Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

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

RE: CCN: 245273
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 16, 2025, we notified you a remedy was imposed.

On April 30, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 30, 2025.

As authorized by CMS the remedy of:

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

In our letter of April 16, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 1, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 30, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

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

Re: Reinspection Results
Event ID: ZUSU12

Dear Administrator:

On April 30, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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April 16, 2025

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

RE: CCN: 245273
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, 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 location for imposition. The CMS location 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 May 1, 2025.

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

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

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2025 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:

Steven.Delich@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 04/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/2/25 and 4/3/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52732125C (MN00111763 and MN00111762) H52732502C (MN00111773) AND The following complaints were reviewed: H52732082C (MN00111701) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
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	F 689		4/25/25

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

Electronically Signed — 04/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to thoroughly investigate falls, establish adequate fall prevention interventions, and follow care planned fall interventions for 2 of 3 residents (R1 and R5) reviewed for falls. This resulted in actual harm when R1 fell and required a visit to the emergency department resulting in a fractured left tenth rib. Findings include: R1's Face Sheet dated 9/30/24, indicated R1 had hemiplegia affecting her right dominant side, dementia, disorientation, and muscle weakness. R1's Fall Risk Assessment dated 1/3/25, indicated R1 was a high risk for falls. R1's quarterly Minimum Data Set (MDS) dated 1/6/25, indicated R1 had severe cognitive impairment, had two or more falls without injury, and needed limited assistance with transfers, toilet use, and bed mobility. R1's care plan undated, indicated R1 was at high risk for falls and to ensure R1 was wearing appropriate footwear: non-skid socks or tennis shoes when ambulating or mobilizing in wheelchair. Other interventions included to educate R1 not to stand without assistance, anticipate needs, ensure call light was within reach, encourage call light usage, prompt response to all requests for assistance, and	F 689	1. The Care Plans for residents R1 and R5 have been reviewed and revised to include appropriate fall prevention interventions. Updates to the Care Plans are automatically populated into the Kardex via PCC to ensure nursing staff are promptly informed of changes. Nursing staff have been educated on the process of updating interventions, revising Care Plans, and utilizing the Kardex for real-time communication and implementation. 2. A facility-wide audit of residents with fall risk has been completed to ensure Care Plans and interventions are appropriate, comprehensive, and up to date. Staff have received additional education on fall incident reporting, investigation protocols, and timely implementation of care plan revisions. 3. The Director of Nursing (DON) or designee will review all fall incidents to ensure thorough investigations are conducted and appropriate follow-up occurs. Random audits of Care Plans and Kardex entries will be completed monthly for 3 months, with results reviewed during Quality Assurance meetings. 4. Nursing staff received in-service education on fall prevention strategies, documentation requirements, and care	

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F 689	Continued From page 2 therapy would evaluate and treat as ordered. R1's unwitnessed fall document dated 12/20/24, indicated R1 was found on the floor next to her wheelchair due to trying to self-transfer to the bathroom. No interventions were identified on the document. R1's witnessed fall document dated 2/4/25, indicated R1 had fallen trying to stand from wheelchair alone. No interventions were identified on the document. R1's unwitnessed fall document dated 2/27/25, indicated R1 had fallen from her wheelchair when trying to stand alone. Intervention indicated R1 was re-educated not to stand up alone. R1's progress note dated 3/22/25 at 6:34 a.m., indicated R1 had fallen as she was trying to use the bathroom at 5:15 a.m., with no injury noted. R1's progress note dated 3/22/25 at 10:00 a.m., indicated R1 was crying in pain at her left lower rib and left hip area. R1 was sent to the emergency department for evaluation. R1's progress note dated 3/22/25 at 1:43 p.m., indicated R1 had a nondisplaced tenth left rib fracture. R1's investigation report undated, indicated R1 would have a call don't fall sign placed in room, care plan would be updated, and staff would be educated on call light times and anticipating the needs of residents who are at risk for falls. R1's care sheet undated, lacked any fall interventions.	F 689	plan adherence. New hires will receive this training as part of their orientation process.	

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F 689	Continued From page 3 R1's medical record lacked IDT review, root cause analysis, or appropriate fall interventions after each fall. R5's Face Sheet dated 1/17/23, indicated R1 has Alzheimer's disease, dementia, mild neurocognitive disorder, and muscle weakness. R5's fall risk assessment dated 2/19/25, indicated R1 was at high risk for falls. R5's significant change MDS dated 2/20/25, indicated R5's memory was not assessed, had 2 or more falls with no injury, and one fall with minor injury. R1 needed extensive assistance with toileting. R5's care plan dated 1/17/23, indicated R1 was at moderate risk for falls. Interventions included anticipate residents needs, currently on hospice to manage end of life care, wear appropriate footwear such as rubber soled skid- free shoes, slippers, or non skid socks when ambulating. R5's unwitnessed fall document dated 3/9/35, indicated R1 missed his chair when attempting to sit down and fell. No interventions were identified on the document. R5's witnessed fall document dated 3/19/25, indicated R1 slid out of his wheelchair and was on the floor. No interventions were identified on the document. R5's fall with suspected head injury document dated 3/29/25 at 12:00 a.m., indicated R1 was found on the floor next to his bed with bowel movement in his brief. Had an injury to the top of	F 689		

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F 689	Continued From page 4 his scalp. No interventions were identified on the document. R5's unwitnessed fall dated 3/29/25 at 2:40 a.m., R1 was found on the floor next to his bed. No interventions were identified on the document. R5's care sheet undated, lacked any fall interventions. R5's medical record lacked IDT review, root cause analysis, or appropriate fall interventions after each fall. During an observation on 4/2/25 at 11:18 a.m., R1 did not have a call don't fall sign in her room. During an observation on 4/3/25 at 8:29 a.m., R1 was in the common area with blue star socks on that did not have grip on the bottoms of them and no shoes on. During an interview on 4/3/25 at 8:40 a.m., nursing assistant (NA)-A stated residents fall interventions would be on the resident care sheets or care plans. NA-A stated she was not aware of what the current interventions were for R1 or R5. On 4/3/25 at 9:10 a.m., NA-B stated fall interventions for R1 and R5 were on the care sheet NA-B keeps in her pocket. NA-B stated currently there were no fall interventions in place for R1 or R5 according to the care sheets. NA-B stated she was not aware of any fall intervention in place for R1 or R5 at this time. On 4/3/25 at 9:15 a.m., licensed practical nurse (LPN)-A stated she assisted R1 and R5 with	F 689		

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F 689	Continued From page 5 cares the morning of 4/3/25 but had not looked at their care plans to see what fall interventions are currently in place. LPN-A stated she put socks on R1 and thought they were gripper socks but was not aware they are not. LPN-A stated R1 should have had gripper socks or shoes on. LPN-A stated there was a process issue with who was responsible for producing interventions after a residents fall. LPN-A stated the director of nursing (DON) and interdisciplinary team (IDT) are the ones who would assign the interventions and put them in the care plans. LPN-A stated she was not sure why interventions had not been put into place after residents had fallen. On 4/3/25 at 10:10 a.m., registered nurse-(RN)-A stated the DON used to be the one who put fall interventions in the care plans, but she was not sure who would be responsible for that now. R1 was expected to have shoes or gripper socks on when she was in her wheelchair. RN-A stated she was not sure why fall interventions were not being put into place or care planned. On 4/3/25 at 10:29 a.m., the DON stated RN-A was expected to update the care plans with fall interventions for R1 and R5. Staff were expected to look at the care plans to find fall interventions. DON stated she was not sure why fall interventions were not being put into place after every fall, but she expected this to be completed. DON stated there were no fall interventions care planned for R1 or R5's falls. On 4/3/25 at 12:20 p.m., the medical director (MD)-A stated he was concerned there were no interventions care planned for R1 and R5 after their falls. MD-A stated he would have expected interventions to be put into place right after the	F 689		

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F 689	Continued From page 6 fall. If R1 had interventions in place after prior falls the potential for falls could have been decreased and could have helped prevent her fracture. The facility should have followed the facility policy in regard to falls. The facility Fall Prevention Program policy reviewed 8/2024, indicated when a resident experienced a fall the facility would review and update the care plan as needed and document all assessments and actions. Interventions would be monitored for effectiveness.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: ZUSU11

Dear Administrator:

The above facility was surveyed on April 2, 2025, through April 3, 2025, 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:

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

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 04/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 4/2/25 and 4/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H52732125C (MN00111763 and MN00111762) H52732502C (MN00111773) AND The following complaints were reviewed. H52732082C (MN00111701) with a licensing order issued at 0830. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	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. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to thoroughly investigate falls, establish adequate fall prevention interventions, and follow care planned fall	2 830	Corrected	4/25/25

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2 830	Continued From page 3 interventions for 2 of 3 residents (R1 and R5) reviewed for falls. This resulted in actual harm when R1 fell and required a visit to the emergency department resulting in a fractured left tenth rib. Findings include: R1's Face Sheet dated 9/30/24, indicated R1 had hemiplegia affecting her right dominant side, dementia, disorientation, and muscle weakness. R1's Fall Risk Assessment dated 1/3/25, indicated R1 was a high risk for falls. R1's quarterly Minimum Data Set (MDS) dated 1/6/25, indicated R1 had severe cognitive impairment, had two or more falls without injury, and needed limited assistance with transfers, toilet use, and bed mobility. R1's care plan undated, indicated R1 was at high risk for falls and to ensure R1 was wearing appropriate footwear: non-skid socks or tennis shoes when ambulating or mobilizing in wheelchair. Other interventions included to educate R1 not to stand without assistance, anticipate needs, ensure call light was within reach, encourage call light usage, prompt response to all requests for assistance, and therapy would evaluate and treat as ordered. R1's unwitnessed fall document dated 12/20/24, indicated R1 was found on the floor next to her wheelchair due to trying to self-transfer to the bathroom. No interventions were identified on the document. R1's witnessed fall document dated 2/4/25, indicated R1 had fallen trying to stand from	2 830		

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2 830	Continued From page 4 wheelchair alone. No interventions were identified on the document. R1's unwitnessed fall document dated 2/27/25, indicated R1 had fallen from her wheelchair when trying to stand alone. Intervention indicated R1 was re-educated not to stand up alone. R1's progress note dated 3/22/25 at 6:34 a.m., indicated R1 had fell as she was trying to use the bathroom at 5:15 a.m., with no injury noted. R1's progress note dated 3/22/25 at 10:00 a.m., indicated R1 was crying in pain at her left lower rib and left hip area. R1 was sent to the emergency department for evaluation. R1's progress note dated 3/22/25 at 1:43 p.m., indicated R1 had a nondisplaced tenth left rib fracture. R1's investigation report undated, indicated R1 would have a call don't fall sign placed in room, care plan would be updated, and staff would be educated on call light times and anticipating the needs of residents who are at risk for falls. R1's care sheet undated, lacked any fall interventions. R1's medical record lacked IDT review, root cause analysis, or appropriate fall interventions after each fall. R5's Face Sheet dated 1/17/23, indicated R1 has Alzheimer's disease, dementia, mild neurocognitive disorder, and muscle weakness. R5's fall risk assessment dated 2/19/25, indicated R1 was at high risk for falls.	2 830		

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2 830	Continued From page 5 R5's significant change MDS dated 2/20/25, indicated R5's memory was not assessed, had 2 or more falls with no injury, and one fall with minor injury. R1 needed extensive assistance with toileting. R5's care plan dated 1/17/23, indicated R1 was at moderate risk for falls. Interventions included anticipate residents needs, currently on hospice to manage end of life care, wear appropriate footwear such as rubber soled skid- free shoes, slippers, or non skid socks when ambulating. R5's unwitnessed fall document dated 3/9/35, indicated R1 missed his chair when attempting to sit down and fell. No interventions were identified on the document. R5's witnessed fall document dated 3/19/25, indicated R1 slid out of his wheelchair and was on the floor. No interventions were identified on the document. R5's fall with suspected head injury document dated 3/29/25 at 12:00 a.m., indicated R1 was found on the floor next to his bed with bowel movement in his brief. Had an injury to the top of his scalp. No interventions were identified on the document. R5's unwitnessed fall dated 3/29/25 at 2:40 a.m., R1 was found on the floor next to his bed. No interventions were identified on the document. R5's care sheet undated, lacked any fall interventions. R5's medical record lacked IDT review, root cause analysis, or appropriate fall interventions	2 830		

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2 830	Continued From page 6 after each fall. During an observation on 4/2/25 at 11:18 a.m., R1 did not have a call don't fall sign in her room. During an observation on 4/3/25 at 8:29 a.m., R1 was in the common area with blue star socks on that did not have grip on the bottoms of them and no shoes on. During an interview on 4/3/25 at 8:40 a.m., nursing assistant (NA)-A stated residents fall interventions would be on the resident care sheets or care plans. NA-A stated she was not aware of what the current interventions were for R1 or R5. On 4/3/25 at 9:10 a.m., NA-B stated fall interventions for R1 and R5 were on the care sheet NA-B keeps in her pocket. NA-B stated currently there were no fall interventions in place for R1 or R5 according to the care sheets. NA-B stated she was not aware of any fall intervention in place for R1 or R5 at this time. On 4/3/25 at 9:15 a.m., licensed practical nurse (LPN)-A stated she assisted R1 and R5 with cares the morning of 4/3/25 but had not looked at their care plans to see what fall interventions are currently in place. LPN-A stated she put socks on R1 and thought they were gripper socks but was not aware they are not. LPN-A stated R1 should have had gripper socks or shoes on. LPN-A stated there was a process issue with who was responsible for producing interventions after a residents fall. LPN-A stated the director of nursing (DON) and interdisciplinary team (IDT) are the ones who would assign the interventions and put them in the care plans. LPN-A stated she was not sure why interventions had not been put into	2 830		

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2 830	Continued From page 7 place after residents had fallen. On 4/3/25 at 10:10 a.m., registered nurse-(RN)-A stated the DON used to be the one who put fall interventions in the care plans, but she was not sure who would be responsible for that now. R1 was expected to have shoes or gripper socks on when she was in her wheelchair. RN-A stated she was not sure why fall interventions were not being put into place or care planned. On 4/3/25 at 10:29 a.m., the DON stated RN-A was expected to update the care plans with fall interventions for R1 and R5. Staff were expected to look at the care plans to find fall interventions. DON stated she was not sure why fall interventions were not being put into place after every fall, but she expected this to be completed. DON stated there were no fall interventions care planned for R1 or R5's falls. On 4/3/25 at 12:20 p.m., the medical director (MD)-A stated he was concerned there were no interventions care planned for R1 and R5 after their falls. MD-A stated he would have expected interventions to be put into place right after the fall. If R1 had interventions in place after prior falls the potential for falls could have been decreased and could have helped prevent her fracture. The facility should have followed the facility policy in regard to falls. The facility Fall Prevention Program policy reviewed 8/2024, indicated when a resident experienced a fall the facility would review and update the care plan as needed and document all assessments and actions. Interventions would be monitored for effectiveness. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 8 The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, to ensure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		