



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 9, 2026

Administrator
Franklin Restorative Care Center
900 3RD STREET SOUTH
FRANKLIN, MN 55333

RE: CCN: 245273

Cycle Start Date: April 23, 2026

Dear Administrator:

On July 2, 2026, we informed you that we may impose enforcement remedies.

On June 23, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On 06/11/2026, the situation of immediate jeopardy to potential health and safety cited at F689-Free of Accident Hazards/Supervision/Devices was removed.

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 July 24, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 24, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 24, 2026.

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.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Franklin Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 23, 2026. This prohibition remains in effect for the specified period even though substantial compliance is

attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

**Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us**

Office: (320) 223-7374 Mobile: (320) 423-0619

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 October 23, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the

Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

A copy of the Department's informal dispute resolution policies is posted on the MDH

Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

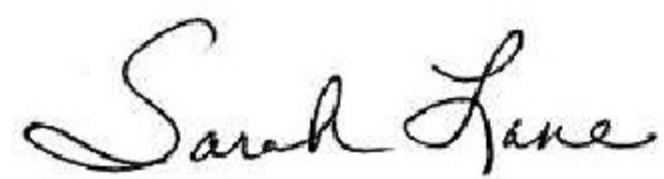
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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Electronically delivered

July 9, 2026

Administrator
Franklin Restorative Care Center
900 3RD STREET SOUTH
FRANKLIN, MN 55333

Re: State Nursing Home Licensing Orders

Event ID: 235F93-H1

Dear Administrator:

The above facility survey was completed on June 23, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

**Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us**

Office: (320) 223-7374 Mobile: (320) 423-0619

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.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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August 19, 2026

Administrator
FRANKLIN RESTORATIVE CARE CENTER
900 3RD STREET SOUTH
FRANKLIN, MN 55333

RE: CCN: 245273

Cycle Start Date: April 23, 2026

Dear Administrator:

On July 9, 2026, we notified you a remedy was imposed. On August 18, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 12, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 24, 2026, be discontinued as of August 12, 2026. (42 CFR 488.417 (b))

In our letter of July 9, 2026, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 23, 2026. 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,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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August 19, 2026

Administrator
FRANKLIN RESTORATIVE CARE CENTER
900 3RD STREET SOUTH
FRANKLIN, MN 55333

Re: Reinspection Results
Event ID: 235F93-H2

Dear Administrator:

On July 30, 2026 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 June 23, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2026	
NAME OF PROVIDER OR SUPPLIER FRANKLIN RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 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
F0000	INITIAL COMMENTS On 6/16/26 through 6/18/26 and 6/22/26 through 6/23/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52732794C with deficiencies issued at F580 and F684 and H52732924C with deficiencies issued at F689, F835, F609, F610 F689 was cited at Immediate Jeopardy, Past Noncompliance resulting in substandard quality of care Based on interview, observation and document reviews, the facility failed to adequately supervise and maintain resident safety when resident (R4), with a history of exiting the facility unsupervised, eloped through the front door of the facility, and drove an employee vehicle in the parking lot. This resulted in an Immediate Jeopardy (IJ) situation for R4. In addition, the facility failed to implement a system to ensure adequate supervision was provided for R4, when the exit alarm system panel was not labeled to alert staff to the exit door that R4 opened. F835 was cited at Immediate Jeopardy Based on interview, video/audio recording review and document review, the facility administration directed staff not to report or document a resident elopement. The administration's direction not to			F0000			07/19/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2026	
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F0000	Continued from page 1 report, prevented immediate identification and correction of failures in supervision, alarm response, staff training, and elopement prevention, leaving residents exposed to continued risk of elopement and serious injury and demonstrated a breakdown of the facility's governing systems for resident protection, quality assurance, and promoted an ongoing culture of fear of the facility being shut down, retaliation and regulatory noncompliance. The former director of nursing (DON), regional clinical consultant (RCC), chief operating officer (COO), social service designee (SSD), and owner all failed to ensure allegations of reportable events were reported to the State Agency (SA) and thoroughly investigated to protect a resident (R4) from further occurrence. This noncompliance had the potential to affect all 31 residents that resided at this facility. 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.			F0000			07/19/2026
F0835 SS = L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, video/audio recording review and document review, the facility administration directed staff not to report or document a resident elopement. The administration's direction not to report, prevented immediate identification and correction of failures in supervision, alarm response, staff training, and elopement prevention, leaving residents exposed to continued risk of elopement and serious injury and demonstrated a breakdown of			F0835	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Immediate education was provided to the Regional Clinical Consultant and Nursing Home Administrator by the Regional Director of Operations on 6/18/2026 on reporting How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected 30 days progress notes reviewed for reportable incidents – there were no documented elopement events in the medical record. Facility completed reportable on the 6/6/26 incident involving G.K		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2026	
NAME OF PROVIDER OR SUPPLIER FRANKLIN RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 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
F0835 SS = L	Continued from page 2 the facility's governing systems for resident protection, quality assurance, and promoted an ongoing culture of fear of the facility being shut down, retaliation and regulatory noncompliance. The former director of nursing (DON), regional clinical consultant (RCC), chief operating officer (COO), social service designee (SSD), and owner all failed to ensure allegations of reportable events were reported to the State Agency (SA) and thoroughly investigated to protect a resident (R4) from further occurrence. This noncompliance had the potential to affect all 31 residents that resided at this facility. The IJ began on 6/6/26 when the former DON notified the administrator and RCC that R4 eloped from the facility, entered an employee's vehicle with the keys inside, and drove the vehicle independently to a loading/delivery dock next to the facility. In addition, when the former DON reported the incident internally, the RCC told the former DON not to report to the SA and not to document the reportable elopement event. The immediate jeopardy was identified on 6/18/26 and the administrator, assistant administrator, and the RCC were informed of the IJ on 6/18/23 at 4:53 p.m. The immediate jeopardy was removed on 6/23/26 at 2:20 p.m., but noncompliance remained at the lower scope and severity of F, which is widespread, level 2, indicating no actual harm with potential for more than minimal harm that is not immediate jeopardy Findings Include: Refer to F689, F609, F610 R4's quarterly Minimum Data Set (MDS) dated 6/2/26, identified severely impaired cognition and indicated he experienced delusions; had acute mental changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former DON reported that R4 had eloped on 6/6/26, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned about R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC) direction.			F0835	Continued from page 2 which was called in to your office 30 days incident reports reviewed for reportable incidents with none identified What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education initiated on Abuse Neglect Exploitation Requirements, Reporting Requirements, Reporting Timelines, Mandated Reporter, Free from Retaliation, Expectation Report, Investigate, Fix with all staff on 6/18/2026 with no staff being allowed to work until they receive education. Effective immediately, the Administrator/designee will conduct daily leadership meetings to review resident safety concerns, unresolved department issues, grievances, reportable events, staffing concerns, pending audits, and follow-up on corrective actions. These meetings will continue daily Monday through Friday for 2 weeks, then weekly for 4 weeks, and then monthly through QAPI until sustained compliance is achieved. The Administrator/designee will complete daily rounds throughout the facility to validate that resident needs are being met, staff concerns are addressed, and any identified concerns are escalated and corrected timely. Findings will be documented and reviewed with the interdisciplinary team. Regional leadership will provide increased oversight to the facility, including review of corrective actions, department follow-through, audit results, and ongoing compliance. The Regional Director of Operations will review progress with the Administrator/DON at least weekly until substantial compliance is sustained. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is		07/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2026	
NAME OF PROVIDER OR SUPPLIER FRANKLIN RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
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F0835 SS = L	Continued from page 3 During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an employee's vehicle, and administration including the RCC and administrator directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. E-B indicated knowledge of reporting requirements and identified although the administrator and RCC were notified immediately, they did not report the elopement event to the state agency (SA). E-B further stated the administrator and corporate overall were not reporting "reportable" events and were threatening staff jobs and licenses if they did report. E-B defined corporate as the administrator and RCC. Further identified nursing staff was "not allowed" to report any event to the SA and there was a fear of retaliation for going against what corporate advises. E-B also voiced concerns related to adequate staff training. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse at approximately 11:20 a.m. to 11:40 a.m., she and other staff were in rooms assisting residents when she heard a "beeping" noise, she investigated and found that it was the door alarm system but the zones on the master alarm board were not labeled so did not know which door was activated. She had available staff check rooms and she went out the east door by the offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck driving into the "dock" or delivery bay area and noted the man in the driver's seat as R4. R4 exited the running truck and tried to get into the locked employees' door when she was able to intervene. R4 then proceeded to get back into the driver's side of the running truck but the former DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The former DON was then able to safely assist R4 back into the building without any apparent injuries. The former DON also identified the facility is surrounded by a corn field, deep "gulch" or drop-off, and a road. The former DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The			F0835	Continued from page 3 maintained		07/23/2026

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F0835 SS = L	Continued from page 4 former DON then called the RCC at 12:48 p.m. per the administrator's direction. The former DON reported she was told, "you don't say anything, don't document it, don't report it, like it never happened because they [SA] will shut the building down and it will be all your fault; listen to what I tell you or I will have your license". The former DON confirmed she did not document the event in R4's medical record, do an incident report, investigate the elopement, or report to the SA. The former DON reported there was an interdisciplinary meeting (IDT) on 6/9/26 at 10:30 a.m. and discussed the elopement event and identified the administrator, social service designee (SSD), corporate SSD, owner, RCC, and COO were present at the meeting and again discussed not reporting the elopement incident to the SA. The former DON stated she was "walked out" by the administrator and RCC the day the abbreviated survey began (6/16/26). The former DON further indicated she was walked out of the building and employment terminated when she told the RCC and administrator that she wanted to talk to the SA surveyor and was not aware of any previous issues with her job performance. During an interview on 6/17/26 at 1:56 p.m., E-H indicated the former DON reported R4's elopement on 6/6/26, but did not know much about the elopement except that it should have been reported and investigated but facility nursing leadership were "threatened" by the administration defined as RCC and administrator not to report the elopement to the SA and was not sure if R4's elopement was investigated. E-H further stated, "there is lots of issues with retaliation threats around here". During an interview on 6/17/26 at 2:40 p.m., the administrator stated on 6/6/26 she was unavailable and did not have cellular service so did not have the details of R4's elopement incident; the former DON did not notify her. The administrator stated, "he [R4] was supervised from what I know". The administrator stated it was not reported to the SA because R4 was supervised the "whole time" he was out of the building on 6/6/26 so it was not considered an elopement and not reportable. The administrator further stated, "unless I see it first-hand, I don't report it" and "there are a lot of differing opinions" The administrator indicated if staff came to her with concerns she would not automatically report. She would request the concern be in writing and then would review the concern to determine if it was reportable or not. The administrator said she is not a nurse and counts on the nursing judgement to decide. The administrator			F0835			07/23/2026

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F0835 SS = L	Continued from page 5 added staff were to report concerns to the rapid response team which includes the RCC. She further stated we got “chewed out” by the medical director at QAPI because they weren’t reporting reportable events. And further identified, “we need to be more diligent about our risk management” and were going to be doing training with the staff today at 5:00 pm. The administrator denied ever telling a staff person not to report to the SA. During a follow-up interview on 6/23/25 at 11:56 a.m., the former DON reviewed her call history log, and it identified the following calls sent and received following R4’s elopement on 6/6/26: 11:57 a.m. the former DON called the administrator and left a voicemail. 12:34 p.m. the administrator returned the DON's call. 12:48 p.m. the former DON called the RCC and had a 22-minute conversation, 1:11 p.m. the DON called the administrator and had an 18-minute conversation. The former DON stated R4’s elopements were discussed during the phone calls. During an interview on 6/17/26 at 3:58 p.m., the RCC stated, “their system is broke” and an elopement is considered neglect and should be reported to the SA. The RCC further stated, “I was not notified on 6/6/26 [of R4’s elopement], the only thing I know was from reviewing his chart” and insisted R4 had direct supervision by staff during the incident on 6/6/26. The RCC further identified she was told by nursing assistants (NA)s and nursing staff and that egress alarms were not loud enough and could not be discerned between them and a call light, so the egress alarms were installed after R4’s 6/6/26 incident and they did not know what the zones to the door alarm were. The RCC stated she would not tell anyone not to report, that she was an “over reporter”, and if she had known about R4’s elopements, they would have been reported to the SA. During an interview on 6/18/26 at 10:06 a.m., E-E indicated on 6/6/26 just before lunch, she witnessed R4 drive her truck up to the side of the building, got out of the truck, attempted to re-enter a locked employee entrance door, and then get back into the running vehicle before the former DON was able to intervene and pulled the keys out of the ignition. E-E stated she immediately called the administrator			F0835			07/23/2026

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F0835 SS = L	Continued from page 6 to tell her what happened, but the administrator wanted to talk to the former DON and was instructed to submit her statement of the incident in writing. E-E then called her immediate supervisor to report the incident as well. E-E stated she wrote a two-page statement of the incident and submitted it to the administrator on 6/8/26 but she had not been contacted or had any follow-up from the administrator. 6/23/26 at 11:13 a.m., a review of screenshots from E-E's phone call history log identified the following calls sent and received following R4's elopement on 6/6/26: 11:50 a.m. E-E called the administrator 12:49 p.m. received a voicemail back from the administrator that stated the administrator thought she had already talked to E-E about the situation and was directed to write out a statement about the situation with her car and she would be talking with the former DON again shortly. On 6/18/26 at 4:33 p.m., a review of E-E's undated written statement to the administrator, identified on 6/6/26 at approximately 11:30 a.m., R4 was able to leave the facility without staff knowledge and get to the employees parking lot and drive her vehicle. Before the resident was able to enter her vehicle, he had exited the building and traveled across the property undetected by staff. R4 operated the vehicle for a short time before the situation was contained. R4 was under supervision and care of the facility at the time of the incident but was still able to leave the building and reach the parking lot with her knowledge or involvement to help search for R4. This statement also identified E-E's biggest concern was the knowledge of R4's history of wandering and wanted to document that R4 was able to exit the facility one or two more times that same day after the elopement and once the following day (6/7/26). E-E understood the fire door alarms inside the building were only activated after the other three elopement incidents occurred later that day and the next day. E-E's written statement also identified E-E had been informed by a nurse that the same door alarms had been turned off because it was disturbing to the other residents at night. E-E also wrote that she was informed that R4 on a different occasion, had entered the former DON's office after it had been left open and began eating Hot Cheetos, despite R4's diet of pureed and thickened-liquid diet. During an interview on 6/18/26 at 2:31 p.m., the			F0835			07/23/2026

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F0835 SS = L	Continued from page 7 facility medical director (MD) indicated R4's elopements were discussed at the 6/15/26 QAPI (Quality Assurance Performance Improvement) meeting and there had been some confusion amongst facility management about what an elopement was. The medical director stated he had not been informed that R4 had gotten into a vehicle and drove it but, even without the knowledge of R4 driving an employee's vehicle, he felt it was reportable to SA. The MD did not know why the facility did not report it, but they should have reported it to the SA and investigated. As a result of the 6/15/26 meeting, he requested they review every elopement for reportability. The MD identified the facility leadership had a lot of turnover. During an interview on 6/18/26 at 1:48 p.m., the administrator stated she was out of town on the weekend of 6/6/26 and there was no record of herself or the RCC being notified of R4's eloping and driving an employee's truck on 6/6/26. When asked about receiving a note from E-E regarding the incident, she stated she had received a note but did not recall when she had received it and presented the note to the surveyor from a file cabinet with an unrelated coaching moment stapled over the top of the two-page note. The administrator then indicated E-E had called her on 6/6/26 to complain about her vehicle and told her not to leave her keys in it. RCC, also present during the interview, stated she was unaware the administrator had received a statement from E-E and was not notified until "sometime the next day" (6/7/26). When asked about a meeting to discuss R4's elopement, RCC stated they had a meeting on Tuesday (6/9/26) about what to do to keep the residents safe but not about reportability. At this time, the surveyor played the video/audio recording of the 6/9/26 meeting and the Administrator and RCC provided no further comments. Review of an employee provided video/audio recording of the meeting that occurred on Tuesday, 6/9/26 at 10:30 a.m., identified those present included the former DON, administrator, social service designee, corporate social service designee, owner, RCC, and COO. The audio identified RCC starting the meeting by stating, "I want everyone to truly be clear and understand why we didn't report this [6/6/26 elopement] this weekend. You all need to understand that we didn't report this, we talked about it in QAPI, because he has done this numerous times that wasn't reported; he left the building. Anytime any resident leaves a secure area unattended, it's technically an elopement; so, when			F0835			07/23/2026

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F0835 SS = L	Continued from page 8 he [R4] went down the basement, it was an elopement and should have been reported.” “If we report this now, they [SA] will dig through his chart with a fine-tooth comb, and your building will be shut down.” The RCC further stated, “I’m gonna tell you it’s killing me because I said at one point that I would never compromise our principles again, but I am having to because you all have decided to keep things in house and not tell us and communicate with us in the past numerous times.”....” If they come in on [referenced another resident’s name] that would be an IJ when she was banging her head against the wall until she was black and blue and no one protected her, that would be an IJ. If they go through your chart and look and dig, there is enough that they could find, so we need to shut the book, we need to start keeping our residents safe, and doing the right thing” ... “so what are we doing right now to keep them safe” SSD then explained the steps about how they are keeping R4 safe. RCC summarized the meeting by stating, “I just need everyone to understand why we didn’t report it”. The former DON stated “I need to say that this weekend I can’t attest that people were standing at the nursing station watching him walk out the building just that they were at the desk after that, looking like they did not know where the zones were, so the zones are labeled as well now” Review of the facility's Licensed Nursing Home Administrator job description indicated the administrator is responsible for ensuring residents receive quality care and services in compliance with all applicable regulations. Responsibilities include oversee compliance with regulatory standards (CMS, state, and local); maintain open communications with residents, families, and staff; ensure ongoing survey readiness and regulatory compliance; promote a positive culture of accountability, respect, and teamwork. Review of facilities undated rapid response protocol indicated in case of a resident elopement, send email to corporate rapid response group; call will be scheduled with the following to review the incident with administrator, DON, COO, RCC, owner, and other staff as necessary. The immediate jeopardy that began on 6/6/26 was removed on 6/23/26, when the regional director of operations educated the corporate clinical consultant and administrator on reporting; the facility educated all staff on abuse neglect exploitation requirements, reporting requirements, reporting timelines, mandated reporter, free from retaliation, expectation of the report, investigative process; reviewed 30			F0835			07/23/2026

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F0835 SS = L	Continued from page 9 days of resident progress notes, grievances, and incident for reportable incidents; and reported R4's elopement to the SA.			F0835			07/23/2026
F0689 SS = SQC-J	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: Based on interview, observation and document reviews, the facility failed to adequately supervise and maintain resident safety when resident (R4), with a history of exiting the facility unsupervised, eloped through the front door of the facility, and drove an employee vehicle in the parking lot. This resulted in an Immediate Jeopardy (IJ) situation for R4. In addition, the facility failed to implement a system to ensure adequate supervision was provided for R4, when the exit alarm system panel was not labeled to alert staff to the exit door that R4 opened. The IJ began on 6/6/2026, when R4, who was assessed to be an elopement risk, was exhibiting exit seeking behavior just prior to the incident, exited through the front door of the facility, was able to enter an employee's vehicle with the keys inside, and drove across the employee parking lot before being observed by staff. The facility Administrator and the regional clinical coordinator (RCC) were notified of the IJ on 6/18/26 at 4:35 p.m. The IJ was removed on 6/8/26 and the deficient practice corrected on 6/11/26, prior to the start of the survey and was therefore past noncompliance. Findings include: R4's Admission Record indicated he was admitted to the facility on 9/4/25. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in			F0689	"Past Noncompliance - no plan of correction required"		07/19/2026

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F0689 SS = SQC-J	Continued from page 10 mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated 6/2/26, identified severely impaired cognition and indicated he experienced delusions; had acute mental changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. R4's care plan also identified him as a high fall risk related to diagnoses and ambulation without well-fit gripped footwear. R4's facility Progress Notes identified the following: 5/17/26 at 11:02 a.m., behavior charting indicated R4 exhibited exit seeking at all doors and agitation. Attempted redirection, distractions, and PRN's (as needed medications) but were ineffective. 5/18/26 at 1:01 p.m., R4 continued to exit seek; was agitated and wanted to go home. R4 was unable to			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 11 be redirected which led to increased behaviors. The note lacked information related to which behaviors R4 demonstrated. 5/20/26 at 5:22 a.m., during the night R4 was confused and tried to get out the doors, R4 redirected. 5/22/26 at 3:07 p.m., R4's son was notified of R4 wandering out of the building and his attempts at trying to elope after learning the door codes from watching staff. The nature of the call was to discuss possible elopement; the facility provided 15-minute checks. 5/24/26 at 4:45 a.m., R4 wandered into other resident rooms, looked for exits to elope, stated he was going home, and was aggressive and combative to redirection. R4 refused to take PRN risperidone (antipsychotic medication). 15-minute checks continued. 5/24/26 at 6:46 p.m., R4 had gotten out into the locked courtyard within a minute or two, but staff redirected him back into the building. The administrator and prior DON were notified by phone. The note lacked additional information or interventions to mitigate continued self-entry into the locked courtyard. 5/25/26 at 9:15 a.m., R4 continued to exit seek with increased agitation when staff redirected. R4 ignored door alarms and any other devices used to keep him away from doors. The note lacked information on intervention(s) to mitigate R4's increased agitation or decrease his exit-seeking behavior. 5/25/26 at 8:49 p.m., R4 was actively exit seeking, wandering, and entering other residents' rooms during the PM (evening) shift, difficult to redirect or reassure; voiced concerns about farm equipment and hogs; asked other residents for a ride "just a few miles up the road". Redirection was only successful for a couple of minutes and repeated behaviors. The note lacked information on intervention(s) to mitigate R4's behaviors or decrease his exit-seeking behavior. 5/31/26 at 10:42 a.m., R4 was agitated, aggressive, and unstoppable, and headed out through an exit door. An ambulance was called and he was transferred to the emergency department for evaluation. R4 returned at 2:00 p.m. with notes to schedule an appointment with physician to follow up on medication adjustments.			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 12 6/2/26 at 10:35 a.m., facility reached out to locked facilities for R4's relocation. 6/3/26 at 9:02 a.m., R4 managed to get out of the locked door by pushing on it for an extended period of time which released the lock's safety feature. R4 immediately tried to re-enter the building. Staff unlocked the door and R4 re-entered. The note lacked information on intervention(s) to mitigate or decrease his exit-seeking behavior. 6/3/26 at 3:57 p.m., R4 wandered hallways, attempted to elope through the exterior door by the business offices. R4 wanted to leave the building to go to work and check on the status of his farm. Interventions attempted were 1:1 time with staff, redirection, and activities but were ineffective. 6/6/26 at 11:18 a.m., R4 wandered and was exit seeking. R4 had been walking with conviction all morning since 6:30 a.m. and seemed to be on edge about how hot it is outside and getting the hogs he had loaded to slaughter. Interventions attempted included removal of departure cues (keys, coats, shoes) from sight, redirection, food, sensory board, socialization with peers and staff but he continued to wander, and exit seek. R4's progress notes, including his medical record, lacked information related to R4's 6/6/26 elopement from the facility and driving an employee's vehicle as evidenced below in staff interviews. 6/6/26 at 3:47 p.m., R4 continued to wander, pushed doors, and went into other residents' rooms. R4 stated he just wanted to get out the door. The note lacked information on intervention(s) to mitigate or decrease his exit-seeking behaviors. 6/7/26 at 1:03 p.m., R4 exhibited severe agitation, anxiety, and exit-seeking behavior throughout the shift; continued to make attempts to leave despite staff interventions. 6/11/26 at 9:09 p.m., R4 was assigned a 1:1 (one-on-one) staff supervision. 6/12/26 at 9:39 a.m., R4 discharged to an assisted living facility. R4's Resident Location Charting from 5/29/26 to 6/8/26, lacked care planned 15-minute checks documentation at the following times: 5/29/26, from 6:45 a.m. to 6:00p.m.			F0689			07/19/2026

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NAME OF PROVIDER OR SUPPLIER FRANKLIN RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
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F0689 SS = SQC-J	Continued from page 13 5/30/26, from 6:45 a.m. to 6:00 p.m. 5/31/26, from 6:30 a.m. to 6:00 p.m. 6/1/26, from 9:30 a.m. to 10:30 a.m. and 2:15 p.m. to 6:00 p.m. 6/2/26 from 12:15 p.m. to 1:15 p.m. 6/4/26 from 5:45 a.m. to 12:00 p.m. 6/5/26 from 6:45 a.m. to 6:00 p.m. 6/6/26 (day of the elopement), from 6:45 a.m. to 6:00 p.m. 6/7/26 from 7:15 a.m. to 6:00 p.m. 6/8/26, from 9:45 a.m. to 12:00 p.m., then identified 1:1 staffing. R4's Every 15-Minute Check Sheet dated 6/8/26 had 15-minute checks crossed out and "at all times" written in because R4 "got outside". This form started at 3:30 p.m. with complete documentation until discharge. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former director of nursing (DON) reported that R4 had eloped on 6/6/26, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned for R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC) direction. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an employee's vehicle, and administration including the RCC and administrator directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 14 facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and two other staff were on duty but were in rooms assisting residents when she heard a “beeping” noise. At first, she thought the beeping noise was a call light and then investigated and realized it was the exit door alarm system, but the zones on the master alarm board were not labeled so she did not know which door had been opened and activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The DON continued across the visitors parking lot and saw a white pickup truck heading into the “dock” or delivery bay and recognized the man in the driver's seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked employees’ door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver's side of the running truck, but the DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The DON was then able to safely assist R4 back into the building without any apparent injuries. The DON identified the facility is surrounded by a corn field, deep “gulch” or drop-off, and a road and all posed risks to R4's safety. The DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The DON then called the RCC at 12:48 p.m. and was instructed to not chart the incident in R4's medical record, not to do an incident report, and not report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4's medical record, did not do an incident report, nor report it to the SA. The DON stated she was “walked out” by the administrator and RCC the day the abbreviated survey began (6/16/26). The former DON further indicated she was walked out of the building and employment terminated when she told the RCC and administrator that she wanted to talk to the SA surveyor and was not aware of any previous issues with her job performance. During interview on 6/17/26 at 1:13 p.m., E-C identified on 6/6/26 “just before lunch” the door alarms went off as they were busy with another resident. The door alarms sounded like call lights, and thus it was hard to tell if it was the call light system or the door alarm. E-C stated they figured it was R4 because R4 frequently tried to get out, and they were unaware which door he went out. By the time R4 was found, he was coming in the back door by the employee parking lot. E-C denied seeing R4			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 15 drive the vehicle but heard about it. E-C explained she thought R4 was on 15-minute checks on 6/6/26, but indicated they did not have enough staff that day to do the 15 minute checks on R4. On 6/8/26, new door alarms were placed on the doors. During an interview on 6/17/26 at 1:27 p.m., E-D indicated on 6/6/26 at approximately 11:30 a.m., she heard the door “buzzers” but was not sure which door it was. By the time they found out which door had alarmed, the DON found R4 in the truck. R4 tried to elope “a lot” and was on 15-minute checks but this was changed to 1:1 staff “at all times” after the elopement. After the 6/6/26 incident, the zones were labeled on the exit door main panel for staff to know which door was alarming. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements the beginning of May and now the one in June that prompted R4’s move to a more secured home. The SSD stated he was not present during the recent elopement, the former DON reported that R4 had gotten into an employee’s vehicle and pulled it forward. He explained the facility front yard sits next to a steep “drop off”, “valley”, “gulch” with trees and brush which put R4 at risk if he were to get too close to the edge and fall down the valley. R4 was on 15-minute checks but after the elopement was changed to 1:1 staffing until his discharge. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she observed R4 driving her truck to the delivery/docking bay next to the employee entrance. R4 got out of the truck, walked around to the employee entrance door, and tried to pull the locked door open. R4 appeared to be talking to someone. Upon further inspection, she saw the DON met him at the employee entrance, in which R4 then walked back to the running truck and got in the driver’s side. At that time, the DON was able to get into the passenger side of the vehicle, shut the ignition off, and pull the keys out of the ignition. E-E explained her truck was parked approximately 5-6 parking spots from the employee entrance and R4 would have had to back up the truck and drive around other parked vehicles and drive by the garage before pulling into the docking/delivery bay. E-E did not know how long R4 had driven the truck. She described the weather that day as hot and muggy and R4 was wearing a sweatshirt, sweatpants, and yellow grippy socks that had grass and gravel stuck to them. E-E identified R4 was an elopement risk and had eloped through the front			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 16 door by the offices two more times the day after he drove her truck. One time, another resident alerted staff that R4 was outside; however, she was not sure where they found him the second time he eloped. Additionally, E-E stated there were a set of double fire doors at the end of the East hall before the actual facility exit doors that were always supposed to be shut and alarmed because he tried to elope so often. The purpose of the double door alarms were to alert staff prior to R4 exiting the building but she had frequently observed that the door alarms were shut off and was told by an un-named charge nurse that the door alarms were shut off because R4 set them off so often, it disturbed the residents. E-E provided two videos of the double fire doors at the end of the hall; one video of the doors alarmed and one that she stated she took on 6/7/26 (after R4's elopement) of the double door alarms not working. E-E stated she took the videos because the facility administration had tried to make R4's elopement on 6/6/26 her fault and she wanted proof that the doors were not alarmed. During interview on 6/22/26 at 12:07 p.m., family member (FM)-A stated R4 did not have a valid driver's license as it was revoked after R4 got into trouble while driving around lost, and when the police tried to pull him over, R4 tried to flee the police officer. FM-A indicated the facility told him R4 tried to get into a vehicle on 6/6/26 but he was not aware that R4 had driven it and further stated, he was not surprised by this because R4 roamed the halls and tried to get out of the facility constantly, FM-A further indicated when he visited R4 on 6/7/26, he learned R4 had just eloped out the back and got away from staff. During an interview on 6/23/26 at 10:04 a.m., E-F indicated she was not present when R4 took an employee's vehicle, but she had observed R4 "escape" out into the courtyard without staff knowledge many times, and on one occasion, he was in the bushes trying to climb the fence. E-F stated that R4 should have had more supervision because of his history of "escaping". During an interview on 6/23/26 at 10:10 a.m., E-G stated she had observed R4 enter the kitchen and was attempting to elope out the door but went down the basement stairs instead. E-G stated she called for nursing, and they responded and redirected him. E-G stated, "they should be supervising him more closely". During an observation with E-E on 6/23/26 at 10:55			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 17 a.m., and following the route out the door R4 exited, based on interviews where the truck was parked in the employee parking lot and the initial sighting of R4 driving in the vehicle, took a person out the front door by the business offices which has a sharp, wooded, drop off behind a two open rail fence beyond approximately 25 feet of grassy area; he then went East and walked through the visitor parking lot and windows of an unoccupied area of the business offices and physical therapy room; walked West across the lawn and between the garage and trash dumpsters to the vehicle parked approximately 50-100 feet into the gravel parking lot with other employee vehicles parked in the lot; a corn field and gravel road were adjacent to the parking lot to the south; entered the truck and backed the truck out forward 50-100 feet to the east edge of the employee parking lot and turned the vehicle to the south between the employee's smoking area and facility garage; pulled the vehicle up the docking/delivery bay with approximately 10 feet between the front of the truck and the facility. During a Follow up interview on 6/23/26 at 11:56 a.m., the prior DON stated she did not document the elopement in R4's medical record because the RCC and administrator told her not to. The former DON reiterated that on 6/6/26, R4 left the building unsupervised. The following facility's corrective actions dated 6/11/2026, were verified as implemented prior to the survey: 6/8/26, zones on the door alarm panel were labeled. 6/9/26 "screamer" door alarms were installed on the exit doors. 6/9/26 elopement assessments were completed on all in-house residents. 6/10/26, the elopement book was reviewed and updated, and care plans were reviewed 6/11/26, education completed with all staff on Abuse, Neglect, and Exploitation Policy, Elopements and Wandering Policy, and Accidents and Supervision Policy to include the 15 second egress on all exit doors and Screamers. Additionally, documentation supports 1:1 staff supervision for R4 was initiated. The undated facility policy titled, Elopements and Wandering Residents indicated the facility ensured that residents who exhibit wandering behavior			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 18 and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Defines elopement when a resident leaves the premises or safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locs/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. The undated facility policy titled, Accidents and Supervision, identified the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This included: identifying hazard(s) and risk(s), Evaluating and analyzing hazard(s) and risk(s), Implementing interventions to reduce hazard(s) and risk(s), Monitoring for effectiveness and modifying interventions when necessary Definitions: "Accident" refers to any unexpected or unintentional incident, which results in injury or illness to a resident; "Environment" refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not			F0689			07/19/2026

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F0689 SS = SQC-J	Continued from page 19 limited to) the residents’ rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas; “Hazards” refers to elements of the resident environment that have the potential to cause injury or illness; “Risk” refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.; “Supervision/Adequate Supervision” refers to intervention and means of mitigating risk of an accident. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision; defined by type and frequency; based on the individual resident's assessed needs and identified hazards in the resident environment			F0689			07/19/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure call lights were functional and within reach for 3 of 8 residents (R1, R5, and R7) reviewed for call light placement. Findings include: R1’s significant change in status Minimum Data Set (MDS) dated 5/24/26, identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included schizophrenia, acute respiratory failure with hypoxia, and malnutrition. R1’s fall focus care plan identified R1 was at risk for falls related to incontinence, poor communication/comprehension, psychoactive drug use, mental health diagnoses, and behavior of throwing herself backwards. Interventions included be sure call light is within reach and courage her to use it for assistance if needed. During observation and interview on 6/17/26 at 9:34 a.m., R1 was lying in bed and stating she needed to			F0558	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R1 was provided a soft touch call light on 6/26/26 R5 was provided a new call light on 6/16/26 R7 call light was provided his call light on 6/16/26 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice Immediate rounds were completed on 6/16/26 to ensure that call lights were accessible and in place An audit was completed on 6/24/26 by plant operations on all rooms to ensure call lights are functional with no exposed wires Residents with limited mobility and/or upper body strength were evaluated by nursing to ensure their ability to use their call light on 6/29/26		07/23/2026

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F0558 SS = D	Continued from page 20 use the bathroom. R1 was unable to locate her call light and when it was given to her, she could not push the button. R1 stated she “couldn’t hold it anymore” and needed to go to the bathroom. Evaluator pushed the call light for her and ADON responded and acknowledged R1 likely did not have the strength to push that button and would get a soft touch call light for her. R5's quarterly Minimum Data Set (MDS) dated 4/22/26, identified R5 had moderately impaired cognition and needed staff assistance for toileting, dressing, bed mobility, and transferring. Diagnoses included cervical disc disorder with myelopathy (arthritic condition affect the neck joints), bipolar disorder (mental health disorder that causes extreme mood swings), and chronic obstructive pulmonary disease (lung disease causing breathing problems). R5's fall focus care plan identified R5 was a high risk for falls related to gait/balance problems and safety awareness (history of impulsiveness). Interventions included to be sure R5's call light was within reach and encourage the resident to use it for assistance. R5 needed prompt response to all requests for assistance. During an observation and interview on 6/16/26 at 9:55 a.m., R5 was sitting in his wheelchair watching television. R5 stated he was sitting in his “torture chair” and had a lot of pain in his “bottom”, rating his pain a “9” on a 0-10 pain scale. R5 wanted a pain pill but could not reach either of the two call lights in his room and stated he could not move his wheelchair to get to them. Defined himself as being “stuck”. Both call lights were closed inside his bedside table drawer and were out of reach. One call light cord appeared frayed with exposed wires. At 10:05 a.m., Licensed practical nurse (LPN)-A entered the room with R5's pain pill and acknowledged R5 could not reach his call lights and proceeded to tie the frayed call light cord to the metal handlebar of his wheelchair. Assistant Director of Nursing (ADON) verified call light cord was frayed and replaced it. R7's quarterly MDS dated 5/19/26, R7 had moderately impaired cognition; had impairment to both legs; used a wheelchair; was dependent on staff for personal hygiene, toileting, bed mobility and transfers. R7's fall focus care plan identified R7 was at high risk for falls related to limited mobility, weakness, cellulitis, history of falls, deconditioning, gait/balance problems, and diagnosis of tremors.			F0558	Continued from page 20 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 7/20/26 with clinical staff on Call Light Accessibility and Timely Response policy, also included in education was the need to enter a work order in TELS if any call lights are noted to have exposed wires, and to notify DON/ADON if resident exhibits difficulty in using call light due to decreased mobility and/or strength. Audits will be completed on resident rooms 3/week x 2 weeks, then 5 rooms 3/week x 4 weeks by DON/Designee to ensure call lights are accessible to residents Call lights audited monthly to ensure functionality and no exposed wired by plant operation. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/26 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 7/23/2026		07/23/2026

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F0558 SS = D	Continued from page 21 The care plan lacked call light placement as an intervention. During observation and interview on 6/16/26 at 12:46 p.m., R7 was sitting in his wheelchair in his room and hollering that he wanted to go to bed. R7's call lights in his room were not within his reach to call staff for assistance. Call light observed clipped to the curtain divider in his room. R7 stated he could not reach them so would just holler until they came. R7 stated he was very uncomfortable and needed to get out of his chair while adjusting his weight in the chair. At 12:54 p.m., the ADON entered the room and acknowledged that R7's call light was not within his reach. During an interview on 6/16/26 at 12:54 p.m., the ADON stated all residents should always have call lights within reach, and her expectation would be for all staff to ensure the call lights are placed within their reach and be able to push them. Review of the facility's Call Light: Accessibility and Timely Response Policy dated 1/2026, identified the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines included: Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations with the resident's room. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly (examples included touch pads, larger buttons, bright colors, etc.).			F0558			07/23/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,			F0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R1 guardian was notified of changes in condition at care conference held on 3/25/2026, communications to guardian on 6/4/2026, 6/5/2026, 6/8/2026, 6/12/2026, 6/16/2026,6/18/2026,6/19/2026, 6/22/2026, 6/24/2026, 7/1/2026, 7/2/2026, 7/7/2026, and 7/8/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		07/23/2026

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F0580 SS = D	Continued from page 22 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to notify the resident representative regarding changes to skin integrity, weight loss, and accidents for 1 of 1 residents (R1) reviewed for change in condition.			F0580	Continued from page 22 All residents have the potential to be affected Past 30 days of progress notes and incident reports were reviewed by the Director of Clinical Services on 7/21/2026 to ensure that appropriate notifications were made. Notifications were made for any items found to be deficient What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 7/20/2026 on Notification of Changes Policy with all staff being educated by end of day on 7/23/2026. Any staff not receiving education will not be allowed to work until education is received. Progress notes, Incident Reports, and Weights out of range will be reviewed as part of the daily clinical stand up Monday – Friday with any notes occurring over the weekend to be reviewed the following Monday as part of the daily clinical stand up process to ensure notification have been made with immediate notification to be made and immediate education provided for any notifications not made appropriately. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 7/23/2026		07/23/2026

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F0580 SS = D	Continued from page 23 Findings include: R1's significant change in status Minimum Data Set (MDS) dated 5/24/26, identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included intellectual disability, schizophrenia, acute respiratory failure with hypoxia, malnutrition, and dehydration. The MDS also indicated R1 had no skin issues, had two or more falls without injury, required a mechanically altered diet, and had a significant weight loss. R1's care plan lacked a focus or intervention that related to when and why to contact R1's guardian. There was no documentation of R1 having a guardian. R1's Department of Human Services letter dated 12/5/24, identified R1's guardian was a delegate or designee of the Commission of Human Services through Renville, may act in the Commissioner's stead as a local guardian of R1. Significant weight loss: R1's weight log identified on 3/19/26 R1 was 166.2 pounds; on 5/5/26 R1 was 124.9 which was a loss of 41.3 pounds. R1's Nutritional Assessment identified a significant weight loss related to weight loss of greater than 6.6 pounds, severe decrease in food intake, severe dementia or depression, and a body mass index (BMI) of less than 19. R1's Progress Notes revealed the following: -5/8/26 at 2:41 p.m. – Dietary Note indicated weight warning for a weight of 124.9 pounds. The medical record lacks evidence of guardian notifications related to weight loss or nutrition concerns. -5/18/26 at 5:03 p.m. current weight of 130 pounds continues to show a significant weight loss from 179 pounds in 12/25. The medical record lacks evidence of guardian notification. Skin: R1's Bath Skin Assessment dated 6/2/26 indicated R1 had an open area to coccyx/sacral area and right knee has scabbed areas with treatments in place. R1 also had bruising on arms. R1's Progress Notes revealed the following:			F0580			07/23/2026

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F0580 SS = D	Continued from page 24 -5/11/26 at 3:40 p.m., R1 noted to have skin tears on her buttocks directly above anus. A note was put in for nurse practitioner to evaluate the next day. R1 has bruising around right eye. No facility incident report related to the skin tears or bruising of right eye and lacked documentation that R1's guardian was notified. -5/15/26 at 1:20 p.m., R1 has open area to inside of anus; wound pictures taken and assessment completed but lacked documentation that R1's guardian was notified. Falls: Facility incident report revealed the following: -2/4/26 at 9:45 a.m., identified R1 had been hitting herself in the face, kicking doors, hitting her head on the wall and had bruising of yes and mid to right shoulder area. The incident report lacked documentation of guardian notification -5/5/26 at 11:30 a.m., R1 had a fall. The incident report lacked documentation of guardian notification. -5/9/26 at 5:30 p.m., R1 fell and had a laceration above her right eyebrow 1 centimeter (cm) x 0.3 cm. The incident report lacked documentation of guardian notification -5/10/26 at 12:55 p.m., R1 fell with no apparent injuries. The incident report lacked documentation of guardian notification -6/12/26 at 8:21 p.m., indicated resident fell with complaints of pain in her right knee; hospice, DON and administrator were notified but the noted lacked documentation that the guardian was informed. There was no facility incident report related to this fall. R1's Personal Safety Plan Worksheet dated 1/16/26, identified trusted supporters and people R1 could to when she needed help included "guardian Barb". During an interview on 6/16/26 at 1:21 p.m., R1's guardian indicated she had not been notified of R1's significant weight loss of 50 pounds, was not always notified of R1's falls specifically the fall on the 6/12/26 and was not notified of R1's skin issues. The guardian was "surprised" at the amount of skin issues R1 received treatment for. During an interview on 6/17/26 at 10:25 a.m.,			F0580			07/23/2026

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F0580 SS = D	Continued from page 25 employee (E)-B identified as part of the interdisciplinary team (IDT) and stated all notifications to resident's families, guardians, or responsible party were only to be done by the social worker during business hours. E-B stated any change of condition, fall, incident, new orders should have been communicated to the residents' responsible parties, but the facility had not been making those notifications as they should have. During an interview on 6/17/26 at 12:32 p.m., E-I indicated R1's guardian was not getting notified of condition changes, behaviors, or med changes because there was some confusion in the facility about who R1's guardian was. E-I stated that resident families, responsible parties, guardians should have been notified if there was significant change like weight loss, behaviors, changes with medications or orders. Also stated the prior social worker was supposed to make all those notifications, but the facility process changed, and nurses are supposed to make those notifications. During an interview on 6/17/26 at 2:05 p.m., the social service designee (SSD) stated all family, guardian, responsible party notifications had been made by the social worker but recognized that was an area that they needed to improve in. The SSD further stated nurses should contact residents' responsible parties for emergent situations, and the SSD made the non-emergent notifications. The SSD said he needed to review the facility policies. During an interview on 6/17/26 at 3:58 p.m., the regional clinical consultant (RCC) noticed that the facility lacked documentation of notifications and would expect families, responsible parties, and guardians to be notified according to the facility policy. The facility's undated policy titled, Notification of Changes identified the purpose of the policy was to ensure the facility promptly informs the resident, consults with the resident's physician; and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification and included accidents resulting in injury or potential to require physician intervention; significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial state which may include:			F0580			07/23/2026

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F0580 SS = D	Continued from page 26 life-threatening conditions or clinical complications and circumstances that require a need to alter treatment which may include new treatment, discontinuation of current treatment, transfer or discharge of a resident, change of room or room assignment, and a change in resident rights. For residents incapable of making their own decision, the representative would make any decisions that need to be made, and the resident should still be told what is happening to him or her.			F0580			07/23/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 observation, interview, and record review the facility failed to ensure an elopement from the facility was recognized and reported to the state agency (SA) for 1 of 1 resident (R4) reviewed for elopement. Findings include:			F0609	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Immediate education was provided to the Regional Clinical Consultant and Nursing Home Administrator by the Regional Director of Operations on 6/18/2026 on reporting DON was relieved of duty on 6/16/2026 Incident was reported by NHA on 6/18/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected 30 days progress notes reviewed for reportable incidents – there were no documented elopement events in the medical record. Facility completed reportable on the 6/6/26 incident involving G.K which was called in to your office 30 days incident reports reviewed for reportable incidents with none identified What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education initiated on Abuse Neglect Exploitation Requirements, Reporting Requirements, Reporting Timelines, Mandated Reporter, Free from Retaliation, Expectation Report, Investigate, Fix with all staff on		07/23/2026

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F0609 SS = D	Continued from page 27 R4's Admission Record indicated he was admitted to the facility on 9/4/25. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated 6/2/26, identified severely impaired cognition and indicated he experienced delusions; had acute mental status changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. R4's care plan also identified him as a high fall risk related to diagnoses and ambulation without well-fit gripped footwear. R4's medical record lacked any documentation of an elopement on 6/6/26.			F0609	Continued from page 27 6/18/2026 with no staff being allowed to work until they receive education Effective immediately, the Administrator/designee will conduct daily leadership meetings to review resident safety concerns, unresolved department issues, grievances, reportable events, staffing concerns, pending audits, and follow-up on corrective actions. These meetings will continue daily Monday through Friday for 2 weeks, then weekly for 4 weeks, and then monthly through QAPI until sustained compliance is achieved. The Administrator/designee will complete daily rounds throughout the facility to validate that resident needs are being met, staff concerns are addressed, and any identified concerns are escalated and corrected timely. Findings will be documented and reviewed with the interdisciplinary team. Regional leadership will provide increased oversight to the facility, including review of corrective actions, department follow-through, audit results, and ongoing compliance. The Regional Director of Operations and/or Regional Clinical Consultant will review progress with the Administrator/DON at least weekly until substantial compliance is sustained. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 7/23/2026		07/23/2026

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F0609 SS = D	Continued from page 28 Review of the facility's incident reports lacked any documentation of the 6/6/26 elopement incident. The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R4's reported elopement attempts on 6/6/26. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former director of nursing (DON) reported that on 6/6/26, R4 had eloped, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned for R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC)'s direction. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an employee's vehicle, and administration directed not to report or document the elopement. Further, E-B stated R4 had made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported to the SA nor documented in R4's record or a facility incident report completed. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and two other staff were on duty but were in rooms assisting residents when she heard a "beeping" noise. At first, she thought the beeping noise was a call light and then investigated and realized it was the exit door alarm system, but the zones on the master alarm board were not labeled so she did not know which door had been opened and activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck heading into the "dock" or delivery bay and recognized the man in the driver's seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked			F0609			07/23/2026

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F0609 SS = D	Continued from page 29 employees' door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver's side of the running truck, but the former DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The former DON was then able to safely assist R4 back into the building without any apparent injuries. The former DON identified the facility is surrounded by a corn field, deep "gulch" or drop-off, and a road and all posed risks to R4's safety. The former DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The former DON then called the RCC at 12:48 p.m. and was instructed to not chart the incident in R4's medical record, not to do an incident report, and not report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4's medical record, did not do an incident report, nor report it to the SA. The former DON stated she was "walked out" by the administrator and RCC the day the abbreviated survey began (6/16/26). During an interview on 6/17/26 at 1:27 p.m., E-D indicated she heard the door "buzzers" but was not sure which door it was. By the time they found out which door had alarmed, the former DON found him in the truck. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements at the beginning of May and now the one in June that prompted R4's move to a more secured home. The SSD stated he was not present during the elopement, but on 6/8/26, the former DON reported R4's elopement incident that occurred on 6/6/26, to him. The former DON reported that R4 had gotten into an employee's vehicle and drove it without staff supervision. The SSD stated he did not report to the SA and did not know what the facility vulnerable adult policy directed. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she observed R4 driving her truck to the delivery/docking bay next to the employee entrance. E-E identified R4 was an elopement risk and had eloped through that front door by the business offices two more times that day after he drove her truck. One time, another resident alerted staff that R4 was outside; however, she was not sure where they found him the second time he eloped.			F0609			07/23/2026

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F0609 SS = D	Continued from page 30 Follow up interview on 6/23/26 at 11:56 a.m., the former DON stated she did not document the elopement in R4's medical record because the RCC and administrator told her not to. The former DON reiterated that on 6/6/26, R4 left the building unsupervised. During an interview on 6/17/26 at 2:40 p.m., the administrator stated on 6/6/26 she was unavailable and did not have cellular service so did not have the details of R4's elopement incident; the former DON did not notify her. The administrator stated, "he [R4] was supervised from what I know". The administrator stated it was not reported to the SA because R4 was supervised the "whole time" he was out of the building on 6/6/26 so it was not considered an elopement and not reportable. The administrator further stated, "unless I see it first-hand, I don't report it" and "there are a lot of differing opinions". The administrator indicated if staff came to her with concerns she would not automatically report. She would request the concern be in writing and then would review the concern to determine if it was reportable or not. The administrator said she is not a nurse and counts on the nursing judgement to decide. Staff was to report concerns to the rapid response team which includes the RCC. During an interview on 6/17/26 at 3:58 p.m., the RCC stated, "their system is broke" and an elopement is considered neglect and should be reported to the SA. The RCC further stated, "I was not notified on 6/6/26 [of R4's elopement], the only thing I know was from reviewing his chart" and insisted R4 had direct supervision by staff. The RCC stated she would not tell anyone not to report, that she was an "over reporter", and if she had known about R4's elopement, it would have been reported to the SA. The undated facility policy titled, Abuse, Neglect, and Exploitation identified the facility will report all alleged violations to the administrator, state agency, adult protective services and to all other required agencies no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; assure the reporters are free from retaliation or reprisal; promote a culture of safety and open communication in the work environment. The administrator will follow up with government agencies during business hours to confirm the initial report was received, and to report the results of the investigation when final			F0609			07/23/2026

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F0609 SS = D	Continued from page 31 within five working days of the incident, as required by state agencies. The undated facility policy titled Elopement and Wandering Residents defines elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Appropriate reporting requirements to the State Survey agency shall be conducted.			F0609			07/23/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 thoroughly investigate a report of elopement for 1 of 1 resident (R4). Findings include: R4's Admission Record indicated he was admitted to the facility on 9/4/25. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated			F0610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Report was filed by NHA on 6/18/2026 DON was relieved of duty on 6/16/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Education was provided to the IDT on completing a thorough and accurate investigation of incidents and grievances by the Regional Clinical Consultant on 7/21/2026. All incident reports for the past 30 days were reviewed by the Regional Clinical Consultant on 7/21/2026 to ensure a thorough investigation was completed, What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education initiated on Abuse Neglect Exploitation Requirements, Reporting Requirements, Reporting Timelines, Mandated Reporter, Free from Retaliation, Expectation Report, Investigate, Fix with all staff on 6/18/2026 with no staff being allowed to work until they receive education		07/23/2026

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F0610 SS = D	Continued from page 32 6/2/26, identified severely impaired cognition and indicated he experienced delusions; had acute mental status changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement care of from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 former director of nurse (DON) reported that on 6/6/26, R4 had eloped, took an employee's car from the employee parking lot, and drove it down the road. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC)'s direction and not investigated any further. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that R4 had gotten into and drove an employee's vehicle on 6/6/26, and administration			F0610	Continued from page 32 Progress notes, Incident Reports, and Grievances will be reviewed as part of the daily clinical stand up Monday – Friday with any notes occurring over the weekend to be reviewed the following Monday as part of the daily clinical stand up process to ensure a complete and thorough investigation with a root cause analysis occurred with appropriate interventions and follow-up being completed Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 7/23/2026		07/23/2026

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F0610 SS = D	Continued from page 33 defined as the RCC and administrator, directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported, investigated, nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and other staff were in rooms assisting residents when she heard a “beeping” noise. , She investigated and found that it was the door alarm system, but the zones on the master alarm board were not labeled so she did not know which door was activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck heading into the “dock” or delivery bay and noted the man in the driver’s seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked employees’ door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver’s side of the running truck, but the former DON was able to enter the passenger’s side, shut off the truck, and pull the keys out of the ignition. The former DON called the administrator and the regional clinical consultant (RCC) and was instructed to not chart the incident in R4’s medical record, do an incident report, or report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4’s medical record, do an incident report, investigate the elopement, nor report it to the SA. During interview on 6/17/26 at 1:13 p.m., E-C identified on 6/6/26 “just before lunch” the door alarms went off as they were busy with another resident. The door alarms sounded like call lights, and thus it was hard to tell if it was the call light system or the door alarm. E-C stated they figured it was R4 because he frequently tried to get out, and they were unaware which door he went out. By the time R4 was found, he was coming in the back door by the employee parking lot. E-C denied being asked any questions by administration about the elopement.			F0610			07/23/2026

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F0610 SS = D	Continued from page 34 During an interview on 6/17/26 at 1:27 p.m., E-D indicated she heard the door “buzzers” but was not sure which door it was. By the time they found out which door had alarmed, the former DON found him in the truck. E-D denied being asked any questions by administration about the incident. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements at the beginning of May and now the one in June that prompted R4's move to a more secured home. The SSD stated he was not present during the elopement, but it was reported on 6/8/26, that R4 had gotten into an employee's vehicle and pulled it forward. The SSD was not aware if the elopement was investigated or not. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she observed R4 driving her truck to the delivery/docking bay next to the employee entrance. R4 got out of the truck, walked around to the employee entrance door, and tried to pull the locked door open. R4 appeared to be talking to someone. Upon further inspection, she saw the former DON met him at the employee entrance, in which R4 then walked back to the running truck and got in the driver's side. At that time, the former DON was able to get into the passenger side of the vehicle, shut the ignition off, and pull the keys out of the ignition. E-E explained her truck was parked approximately 5-6 parking spots from the employee entrance and R4 would have had to back up the truck and drive around other parked vehicles and drive by the garage before pulling into the docking/delivery bay. E-E indicated they notified the administrator and her immediate supervisor and was asked to provide a written statement but then did not have any further conversations with the former DON or the administrator regarding the elopement. R4's medical record was reviewed and lacked any documentation related to the reported elopements. Review of facility incident reports did not include any risk management, incident reports, or investigations related to the reported elopements. The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R4's reported elopement attempts. R4's nurse progress notes lacked any			F0610			07/23/2026

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F0610 SS = D	Continued from page 35 documentation of the elopement on 6/6/26. R4's nursing progress note on 6/7/26 (the day after the elopement) was noted to have a left great toenail almost detached from the nail bed with the nail hanging loosely. On-call provider notified and advised to soak the toe and trim/remove as much detached nail as possible. The medical record lacked any further investigation; the facility lacked any incident report/risk management or investigation regarding R4's injury. During interview on 6/17/26 at 2:40 p.m., the administrator stated she was aware of R4's alleged elopement incident but she did not know the details of the incident and stated she thought he was supervised the whole time. She further indicated she did not have an investigation into R4's alleged elopement because she did not think it was a true elopement. During an interview on 6/17/26 at 3:58 p.m., the RCC stated she was aware of R4's alleged elopement incident and elopement should be investigated and reported. The RCC further denied being notified on 6/6/26 of R4's elopement and the only information she had was by reviewing R4's medical record and it said he had direct supervision. The RCC was a part of an interdisciplinary meeting on 6/9/26 at 10:30 a.m. that discussed R4's elopement incident. During a follow up interview on 6/18/26 at 1:48 p.m., the RCC stated R4's alleged elopement was discussed on 6/8/26 but lacked documentation of further investigation. Review of the facility's undated Rapid Response protocol indicated post elopement documentation should include an incident report/risk management; report DHS (department of human services); timeline of search and actions taken; resident assessment after recovery; notifications; and investigative findings. Follow up should include a root cause analysis and after action summary. Review of the facility's undated policy titled, Abuse, Neglect, and Exploitation defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It defined alleged violation as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigation and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse,			F0610			07/23/2026

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F0610 SS = D	Continued from page 36 including injuries of unknown source, and misappropriation of property. The policy directs an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation and determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, the cause, and proving complete and thorough documentation of the incident. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies.			F0610			07/23/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to monitor, report, and implement timely interventions for 1 of 2 residents (R1) reviewed for significant weight loss. Findings include: R1's significant change in status minimum data set (MDS) dated 5/24/26, indicated severely impaired cognition. Diagnoses included paranoid schizophrenia, moderate intellectual disabilities, protein-calorie malnutrition, acute respiratory failure with hypoxia, and dysphagia.			F0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R1 expired on 6/14/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected CDM and RD were educated by Director of Clinical Services on 6/21/2026 on need to make timely interventions with significant weight changes. Past 90 days of weight changes were reviewed by Director of Clinical Services to ensure all weight losses were addressed with interventions in place What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and:		07/23/2026

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F0684 SS = D	Continued from page 37 R1's Nutritional Assessment dated 2/5/26, identified R1 was malnourished, independent with eating after meal set up, did not receive a therapeutic nutritional supplement, did not use dentures as they were poor fitting, had poor meal intakes, was at risk for dehydration due to vomiting. The assessment further identified R1's admission weight 30 days prior was 179 pounds, but current weight was not documented and left blank. There was no change in weight and either no weight loss or gain or unknown if there was a weight loss or gain. R1's total nutritional intakes and supplements met her nutritional needs. Nutritional goals and interventions were updated and in R1's care plan. Dietary was to monitor for any abnormal weight changes. R1's nutrition focused care plan initiated on 5/18/26, identified R1 was at risk for nutrition/hydration problems related to the need for hospice services, dentures not fitting properly, advanced age, compromised appetite due to refusing meals, nausea/vomiting, weakness, refused weights, open areas on bottom, dysphagia, weight loss. Interventions included monitoring weights per MD (medical doctor)/hospice orders and/or facility policy; offer extra fluids between meals for hydration at activities; monitor for signs of dehydration; provide diet per MD/hospice order of a 7 regular diet as tolerated; provide R1 with assistance and cues as needed; safe swallowing strategies; sit upright; limit distractions, and meds crushed. R1's treatment administration record for April 2026, identified an order dated 3/5/26, for weekly weights and vital signs on bath day every Thursday. R1's weight on 4/2/26, was documented as 166.1 pounds; on 4/9/26, not applicable (NA) was documented; on 4/16/26, no documented weight; on 4/23/26, NA was documented; on 4/30/26, NA was documented. R1's treatment administration record for May 2026, identified an order dated 3/5/26, for weekly weights and vital signs on bath day every Thursday. R1's weight on 5/7/26 was not documented and all vital signs left blank; on 5/14/26 weight documented as 130 pounds (loss of 36.1 pounds in 6 weeks). R1's Weight Summary identified on 4/2/26, weight was 166.1 pounds and no other weights documented until 5/5/26, when R1's weight was 124.9 pounds (loss of 41.2 pounds). R1's Care Conference Summary dated 3/25/26, did not contain a dietary summary, nursing summary,			F0684	Continued from page 37 Education was initiated with clinical staff on Weight Monitoring Policy on 6/21/2026 with clinical staff receiving education by end of day on 6/23/2026. Any staff not receiving education by end of day of 6/23/2026 will not be allowed to work until education is received. Weights will be reviewed Monday-Friday as part of the daily clinical stand up to ensure all weights are obtained per the MD orders and any significant changes in weight have been addressed with appropriate interventions. Any weights occurring over the weekend will be reviewed on Monday. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 7/20/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 7/23/2026		07/23/2026

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F0684 SS = D	Continued from page 38 and no weight or dietary concerns. R1's dietary progress notes reflected the following: -3/13/26, at 10:50 a.m., R1 had weight loss over time and continued compromised appetite and recommended a house supplement between meals. Dietary was to continue to monitor weights and appetite. -R1's progress notes lacked any dietary note from 3/13/26 to 5/8/26 and no evidence of implementation of nutritional supplement. -5/8/26 at 2:41 a.m., identified weight warning for R1 with a weight of 124.9 pounds and requested a reweigh. -5/13/26 at 10:54 a.m., R1 needed more cues and assistance with meals and provided lipped plate and straws to aide with independence with meals. Weight Note on 6/05/26 at 9:55 a.m., identified weight warning with R1's weight at 121.7 pounds; R1 had decreased meal intakes, was sleeping through meals, and having emesis after most meals causing weight loss. R1 was recently admitted to hospice and per dietician recommendation, fax sent to hospice for a supplement order to aide with nutritional intake due to her compromised appetite. On 6/5/26 at 12:17 p.m., hospice and R1's guardian approved use of a nutritional supplement and order was requested from physician. During interview on 6/16/26 at 1:21 p.m., R1's guardian indicated R1 had always had a bit of an issue with eating but had concerns with the facility's monitoring of R1's weight and had not received any notifications of R1's significant weight loss until she requested a care conference in May. R1 was 178 pounds when she was admitted to the facility on 12/25, and weight had decreased to 120 pounds without any interventions. R1's guardian also stated that the facility did not try any nutritional supplements or interventions until recently which she felt was "after the fact" and "too late". During an interview on 6/17/26 at 3:58 p.m., the regional clinical consultant (RCC) indicated overall documentation is lacking. The RCC indicated her expectations of the facility nursing staff was to monitor weights, track and trend weights, put interventions in place, and document. During an interview on 6/23/26 at 10:30 a.m., the dietary manager (DM) indicated R1 would have behaviors of throwing up but did eat "relatively ok"			F0684			07/23/2026

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F0684 SS = D	Continued from page 39 until she went to the hospital in May. The DM further explained the nurses did not get R1's weights so when R1 returned from the hospital, a "huge" weight loss triggered. The DM stated that nursing is expected to notify her of any residents' weight changes but, "some will, and some will not". The facility policy related to monitoring resident weights, reporting weight changes, and implementing interventions was requested but not received.			F0684			07/23/2026

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER FRANKLIN RESTORATIVE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
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20000	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 6/16/26, 6/17/26, 6/18/26, 6/22/26, and 6/23/26, 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. The following complaints were reviewed during the survey. H52732794C (3035614) and H52732924C (3038472) with licensing orders were issued at 0810 and 0830.			20000			07/19/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1		20000			07/19/2026	
21810	Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure call lights were functional and within reach for 3 of 8 residents (R1, R5, and R7) reviewed for call light placement. Findings include: R1's significant change in status Minimum Data Set (MDS) dated 5/24/26, identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included schizophrenia, acute respiratory failure with hypoxia, and malnutrition. R1's fall focus care plan identified R1 was at risk for falls related to incontinence, poor communication/comprehension, psychoactive drug use, mental health diagnoses, and behavior of throwing herself backwards. Interventions included be sure call light is within reach and courage her to use it for assistance if needed. During observation and interview on 6/17/26 at 9:34 a.m., R1 was lying in bed and stating she needed to use the bathroom. R1 was unable to locate her call light and when it was given to her, she could not push the button. R1 stated she "couldn't hold it anymore" and needed to go to the bathroom. Evaluator pushed the call light for her and ADON responded and acknowledged R1 likely did not have the strength to push that button and would get a soft touch call light for her. R5's quarterly Minimum Data Set (MDS) dated 4/22/26, identified R5 had moderately		21810	Corrected		07/23/2026	

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21810	Continued from page 2 impaired cognition and needed staff assistance for toileting, dressing, bed mobility, and transferring. Diagnoses included cervical disc disorder with myelopathy (arthritic condition affect the neck joints), bipolar disorder (mental health disorder that causes extreme mood swings), and chronic obstructive pulmonary disease (lung disease causing breathing problems). R5's fall focus care plan identified R5 was a high risk for falls related to gait/balance problems and safety awareness (history of impulsiveness). Interventions included to be sure R5's call light was within reach and encourage the resident to use it for assistance. R5 needed prompt response to all requests for assistance. During an observation and interview on 6/16/26 at 9:55 a.m., R5 was sitting in his wheelchair watching television. R5 stated he was sitting in his "torture chair" and had a lot of pain in his "bottom", rating his pain a "9" on a 0-10 pain scale. R5 wanted a pain pill but could not reach either of the two call lights in his room and stated he could not move his wheelchair to get to them. Defined himself as being "stuck". Both call lights were closed inside his bedside table drawer and were out of reach. One call light cord appeared frayed with exposed wires. At 10:05 a.m., Licensed practical nurse (LPN)-A entered the room with R5's pain pill and acknowledged R5 could not reach his call lights and proceeded to tie the frayed call light cord to the metal handlebar of his wheelchair. Assistant Director of Nursing (ADON) verified call light cord was frayed and replaced it. R7's quarterly MDS dated 5/19/26, R7 had moderately impaired cognition; had impairment to both legs; used a wheelchair; was dependent on staff for personal hygiene, toileting, bed mobility and transfers. R7's fall focus care plan identified R7 was at high risk for falls related to limited mobility, weakness, cellulitis, history of falls, deconditioning, gait/balance problems, and diagnosis of tremors. The care plan lacked call light placement as an intervention. During observation and interview on 6/16/26 at 12:46 p.m., R7 was sitting in his wheelchair in his room and hollering that he wanted to go to bed. R7's call lights in his room were not within his reach to call staff for assistance. Call light observed clipped to the curtain divider in his room. R7 stated he could not reach them so would just holler until they came. R7 stated he was very uncomfortable and			21810			07/23/2026

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21810	Continued from page 3 needed to get out of his chair while adjusting his weight in the chair. At 12:54 p.m., the ADON entered the room and acknowledged that R7's call light was not within his reach. During an interview on 6/16/26 at 12:54 p.m., the ADON stated all residents should always have call lights within reach, and her expectation would be for all staff to ensure the call lights are placed within their reach and be able to push them. Review of the facility's Call Light: Accessibility and Timely Response Policy dated 1/2026, identified the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines included: Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations with the resident's room. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly (examples included touch pads, larger buttons, bright colors, etc.). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on call light placement and response; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days		21810				
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.		21830	Corrected		07/23/2026	

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21830	Continued from page 4 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been			21830			07/23/2026

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21830	Continued from page 5 admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to notify the resident representative regarding changes to skin integrity, weight loss, and accidents for 1 of 1 residents (R1) reviewed for change in condition. Findings include: R1's significant change in status Minimum Data Set (MDS) dated 5/24/26, identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included intellectual disability, schizophrenia, acute respiratory failure with hypoxia, malnutrition, and dehydration. The MDS also indicated R1 had no skin issues, had two or more falls without injury, required a mechanically altered diet, and had a significant weight loss. R1's care plan lacked a focus or intervention that related to when and why to contact R1's guardian. There was no documentation of R1 having a guardian. R1's Department of Human Services letter dated 12/5/24, identified R1's guardian was a delegate or designee of the Commission of Human Services through Renville, may act in the Commissioner's stead as a local guardian of R1. Significant weight loss: R1's weight log identified on 3/19/26 R1 was 166.2 pounds; on 5/5/26 R1 was 124.9 which was a loss of 41.3 pounds. R1's Nutritional Assessment identified a significant weight loss related to weight loss of greater than 6.6 pounds, severe decrease in food intake, severe			21830			07/23/2026

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21830	Continued from page 6 dementia or depression, and a body mass index (BMI) of less than 19. R1's Progress Notes revealed the following: -5/8/26 at 2:41 p.m. – Dietary Note indicated weight warning for a weight of 124.9 pounds. The medical record lacks evidence of guardian notifications related to weight loss or nutrition concerns. -5/18/26 at 5:03 p.m. current weight of 130 pounds continues to show a significant weight loss from 179 pounds in 12/25. The medical record lacks evidence of guardian notification. Skin: R1's Bath Skin Assessment dated 6/2/26 indicated R1 had an open area to coccyx/sacral area and right knee has scabbed areas with treatments in place. R1 also had bruising on arms. R1's Progress Notes revealed the following: -5/11/26 at 3:40 p.m., R1 noted to have skin tears on her buttocks directly above anus. A note was put in for nurse practitioner to evaluate the next day. R1 has bruising around right eye. No facility incident report related to the skin tears or bruising of right eye and lacked documentation that R1's guardian was notified. -5/15/26 at 1:20 p.m., R1 has open area to inside of anus; wound pictures taken and assessment completed but lacked documentation that R1's guardian was notified. Falls: Facility incident report revealed the following: -2/4/26 at 9:45 a.m., identified R1 had been hitting herself in the face, kicking doors, hitting her head on the wall and had bruising of yes and mid to right shoulder area. The incident report lacked documentation of guardian notification -5/5/26 at 11:30 a.m., R1 had a fall. The incident report lacked documentation of guardian notification. -5/9/26 at 5:30 p.m., R1 fell and had a laceration above her right eyebrow 1 centimeter (cm) x 0.3 cm. The incident report lacked documentation of guardian notification -5/10/26 at 12:55 p.m., R1 fell with no apparent			21830			07/23/2026

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21830	Continued from page 7 injuries. The incident report lacked documentation of guardian notification -6/12/26 at 8:21 p.m., indicated resident fell with complaints of pain in her right knee; hospice, DON and administrator were notified but the noted lacked documentation that the guardian was informed. There was no facility incident report related to this fall. R1's Personal Safety Plan Worksheet dated 1/16/26, identified trusted supporters and people R1 could to when she needed help included "guardian Barb". During an interview on 6/16/26 at 1:21 p.m., R1's guardian indicated she had not been notified of R1's significant weight loss of 50 pounds, was not always notified of R1's falls specifically the fall on the 6/12/26 and was not notified of R1's skin issues. The guardian was "surprised" at the amount of skin issues R1 received treatment for. During an interview on 6/17/26 at 10:25 a.m., employee (E)-B identified as part of the interdisciplinary team (IDT) and stated all notifications to resident's families, guardians, or responsible party were only to be done by the social worker during business hours. E-B stated any change of condition, fall, incident, new orders should have been communicated to the residents' responsible parties, but the facility had not been making those notifications as they should have. During an interview on 6/17/26 at 12:32 p.m., E-I indicated R1's guardian was not getting notified of condition changes, behaviors, or med changes because there was some confusion in the facility about who R1's guardian was. E-I stated that resident families, responsible parties, guardians should have been notified if there was significant change like weight loss, behaviors, changes with medications or orders. Also stated the prior social worker was supposed to make all those notifications, but the facility process changed, and nurses are supposed to make those notifications. During an interview on 6/17/26 at 2:05 p.m., the social service designee (SSD) stated all family, guardian, responsible party notifications had been made by the social worker but recognized that was an area that they needed to improve in. The SSD further stated nurses should contact residents' responsible parties for emergent situations, and the SSD made the non-emergent notifications. The SSD said he needed to review the facility policies.			21830			07/23/2026

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21830	Continued from page 8 During an interview on 6/17/26 at 3:58 p.m., the regional clinical consultant (RCC) noticed that the facility lacked documentation of notifications and would expect families, responsible parties, and guardians to be notified according to the facility policy. The facility's undated policy titled, Notification of Changes identified the purpose of the policy was to ensure the facility promptly informs the resident, consults with the resident's physician; and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification and included accidents resulting in injury or potential to require physician intervention; significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial state which may include: life-threatening conditions or clinical complications and circumstances that require a need to alter treatment which may include new treatment, discontinuation of current treatment, transfer or discharge of a resident, change of room or room assignment, and a change in resident rights. For residents incapable of making their own decision, the representative would make any decisions that need to be made, and the resident should still be told what is happening to him or her. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and implement applicable policies on the notification of family, resident, and responsible parties; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days			21830			07/23/2026