON would meet with all staff and re-educate. He was not aware of the process when medications were not available, but would expect staff to order ahead in a timely manner, and monitor for delivery. Staff were to contact pharmacy prior to the next scheduled dose to alert them medication had not arrived for dispensation. The A agreed staff needed training on medication administration and order transcription. The pharmacist consultant was critical to identify ways to prevent medication errors and should have been involved in oversight	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 20 of the medication administration process. Review of the 3/16/20, Quality Assurance Performance Improvement (QAPI) meeting minutes identified there was one medication error listed as discussed. The minutes failed to identify what the error was, the total number of medication errors reported (3 were documented in incident reports from January 1, 2020 through 3/16/20) were reviewed to identify causes, corrective action needed, potential or actual staff training, or how QAPI planned to monitor the concern to ensure compliance. Review of nursing meeting agenda for 1/22/20 and 1/23/20, identified staff were to review medication orders. The education noted: "Do not enter orders in computer that are incomplete. Always call and ask for clarification if the order is not understandable. All new orders must be double checked by another nurse for accuracy. TMA's (medication aides) always seek your nurse for clarification if something does not feel right." There was no indication follow-up audits occurred to ensure the education provided had corrected the concern. Review of the undated, Medication Therapy Superior Healthcare Management Minnesota Region policy, identified the facility was to review medication related issues as part of their QAPI meetings. The MD and PC were to collaborate and address concerns identified. The PC was to review resident medications monthly, and as requested. There was no specific plan outlined in the policy how or when the MD and PC were to collaborate on medication errors, nor the PC was to oversee the medication administration process to ensure staff followed best practice, physician	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 08/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 21 orders and pharmacy polices appropriately.	F 760		