



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 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 informed you of imposed enforcement remedies.

On July 20, 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 20, 2026, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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.

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.

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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August 4, 2026

Administrator

FRANKLIN RESTORATIVE CARE CENTER

900 3RD STREET SOUTH

FRANKLIN, MN 55333

Re: State Nursing Home Licensing Orders

Event ID: 284E21-H1

Dear Administrator:

The above facility survey was completed on July 20, 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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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: 284E21-H2

Dear Administrator:

On August 18, 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 July 20, 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

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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 07/20/2026	
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 7/14/26, 7/15/26, 7/16/26, and 7/20/26, 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: H52733231C (3074373) and H52733345C (3093759) with deficiencies issued at F600 and F689. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to develop and implement effective interventions to prevent resident-to-resident physical abuse for 3 of 3 residents (R1, R2, and R3) reviewed for abuse. This resulted in the likelihood of serious harm, injury, or death when on 7/9/26 R1 wandered into R2's room and began choking R2, requiring staff intervention to separate the residents. After, R1 continued to exhibit wandering behaviors and on 7/15/26 R1 wandered into R3's room and the two exchanged punches before staff could intervene. The IJ began on 7/9/26 and the immediacy was removed on 7/20/26. The above findings constituted substandard quality of care, and an extended survey was conducted on 7/20/26. 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			08/13/2026
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)			F0600	Immediate actions taken for the residents found to have been affected: R1 was immediately placed on 1:1 supervision on the morning of 7-15-2026 and will remain on 1:1 until placement is obtained. R1		08/12/2026

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 07/20/2026	
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
F0600 SS = SQC-J	Continued from page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement effective interventions to prevent resident-to-resident physical abuse for 3 of 3 residents (R1, R2, and R3) reviewed for abuse. This resulted in the likelihood of serious harm, injury, or death when on 7/9/26 R1 wandered into R2's room and began choking R2, requiring staff intervention to separate the residents. After, R1 continued to exhibit wandering behaviors and on 7/15/26 R1 wandered into R3's room and the two exchanged punches before staff could intervene. These findings constituted an Immediate Jeopardy (IJ) situation. The Immediate Jeopardy began on 7/9/26 when the facility failed to implement and maintain effective interventions following the resident-to-resident choking incident involving R1 and R2. Although the facility initially implemented 1:1 supervision, it discontinued continuous observation on 7/14/26 and replaced it with 15-minute safety checks and a motion sensor door alarm. Within approximately 24 hours of reducing supervision, R1 again entered another resident's room and became involved in a physical altercation with R3, demonstrating the continued noncompliance and ongoing likelihood of serious harm. The recurrence of resident-to-resident physical aggression after the reduction in supervision showed that the interventions did not prevent continued exposure of residents to the risk of serious harm. The administrator and director of nursing (DON) were notified of the IJ on 7/16/26 at 1:06 p.m. The immediate jeopardy was removed on 7/20/26 at 3:15 a.m. but noncompliance remained at			F0600	Continued from page 1 care plan was updated to reflect continuous 1:1 supervision. R1 medication Invega was increased on 7-16-2026 by psych. R1 was discharged to another facility on 8-6-2026. Identification of other residents having the potential to be affected was accomplished by: Interview were completed with other residents in the facility with all denying any resident had an altercation with them. Interviews with staff were completed to identify 5 residents with the potential for physical aggression towards other staff. Actions taken/systems put into place to reduce the risk of future occurrence include: Education was initiated on 7-15-2026 with facility staff on Abuse, Neglect, and Exploitation policy, Accidents and Supervision Policy, and Managing Residents Aggression with all staff being educated by end of day on 7-16-2026. Any staff not receiving education by end of day on 7-16-2026 will not be allowed to work until education is received. Education will be ongoing as needed. Education was completed with IDT on 7-16-2026 on ensuring thorough review of the residents behavior, effectiveness of medication changes, as well as the psych consult recommendations prior to removing or decreasing any level of supervision on residents receiving 1:1 supervision. Skin checks in house were completed on 7-16-2026 to look for any new bruising or s/s of abuse with no signs noted. Vulnerable Adult assessments were completed on in house residents 7-16-2026 with care plans updated. Progress notes and incident reports were reviewed for the past 30 days for new or worsening aggression with no other resident to resident altercations identified. Psych assessments were completed on 7-16-2026 with residents involved in the 2 reported incidents to assess for psychosocial harm with no harm noted. Skin assessments will continue weekly for all in house residents. Resident Vulnerability & Abuse Assessments,and Psychosocial assessments will continue quarterly and as needed. How the corrective actions will be monitored to ensure the practice will not recur: Skin Assessments will continue weekly for all in house residents. Resident Vulnerability & Abuse Assessments and Psychosocial Assessments will continue quarterly, upon admission and as needed. Risk management incidents, and clinical progress notes will be discussed and reviewed daily Monday through Friday at IDT. All incidents will be reviewed and		08/12/2026

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 07/20/2026	
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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F0600 SS = SQC-J	Continued from page 2 the lower scope and severity level 2 D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a Facility Reported Incident (FRI) dated 7/9/26 at 7:35 a.m., indicated on 7/9/26 at 6:30 a.m., housekeeper (HSKP)-A and licensed practical nurse (LPN)-A witnessed R1 choking R2 in R2's room. R2 grabbed R1's arms to stop him. R1 had marks on his left arm. Review of a FRI dated 7/15/26 at 6:15 a.m., indicated on 7/15/26 at 4:00 a.m., LPN-B witnessed R1 trying to enter R3's room. R3 tried to push the door closed so R1 could not enter. R3 stated he and R2 exchanged hits to the chest area. R1's Vulnerable Adult Screen dated 5/5/26, identified R1's vulnerability risks were memory problems, poor decision making, wandering, the need for activities of daily living (ADL) assistance, difficulty making needs known, lack of ability to communicate reliability and no history of abuse towards others. R1's risk of harming other/exhibiting physical aggression to other residents or visitors was marked as N/A (not applicable). See care plan. R1's comprehensive Minimum Data Set (MDS) dated 5/31/26, indicated R1 had severely impaired cognition and had behaviors of disorganized thinking, inattention, physical behavior toward others 1 to 3 days a week, and wandered daily. R1 had no physical impairment to upper and lower extremities and was independent with bed mobility, transferring, and walking. Diagnoses included schizophrenia (mental disorder causing disruption in thought processes, perceptions, emotional responsiveness, and social interactions), anxiety disorder, major depressive disorder, and dementia with behavioral disturbances. R1's Care Plan Safety focus last revised on 6/30/26, identified R1's safety was at risk and there was a potential for abuse related to decreased cognitive ability with dementia, schizophrenia, anxiety, major depressive disorder, and his inability to understand English as his primary language was Lao. Interventions were to not allow other residents to enter his room; remove R1 from dangerous situations; explain the environment to R1 if he does			F0600	Continued from page 2 discussed at QAPI monthly		08/12/2026

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 07/20/2026	
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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F0600 SS = SQC-J	Continued from page 3 not understand what was going on around him; R1 would not be placed where others would disturb him; stop sign on his door to prevent others from entering his room; and redirect if R1 seemed confused. R1's Care Plan Report printed on 7/14/26, identified R1 had a behavioral mood problem related to dementia, schizophrenia, anxiety, and depression. R1 demonstrated behaviors of delusional thinking patterns, spitting on the floor, refusing cares, and engaging in physical and verbal altercations with his peers and staff. Interventions included 1:1 monitoring on 7/9/26 and revised on 7/14/26 to every 15 minute checks and a motions sensor door alarm; intervene as necessary to protect the rights and safety of others; approach in a calm manner; divert attention; remove from situation and take to an alternative location as necessary; monitor for changes in behavior, mood, cognition, spitting in public places, delusional thinking, physical and verbal altercations, and refusal of cares; and remind staff and peers not to yell at R1 as that aggravates the situation. Medical record review documented progressively increasing wandering into other residents' rooms, aggression toward staff, physical aggression toward residents, and repeated behavioral escalation despite interventions and medication adjustments. R1's medical record identified the following timeline: Physician order (PO) dated 5/5/26, to decrease Invega to 1.5mg daily every a.m. (medication for schizophrenia) R1's progress notes identified the following: -5/25/26 at 9:44 a.m.: R1 was hitting at staff, attempted redirection and distraction with no change in behavior. -5/28/26 at 9:00 a.m.: R1 entered another resident's room and the other resident yelled at R1 to get out. Staff intervened and removed R1 from the room. -6/2/26 at 2:10 p.m.: R1's Aricept (dementia medication) was discontinued, and staff were directed to monitor for changes in behavior or mood. -6/19/26 at 2:00 p.m.: R1's Cymbalta (used to treat anxiety and depression) was reduced by the nurse practitioner following R1's pharmacy drug regimen			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 4 review. -6/22/26 at 10:10 a.m.: R1 was moved to a room closer to the nursing station (a more populated hallway) due to increased falls. -6/24/26 at 4:43 a.m.: R1 wandered into two other resident rooms which caused one resident to become upset and start yelling. -6/25/26 at 8:17 a.m.: R1 was going into other residents' rooms and laying on their beds. When staff tried to intervene, R1 became aggressive and started shoving his walker into staff. -6/27/26 at 4:57 a.m.: R1 went into another resident's room. -7/3/26 at 12:41 a.m.: R1 was hitting, pushing his walker into staff, yelling incoherently, and exhibiting other undefined behaviors. -7/7/26 at 11:11 a.m.: R1 had a telemedicine visit with rural psychiatric provider and no changes were noted in his baseline behavior, mood, or cognitive status reported by staff or observed during the assessment. -7/7/26 at 2:08 p.m.: R1 grabbed a mop from housekeeping staff and hit her with it and then grabbed another unidentified staff member's breast. -7/9/26 at 7:07 a.m.: LPN-A responded to yelling in R2's room and witnessed R1's hands around R2's neck. R2 stated he grabbed R1's arms when R1 started choking him. Bruise marks were noted on R1's left arm. R1's provider was notified with labs and urinalysis ordered, along with a scheduled visit for 7/14/26. -7/10/26 at 10:05 p.m.: R1 would remain with 1:1 staffing until after his psych consult on 7/14/26. -7/14/26 at 3:53 p.m.: R1 was reviewed by psychiatric provider and had been discontinued from 1:1 observation per provider recommendation. A door alarm was placed on R1's doorway to alert staff when R1 exits the room. Staff were notified of the change and told to monitor R1 closely and document all behaviors and observations. -7/14/26 at 8:18 a.m.: R1 was placed on 1:1 supervision after increased nighttime wandering behaviors. During the overnight shift, R1 was observed entering other residents' rooms on multiple occasions despite redirection. Frequent			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 5 redirection had been required. While in R3's room, an altercation occurred between R1 and R3 which created a potential safety concern for both individuals. R1 continued to exhibit confusion, poor judgement, and decreased awareness of personal boundaries which contributed to wandering behaviors. R1 would remain on 1:1 supervision, with ongoing monitoring, behavioral documentation, safety checks, and redirection as needed until psychiatry appointment on 7/21/26. R1's psychiatry physician visit note dated 7/7/26 at 8:15 a.m., staff were overheard yelling, "R1 don't". R1 was angry and when the housekeeper tried to redirect him, he grabbed the mop from her and attempted to strike the housekeeper with it. When another staff member attempted to intervene verbally, R1 grabbed her by the chest. Nursing reported it was the first incident of physical abuse in a long time. It appeared to be an isolated incident, and nursing was to monitor for any worsening agitation or increased physical aggression as that might warrant titrating his Invega back to prior dose. R1's psychiatry physician noted dated 7/14/26 at 11:30 a.m., documented staff reported they believed R2 provoked R1 on 7/9/26. On 7/9/26 R1 entered R2's room and R2 yelled at him to leave and physically grabbed R1 by the arms to push him out and R1 responded by choking R2. A motion sensor had been added to R1's door and he had 1:1 supervision instead of the 15-minute checks previously implemented for fall prevention. 1:1 observation was discontinued and returned to 15-minute safety checks due to fall risk and behavioral monitoring with motion sensor system to alert staff to his movements. Despite repeated documentation of wandering into other residents' rooms, physical aggression toward staff, behavioral escalation, and implementation of temporary 1:1 supervision, the facility reduced supervision before sustained behavioral stabilization was demonstrated. Within approximately 24 hours, another resident-to-resident physical altercation occurred. The medical record contained documentation regarding changes in the level of supervision on 7/14/26. Psychiatry documentation reflected discontinuation of 1:1 observation in favor of 15-minute checks with a motion sensor, while another nursing progress note documented continuation of 1:1 supervision pending psychiatric			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 6 follow-up. Interview statements from the DON and psychiatric NP corroborated that continuous 1:1 supervision had been discontinued before the 7/15/26 altercation. R2: R2's Vulnerability and Susceptibility to Abuse form dated 3/19/26 identified R2's vulnerabilities were cognitive impairment; exhibited psychotic behavior such as hallucinations or delusions; inability to control their actions; physical impairment; sensory impairment; verbally threatening to others; displayed rage or poor impulse control or was unable to express anger appropriately; and exhibits personal habit patters which were offensive or antisocial. R2's Care plan revised on 6/1/26, indicated R2 had a behavior/mood problem related to a history of delusional thinking patterns, and when frustrated, would yell, scream, and curse at staff and residents. Interventions included intervene as necessary to protect the rights and safety of others; remove from situation and take to alternate location as needed. R2 displayed episodes of delusional behavior related to his belief that his room was haunted and contributed to safety events at times. Intervention included, ensure the safety of resident and others. R2's safety was at risk and there was a potential for abuse related to dementia with agitation. Interventions included, ensure R2 was safe around others that might take advantage of his confusion. R2's annual MDS dated 6/18/26, indicated R2 had intact cognition with no physical or verbal behaviors towards others noted. R2 was independent with transferring but did not walk and used a wheelchair. R2 had diagnoses of stroke, diabetes and dementia. R2's progress note dated 7/9/26 at 2:01 p.m. indicated, Staff responded to R2's room and witnessed R1's arms while R1 was choking R2. Staff intervened. R2 was assessed for injury with no noted findings. R1 was assessed for injury and noted to have visible bruising marks on R1's left arm and open area to face following the altercation. During an interview on 7/14/26 at 10:19 a.m., R2 identified he was mad because people came into his room several times and stole his stuff. R2 further stated he preferred the door to his room to stay shut all the time because the week prior a man came into			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 7 his room and tried to choke him. R2 did not feel safe when it was open because that man (R1) would come back. R2 further explained that R1 had tried to enter his room one morning and R1 told him to get out but R1 came in anyway and tried to punch him and put his hands around his neck and R2 had to grab his arms to try to get R1 off him. R2 stated he did not want R1 to come into his room and if R1 did enter his room again, he would “punch him until he could never come back again”. R2 stated HSKP-A was in the room cleaning the bathroom at the time and she screamed for help. R2’s Skin Check dated 7/14/26 at 3:22 p.m. indicated R2 refused to allow the skin check but no significant findings on his arms or face. R3: R3’s quarterly MDS dated 4/8/26, indicated R3 had severe cognitive impairment and had behaviors of inattention, disorganized thinking, hallucinations, and delusions. R3 had no physical or verbal behaviors noted and did not wander. R3 required minimal assistance from staff for activity of daily living (ADL)s and used a wheelchair. R3 diagnoses included dementia, Parkinson’s, post-traumatic stress disorder (PTSD), paranoid personality, insomnia, anxiety and delusional disorders. R3’s care plan dated 6/30/26, identified R3 was at risk for abuse and further identified R3 was easily exploited, had antisocial behavior, sensitive to loud tones/sensory, mental health, physical health, and physical aggression. Interventions included, ensure R3 was safe around others that may take advantage of his confusion; do not have R3 near others that disturb him; and remove him from potentially dangerous situations. R3’s progress note dated 7/15/26 at 1:23 p.m., identified R3 was involved in an altercation with R1 when R1 repeatedly attempted to enter R3’s room and continued to try to open R3’s door. R3 became upset and staff intervened and separated residents. R3 had a psychosocial well-being problem related to dementia and diagnosed mental illness. Interventions included reassure R3 that others would not harm him or take things from him. R3 had a behavior problem with identified behaviors of refusal of cares, yell and swear at others, occasional physical aggression, and throwing items. R3’s behaviors were often disruptive to the environment and difficult			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 8 to redirect. De-escalation techniques included lower noise levels; reduce the number of people interacting with R3, ensure he was in a safe environment. During an interview on 7/16/26 at 9:05 a.m., R3 was lying bed on top of the covers, fully dressed, and had sweatpants stuffed under the door of his room and the door leading to his shared bathroom. R3 stated he wanted his door shut and put the sweatpants under the door because the “bad guys” were trying to come into his room and kill him. R3 further explained he was a Vietnam veteran, and the “bad guys” had tracked him down, killed his sister, and had tried to kill him. R3 expressed fear and stated he did not feel safe in his room because a man tried to come into his room to kill him during the night, but he fought back. R5: R5’s annual MDS dated 4/30/26 identified R5 had intact cognition and no behaviors. R5 was dependent on staff for bed mobility, transferring, ADLs, and did not walk. R5 had diagnoses of depression, anxiety, and major depressive disorder. During an interview on 7/15/26 at 3:42 p.m., R5 stated that R1 comes into her room “sometimes” and further stated, R1 came into her room three times in one night. R5 stated R1 came into her room and stood by her roommates’ (R6) bed. R5 said the first two times R1 entered her room, she was able to tell R1 to leave and he left but, the third time he came into her room she had to call for staff help to get him out of her room. R5 stated that she did not want R1 in her room and that it made her feel “very uncomfortable”. R5 further indicated that R1 should not be allowed to enter other residents’ rooms and that the staff should be watching him closer. During an interview on 7/14/26 at 12:26 p.m., nursing assistant (NA)-A stated she was doing 1:1 supervision with R1 due to an incident between him and another resident. NA-A further stated although R1 was not very busy that day but could “keep you on your toes”, further indicating R1 liked to wander and needed a lot of redirection and liked his 1:1 attention. During an interview on 7/14/26 at 12:46 p.m., NA-B described R1 could make his needs known and would yell when he wanted attention. Further			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 9 described R1 as “quick,” further clarifying that he moves fast when he walks. During an observation on 7/14/26 at 1:51 p.m., R1 was in his room with the privacy curtain closed. There were 10 resident rooms in the immediate vicinity of R1's room, occupied by 12 residents. During an interview on 7/15/26 at 2:20 p.m., LPN-A stated R1 would try to hit out if you tell him he cannot do something. R1 had routinely been on 15-minute checks related to frequent falls and was recently moved to a room closer to the nurse's station to be more visible to staff. Identified the room that R1 was moved to was on a busier and more populated hallway. LPN-A described that on the morning of 7/9/26, she heard R2 yelling, “get out of my room” and responded, finding R1 putting his hands around R2's neck and R2 pushing R1 away. R1 was placed on 1:1 supervision at that time. LPN-A indicated she believed R1 wandered more, and wandered more into others rooms, after the room change. LPN-A stated R1 had some recent medication changes but had been seen by his provider just before the interview and the facility was discontinuing the 1:1 supervision and placing a door exit alarm on R1's door and decreasing to every 15-minute checks as care planned for fall prevention. During an interview on 7/15/26 at 2:51 p.m., NA-C stated that on 7/9/26, she heard HSKP-A screaming and responded to R2's room. NA-C states she witnessed R1 on top of R2 and had R2 in a “choke hold”; R2 had slid back to a reclined position in his wheelchair and had R1 by the arms trying to get R1 off him. R2 was telling R1 to get off him or he would kill him. Staff were assigned to 1:1 supervision with R1 after that incident. NA-C described R1 as a strong little guy who can get feisty. R1 had previously gone into R2's room and tried to eat food from R2's breakfast tray. Once R1's room was changed, he wandered more. R1 became aggressive over food and if you get too close to him, R1 would swing. R1 had an incident just two days prior when he hit HSKP-A over the head with a broom. R1 would wander into other residents' rooms, and the residents would tell him to get out. During an interview on 7/15/26 at 10:05 a.m., LPN-A stated the facility had filed another vulnerable adult report to the SA that morning because at			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 10 approximately 4:00 a.m., R1 tried to enter R3's room and punches were exchanged. LPN-A explained that during report LPN-B reported they heard the door alarm and responded but R1 was already in R3's room with where the altercation was already occurring. Further indicated R3's usual wake time was 4:00 a.m. so he was up and able to defend himself but the incident "could have been worse". LPN-A stated R1 had been wandering more since his room changed and even wandered down the west hall which he had never done before. R1 was put on 1:1 staff supervision and the facility was in the process of finding R1 a more secure facility because staff were unable to consistently prevent R1 from entering other residents' rooms despite implemented interventions. During an interview on 7/15/26 at 10:13 a.m., HSKP-A stated she was cleaning R2's bathroom when R1 entered R2's room and put his hands around R2's neck and choked him. Further identified R2 was gasping a lot and started cussing at R1 to get out of his room then some "hitting and stuff" went on. HSKP-A called for help and LPN-A and NA-C intervened and took R1 out of R2's room. HSKP-A stated two days prior, R1 had pushed her cleaning cart at her and came after her with a broom and a dustpan. She screamed for help, and HSKP-B intervened. R1 had hit her in the chest with his fist. During an interview on 7/15/26 at 11:32 am., HSKP-B identified she witnessed the event on 7/7/26 when R1 had a mop in his hand and went after HSPK-A. She took the mope from R1 and notified the nurse. During an interview on 7/15/26 at 12:28 p.m., R1's psychiatric nurse practitioner (NP)-A indicated that R1 had three resident- to- resident altercations in the two weeks prior. R1 had been having aggressive behaviors approximately a year ago which decreased when they increased his Invega. Because of R1's falls, the Invega was decreased in 5/26, but the falls continued so discontinued his Aricept in 6/26 which decreased R1's falls but increased his agitation. NP-A was aware of R1's 7/7/26 incident with the housekeeper and instructed staff to monitor his behaviors and schedule R1's follow up for two weeks. They became aware of the second incident and was told by facility staff that R1's actions were because he was provoked by another resident and were doing 1:1 staff supervision of R1. NP-A saw him on 7/14/26 and was told by facility staff that he			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 11 was doing well so decreased 1:1 supervision to 15-minute checks because of his high fall risk; increased R1's Invega at that time. NP-A also indicated R1 had a urinary tract infection and had several head injuries from his recent falls that likely contributed to his behaviors. During an interview on 7/15/26 at 12:40 p.m., the director of nursing (DON) stated she had been employed at the facility for two weeks. The DON stated R1 had 1:1 staff supervision discontinued on 7/14/26 because of R1's psych NP's recommendations and R1 had been "good" with no wandering into other residents' rooms, no behavioral concerns, and easily redirected by staff. During an interview on 7/15/26 at 1:34 p.m., LPN-B indicated R1 had been "restless" during the night shift of 7/14/26 and but had been "ok" through 4:00 a.m. when she was caring for another resident, one NA was giving a resident a shower, and the other NA was making a bed. LPN-B heard R1's door alarm and responded within 3-4 minutes and witnessed R1 pushing R3's door open while R3 was trying to push the door shut on R1. LPN-B stated R3 told her that he had told R1 to get out, when R1 did not, he was pushing R1 out of the room when R1 punched R3 in the chest so R3 punched R1 in the chest. LPN-B described R1 as aggressive most of the time and staff needed to take care of R1's needs immediately or he became aggressive, in which staff could not tell R1 no or take something away from him or he would get aggressive. R1's behavior trigger was other residents telling him to get out of their room. During an interview on 7/15/26 at 2:00 p.m., NA-D stated she had done 1:1 supervision of R1 and he was active during that time and would try to enter other residents' rooms, but she would redirect and distract him. During an interview on 7/16/26 at 11:12 a.m., the facility's consultant pharmacist stated that the onset of Invega was 1-2 weeks but could take up to 4-6 weeks for the full effect of medication. Review of facility's undated policy titled Abuse, Neglect, and Exploitation, explained it was the policy of the facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures			F0600			08/12/2026

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F0600 SS = SQC-J	Continued from page 12 that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse is defined as the willful infliction of injury and includes certain resident altercations. The facility would identify, correct, and intervene in situations in which abuse, is more likely to occur with the deployment of trained and qualified, registered, and licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; Assign responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors The IJ was removed on 7/20/26 at 3:15 p.m., when it was verified, the facility completed the following actions: R1 was placed on 1:1 supervision and care plan was updated. The facility provided education to all facility staff on the Abuse, Neglect, and Exploitation policy Education was done with the interdisciplinary team to ensure a thorough review of resident behavior, effectiveness of medication changes as well as the psych consult recommendations prior to removing ore decreasing any level of supervision on residents receiving 1:1 supervision. Skin checks were completed on residents to look for any signs or symptoms of abuse. Vulnerable adult and Psychosocial assessments were completed on all in-house residents Progress notes and incident reports were reviewed for the past 30 days for new or worsening behavior of aggression Interviews with staff were completed to identify 4 residents with the potential for physical aggression toward staff or others. Care plans for those identified residents were reviewed for appropriate levels of supervision and diversion techniques. Interviews were completed with other residents in the facility with all denying any resident had an altercation with them.			F0600			08/12/2026

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F0689 SS = D	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 observation, interview and document review, the facility failed to comprehensively assess falls and injuries, identify causal factors and implement interventions to decrease the risk of fall or injury for 2 of 3 residents (R1 and R4) reviewed for injury and falls. Findings include: R1: R1's comprehensive Minimum Data Set (MDS) dated 5/31/26, indicated R1 had severely impaired cognition and had behaviors of disorganized thinking, inattention, physical behavior toward others 1 to 3 days a week, and wandered daily. R1 had no physical impairment to upper and lower extremities and was independent with bed mobility, transferring, and walking. Diagnoses included schizophrenia (mental disorder causing disruption in thought processes, perceptions, emotional responsiveness, and social interactions), anxiety disorder, major depressive disorder, and dementia with behavioral disturbances. R1's Fall Risk Assessment, dated 5/8/26, identified R1 was at high risk for falls due to disorientation; 3 or more falls in the past 3 months; ambulatory and incontinent; took 3-4 high risk medications; recent medication changes; and 3 or more high risk diseases. R1's care plan, initiated 8/23/25, identified R1 was a fall risk related to abnormalities of gait and mobility, cognitive impairment, bilateral hearing deficit with tinnitus (ringing in the ear), insomnia, and will self-transfer without calling for help. Interventions			F0689	Immediate actions taken for the residents found to have been affected: R1, reviewed fall interventions but did not update due to resident discharging from facility. R4, reviewed care plan for skin integrity, updated care plan with interventions to detour bruising, such as; skin monitoring each shift, lotion skin daily, adequate lighting, keep room uncluttered, guide residents arms with light lifting not grasping. Identification of other residents at risk for falls and impaired skin integrity was completed by reviewing fall scores and Braden scores. All residents are at risk for falls, 17 residents identified with low Braden scores. Actions taken/systems put into place to reduce the risk for future occurrence include: Performed Falls training with staff 7-21-2026. Skin checks in house were completed on every resident 7-16-2026.Skin checks performed weekly. Nursing staff will ensure completion of risk management with root cause analysis for each incident in progress notes and assure interventions are updated in the care plan. DON will complete audit of risk mgmt daily Monday through Friday at IDT and falls & skin impairment will be reviewed monthly at QAPI.		08/12/2026

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 07/20/2026	
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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F0689 SS = D	Continued from page 14 included analyzing all falls to determine the cause, reviewing medications for possible changes; appropriate footwear to prevent slipping, R1's bed at appropriate height to get R1 to a standing position; if R1 exhibited increased ambulation or pacing, anticipate needs, and offer snacks, or assist to sit down; keep environment well-lit and clutter free; put items away after using to prevent R1 from tripping. R1's Un-witnessed Fall Report, dated 4/29/26, at 8:20 a.m., indicated that R1 was lying flat on the floor, head near closet and feet were pointed towards clothing rack. R1 was noted to have a “gash” on his right rear skull that was “seeping” blood and redness along his spine. R1 transferred to the emergency department (ED) for evaluation. R1 was wearing gripper socks. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Witnessed Fall Report, dated 5/3/26 at 9:06 a.m., identified licensed practical nurse (LPN)-C witnessed R1 fall to the floor and land on his butt. R1 appeared to have lost strength in his legs, and they gave out. R1 was restless all morning. R1 was wearing gripper socks. Immediate action taken was R1 was assisted to his feet and brought to the day room. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Unwitnessed Fall Report, dated 5/3/26 at 9:30 a.m. indicated that R1 was observed walking out of his room with one hand on the back of his head which was bleeding “profusely”. R1 transferred to ED. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's fall focused care plan was updated on 5/4/26 to encourage R1 to use the bathroom upon waking from night and daytime nap; a sign was posted to remind R1 to use walker.			F0689			08/12/2026

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F0689 SS = D	Continued from page 15 R1's Unwitnessed Fall Report, dated 5/15/26 at 10:15 p.m., indicated staff heard a “bang” and found R1 sitting by his door facing the hallway and holding onto his walker. R1 had gripper socks on and was using the wheelchair for stability before the fall. R1 had no injuries noted. Immediate action taken was resident was assessed, was offered snack and fluids related to low blood pressure and walked R1 back to bed. Follow up progress note on 5/18/26 at 5:21 p.m., fall care plan updated to provide increased frequency of safety rounds when R1 is in his room. The report lacked parameters of what “increased frequency” was. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Unwitnessed Fall Report, dated 6/1/26 at 9:45 a.m., indicated R1 was found sitting on buttocks on the floor. No injuries noted. R1 was assisted to his feet and to the bathroom. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/1/26 at 3:22 p.m., R1 was on the floor in his room with his walker tipped over next to him. R1 received a new reddened area to back right head near previous staple site and pain to hips. R1 was offered to use the bathroom and fall protocol initiated. Fall was unwitnessed. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/1/26 at 3:28 p.m., R1 on the floor and was getting himself up from a sitting position. R1 was hungry and had an upset stomach. An IDT note dated 6/2/26, identified the root cause of the fall was improper footwear as R1 was wearing regular socks at the time of the fall. The interdisciplinary team identified improper footwear as the root cause of the fall. The subsequent care plan identified gripper socks as an intervention; however, the existing care plan already included gripper socks as a fall intervention before the fall occurred. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, and available documentation lacked evidence that resident-specific interventions were developed or			F0689			08/12/2026

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F0689 SS = D	Continued from page 16 implemented to address the identified fall risks R1's Progress Note dated 6/2/26 at 10:05 a.m., R1 fell at 7:15 a.m. and received 2 "gashes" on rear skull. R1 was transferred to the ED. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/2/26 at 10:52 a.m., R1 returned from ED with 4 staples placed to laceration to back of head. R1's Progress Note dated 6/3/26 at 11:14 a.m., R1 found on buttocks on the floor of his room. The progress note indicated R1 had experienced several recent falls related to a shuffling gait. R1 was restless and incontinent of bowel and bladder. R1 was on 15-minute checks related to previous fall intervention. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/6/26 at 4:39 p.m., indicated an unidentified resident observed R1 miss the chair while attempting to sit and slide to the floor. R1's stapled wound area to his head was noted to be bleeding but staples remained intact. Neuro checks were initiated. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's fall focused care plan was updated on 6/16/26, R1 was to wear gripper socks; on 6/18/26, pharmacy review; toilet upon rising, before and after meals, and when agitated; when checking on R1, offer fluids, and on 6/23/26, room changed. R1's Progress Initial Fall Note dated 6/21/26 at 7:50 p.m., R1 fell in room by his bed. R1 sustained an open area at the back of his head where his staples were removed a few days prior. Immediate			F0689			08/12/2026

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F0689 SS = D	Continued from page 17 intervention was to continue 15-minute checks and to do frequent checks when he is awake. Documentation did not define the frequency of the additional checks. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/22/26 at 10:10 a.m., R2 moved to a room closer to nurse's station due to recent falls. Post-fall assessment dated 6/23/26 at 9:02 a.m., root cause analysis identified impaired gait and poor safety awareness. R1's Witnessed Fall Report dated 6/29/26 at 7:04 p.m., R1 had fallen next to the table in the dayroom. No injuries noted. Resident witness indicated R1 had attempted to pick something off the ground and fell. Second resident witness indicated R1 tried to get through the group of wheelchairs and fell. R1 did not have any apparent injuries. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's fall focused care plan was updated on 6/30/26, advised staff to keep bathroom door and room entrance open to help R1 find his bathroom and room entrance/exit, keep R1's door open for visual assessment of his location and status; place R1's walker within his reach; provide R1 assistance if observed ambulating independently; R1 to use his two wheel walker when ambulating; sign printed on green paper with large font to remind R1 to use his walker. On 7/2/26, intervention added to attempt to have R1 stay out of cluttered areas; redirect R1 to less congested area; bring walker to R1 when seen without it; call for staff assistance and stay with R1 until walker arrives. On 7/14/26, added instruction to keep dining style chairs out of room related to fall from chair; and requested physical therapy to evaluate and treat. R4 R4's quarterly MDS dated 6/12/26, indicated R4 had moderately impaired cognition and delusions. R4 required staff assist with dressing, toileting, transferring, wheeling wheelchair, and dressing. R4			F0689			08/12/2026

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F0689 SS = D	Continued from page 18 did not walk. Diagnoses included Alzheimer’s Disease, seizure disorder, diabetes, and arthritis. R4 received hospice services. R4’s Vulnerability and Susceptibility to Abuse dated 7/16/26 at 4:24 p.m., identified R4 was at risk for abuse related to cognitive impairment, psychotic behavior, unable to control their actions, physical impairment, communication impairment, sensory impairment. R4 was identified as a vulnerable adult unable to report but no signs of abuse or neglect present. R4’s Care Plan Report did not identify risk of abuse, risk of bruising, or vulnerable adult risk. R4’s Injury of Known Cause Report dated 6/18/26 at 1:30 p.m., identified R4 had 4 bruises to right lower inner arm; 3 are purplish in color and one is red in color; unknown where they came from; R4 unable to state what happened. The injury report did not document a comprehensive assessment regarding the cause of the bruising, contributing factors, or resident-specific interventions to reduce the risk of additional unexplained injuries. R4’s Injury of Known Cause Report dated 6/29/26 at 9:00 a.m., identified R4 had a 3 centimeter (cm) fading bruise on her left knee; R4 unaware of how the bruise occurred; denied that anyone hurt her; no immediate interventions required. The injury report did not document a comprehensive assessment regarding the cause of the bruising, contributing factors, or resident-specific interventions to reduce the risk of additional unexplained injuries. During an interview on 7/14/26 at 2:10 a.m., the regional clinical consultant (RCC) stated she could not answer questions regarding the facility. The director of nursing (DON) indicated she had been employed at the facility for two weeks but stated if there was an incident or a fall, the comprehensive assessment, root cause analysis, and interventions should be in a post incident progress note. During an interview on 7/14/26 at 2:20 p.m., LPN-A stated R1 fell frequently during the late evening shifts, and they had implemented the walker, checked him for orthostatic hypotension, and moved			F0689			08/12/2026

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F0689 SS = D	Continued from page 19 his room. If there was an incident or a fall, an incident report should be done and follow fall protocol. During an interview on 7/15/26 at 12:28 p.m., R1's psychiatric nurse practitioner (NP) indicated that R1 had fallen frequently and had some medication changes because they were concerned the medications were lowering his blood pressure. The facility also did 15-minute checks for fall prevention. The NP stated R1 had sustained multiple head injuries from recent falls and believed those injuries likely contributed to R1's behaviors. During an interview on 7/15/26 at 12:40 p.m., the DON indicated the facility does not have any evidence of fall investigations, root cause analysis, or interventions for R1's falls or R4's bruising and did not know why some fall reports were not done. Review of facility's undated policy titled, Accidents and Supervision indicated the resident environment would remain as free of accident hazards as is possible. Each resident would receive adequate supervision (intervention and means of mitigating risk of accidents) and assistive devices to prevent accidents. This included identifying and evaluating hazards (elements of the resident environment that have the potential to cause injury or illness) and risks (any external factor, facility characteristic (staffing, or physical environment) or characteristic of an individual resident that influences the likelihood of an accident); implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Additionally, the facility should establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents in which all staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. Review of the facility's undated policy titled, Fall Prevention Program indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A "fall" is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not because of an overwhelming external force			F0689			08/12/2026

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F0689 SS = D	Continued from page 20 (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. The nurse will indicate on the “(specify location)” the resident’s fall risk and initiate interventions on the resident’s baseline care plan, in accordance with the resident’s level of risk. The nurse as to refer to the facility’s “High Risk or Low/Moderate Risk protocols” when determining primary interventions. The High-Risk Protocols instructed, but is not limited to: - The resident was to be placed on the facility’s Fall Prevention program which would be identified on the care plan which was to be developed based on risk factors and environmental hazards for the resident. Once developed, the care plan interventions were to be monitored for effectiveness and revised as needed. - Implement interventions from the Low/Moderate Risk Protocols. - Provide interventions that address unique risk factors measured by the risk assessment tool; medications, psychological, cognitive status, or recent change in functional status. - Provide additional interventions as directed by the resident’s assessment, including but not limited to: increased frequency of rounds, sitter, if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, therapy services referral, etc. - When a fall occurred, the facility was expected to assess the resident, complete a post-fall assessment and an incident report, notify the physician and family, review the care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of an injury.			F0689			08/12/2026

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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 7/14/26, 7/15/26, 7/16/26, and 7/20/26, a complaint survey was conducted at your facility by a surveyor 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: H52733231C (3074373) and H52733345C (3093759) with licensing order was issued		20000			08/13/2026	

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			08/13/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess falls and injuries, identify causal factors and implement interventions to decrease the risk of fall or injury for 2 of 3 residents (R1 and R4) reviewed for injury and falls. Findings include: R1: R1's comprehensive Minimum Data Set (MDS) dated 5/31/26, indicated R1 had severely impaired cognition and had behaviors of disorganized thinking, inattention, physical behavior toward others 1 to 3 days a week, and wandered daily. R1 had no physical impairment to upper and lower extremities and was independent with bed mobility, transferring, and walking. Diagnoses included schizophrenia (mental disorder causing disruption in thought processes, perceptions, emotional responsiveness, and social interactions), anxiety disorder, major depressive disorder, and dementia with behavioral disturbances. R1's Fall Risk Assessment, dated 5/8/26, identified R1 was at high risk for falls due to disorientation; 3 or more falls in the past 3 months; ambulatory and incontinent; took 3-4 high risk medications; recent medication changes; and 3 or more high risk diseases.		20830	Corrected		08/12/2026	

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20830	Continued from page 2 R1's care plan, initiated 8/23/25, identified R1 was a fall risk related to abnormalities of gait and mobility, cognitive impairment, bilateral hearing deficit with tinnitus (ringing in the ear), insomnia, and will self-transfer without calling for help. Interventions included analyzing all falls to determine the cause, reviewing medications for possible changes; appropriate footwear to prevent slipping, R1's bed at appropriate height to get R1 to a standing position; if R1 exhibited increased ambulation or pacing, anticipate needs, and offer snacks, or assist to sit down; keep environment well-lit and clutter free; put items away after using to prevent R1 from tripping. R1's Un-witnessed Fall Report, dated 4/29/26, at 8:20 a.m., indicated that R1 was lying flat on the floor, head near closet and feet were pointed towards clothing rack. R1 was noted to have a “gash” on his right rear skull that was “seeping” blood and redness along his spine. R1 transferred to the emergency department (ED) for evaluation. R1 was wearing gripper socks. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Witnessed Fall Report, dated 5/3/26 at 9:06 a.m., identified licensed practical nurse (LPN)-C witnessed R1 fall to the floor and land on his butt. R1 appeared to have lost strength in his legs, and they gave out. R1 was restless all morning. R1 was wearing gripper socks. Immediate action taken was R1 was assisted to his feet and brought to the day room. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Unwitnessed Fall Report, dated 5/3/26 at 9:30 a.m. indicated that R1 was observed walking out of his room with one hand on the back of his head which was bleeding “profusely”. R1 transferred to ED. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1’s fall focused care plan was updated on 5/4/26			20830			08/12/2026

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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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20830	Continued from page 3 to encourage R1 to use the bathroom upon waking from night and daytime nap; a sign was posted to remind R1 to use walker. R1's Unwitnessed Fall Report, dated 5/15/26 at 10:15 p.m., indicated staff heard a “bang” and found R1 sitting by his door facing the hallway and holding onto his walker. R1 had gripper socks on and was using the wheelchair for stability before the fall. R1 had no injuries noted. Immediate action taken was resident was assessed, was offered snack and fluids related to low blood pressure and walked R1 back to bed. Follow up progress note on 5/18/26 at 5:21 p.m., fall care plan updated to provide increased frequency of safety rounds when R1 is in his room. The report lacked parameters of what “increased frequency” was. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Unwitnessed Fall Report, dated 6/1/26 at 9:45 a.m., indicated R1 was found sitting on buttocks on the floor. No injuries noted. R1 was assisted to his feet and to the bathroom. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/1/26 at 3:22 p.m., R1 was on the floor in his room with his walker tipped over next to him. R1 received a new reddened area to back right head near previous staple site and pain to hips. R1 was offered to use the bathroom and fall protocol initiated. Fall was unwitnessed. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/1/26 at 3:28 p.m., R1 on the floor and was getting himself up from a sitting position. R1 was hungry and had an upset stomach. An IDT note dated 6/2/26, identified the root cause of the fall was improper footwear as R1 was wearing regular socks at the time of the fall. The interdisciplinary team identified improper footwear as the root cause of the fall. The subsequent care plan identified gripper socks as an intervention; however, the existing care plan already			20830			08/12/2026

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20830	Continued from page 4 included gripper socks as a fall intervention before the fall occurred. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks R1's Progress Note dated 6/2/26 at 10:05 a.m., R1 fell at 7:15 a.m. and received 2 "gashes" on rear skull. R1 was transferred to the ED. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/2/26 at 10:52 a.m., R1 returned from ED with 4 staples placed to laceration to back of head. R1's Progress Note dated 6/3/26 at 11:14 a.m., R1 found on buttocks on the floor of his room. The progress note indicated R1 had experienced several recent falls related to a shuffling gait. R1 was restless and incontinent of bowel and bladder. R1 was on 15-minute checks related to previous fall intervention. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/6/26 at 4:39 p.m., indicated an unidentified resident observed R1 miss the chair while attempting to sit and slide to the floor. R1's stapled wound area to his head was noted to be bleeding but staples remained intact. Neuro checks were initiated. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's fall focused care plan was updated on 6/16/26, R1 was to wear gripper socks; on 6/18/26, pharmacy review; toilet upon rising, before and after meals, and when agitated; when checking on R1, offer fluids, and on 6/23/26, room changed.			20830			08/12/2026

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20830	Continued from page 5 R1's Progress Initial Fall Note dated 6/21/26 at 7:50 p.m., R1 fell in room by his bed. R1 sustained an open area at the back of his head where his staples were removed a few days prior. Immediate intervention was to continue 15-minute checks and to do frequent checks when he is awake. Documentation did not define the frequency of the additional checks. The facility lacked evidence of a Fall Report for the fall, comprehensive assessment, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's Progress Note dated 6/22/26 at 10:10 a.m., R2 moved to a room closer to nurse's station due to recent falls. Post-fall assessment dated 6/23/26 at 9:02 a.m., root cause analysis identified impaired gait and poor safety awareness. R1's Witnessed Fall Report dated 6/29/26 at 7:04 p.m., R1 had fallen next to the table in the dayroom. No injuries noted. Resident witness indicated R1 had attempted to pick something off the ground and fell. Second resident witness indicated R1 tried to get through the group of wheelchairs and fell. R1 did not have any apparent injuries. The fall report lacked a comprehensive assessment, root cause analysis, and available documentation lacked evidence that resident-specific interventions were developed or implemented to address the identified fall risks. R1's fall focused care plan was updated on 6/30/26, advised staff to keep bathroom door and room entrance open to help R1 find his bathroom and room entrance/exit, keep R1's door open for visual assessment of his location and status; place R1's walker within his reach; provide R1 assistance if observed ambulating independently; R1 to use his two wheel walker when ambulating; sign printed on green paper with large font to remind R1 to use his walker. On 7/2/26, intervention added to attempt to have R1 stay out of cluttered areas; redirect R1 to less congested area; bring walker to R1 when seen without it; call for staff assistance and stay with R1 until walker arrives. On 7/14/26, added instruction to keep dining style chairs out of room related to fall from chair; and requested physical therapy to evaluate and treat. R4			20830			08/12/2026

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20830	Continued from page 6 R4's quarterly MDS dated 6/12/26, indicated R4 had moderately impaired cognition and delusions. R4 required staff assist with dressing, toileting, transferring, wheeling wheelchair, and dressing. R4 did not walk. Diagnoses included Alzheimer's Disease, seizure disorder, diabetes, and arthritis. R4 received hospice services. R4's Vulnerability and Susceptibility to Abuse dated 7/16/26 at 4:24 p.m., identified R4 was at risk for abuse related to cognitive impairment, psychotic behavior, unable to control their actions, physical impairment, communication impairment, sensory impairment. R4 was identified as a vulnerable adult unable to report but no signs of abuse or neglect present. R4's Care Plan Report did not identify risk of abuse, risk of bruising, or vulnerable adult risk. R4's Injury of Known Cause Report dated 6/18/26 at 1:30 p.m., identified R4 had 4 bruises to right lower inner arm; 3 are purplish in color and one is red in color; unknown where they came from; R4 unable to state what happened. The injury report did not document a comprehensive assessment regarding the cause of the bruising, contributing factors, or resident-specific interventions to reduce the risk of additional unexplained injuries. R4's Injury of Known Cause Report dated 6/29/26 at 9:00 a.m., identified R4 had a 3 centimeter (cm) fading bruise on her left knee; R4 unaware of how the bruise occurred; denied that anyone hurt her; no immediate interventions required. The injury report did not document a comprehensive assessment regarding the cause of the bruising, contributing factors, or resident-specific interventions to reduce the risk of additional unexplained injuries. During an interview on 7/14/26 at 2:10 a.m., the regional clinical consultant (RCC) stated she could not answer questions regarding the facility. The director of nursing (DON) indicated she had been employed at the facility for two weeks but stated if there was an incident or a fall, the comprehensive assessment, root cause analysis, and interventions should be in a post incident progress note.			20830			08/12/2026

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20830	Continued from page 7 During an interview on 7/14/26 at 2:20 p.m., LPN-A stated R1 fell frequently during the late evening shifts, and they had implemented the walker, checked him for orthostatic hypotension, and moved his room. If there was an incident or a fall, an incident report should be done and follow fall protocol. During an interview on 7/15/26 at 12:28 p.m., R1's psychiatric nurse practitioner (NP) indicated that R1 had fallen frequently and had some medication changes because they were concerned the medications were lowering his blood pressure. The facility also did 15-minute checks for fall prevention. The NP stated R1 had sustained multiple head injuries from recent falls and believed those injuries likely contributed to R1's behaviors. During an interview on 7/15/26 at 12:40 p.m., the DON indicated the facility does not have any evidence of fall investigations, root cause analysis, or interventions for R1's falls or R4's bruising and did not know why some fall reports were not done. Review of facility's undated policy titled, Accidents and Supervision indicated the resident environment would remain as free of accident hazards as is possible. Each resident would receive adequate supervision (intervention and means of mitigating risk of accidents) and assistive devices to prevent accidents. This included identifying and evaluating hazards (elements of the resident environment that have the potential to cause injury or illness) and risks (any external factor, facility characteristic (staffing, or physical environment) or characteristic of an individual resident that influences the likelihood of an accident); implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Additionally, the facility should establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents in which all staff are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. Review of the facility's undated policy titled, Fall Prevention Program indicated each resident will be assessed for fall risk and will receive care and			20830			08/12/2026

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20830	Continued from page 8 services in accordance with their individualized level of risk to minimize the likelihood of falls. A “fall” is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not because of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. The nurse will indicate on the “(specify location)” the resident’s fall risk and initiate interventions on the resident’s baseline care plan, in accordance with the resident’s level of risk. The nurse as to refer to the facility’s “High Risk or Low/Moderate Risk protocols” when determining primary interventions. The High-Risk Protocols instructed, but is not limited to: - The resident was to be placed on the facility’s Fall Prevention program which would be identified on the care plan which was to be developed based on risk factors and environmental hazards for the resident. Once developed, the care plan interventions were to be monitored for effectiveness and revised as needed. - Implement interventions from the Low/Moderate Risk Protocols. - Provide interventions that address unique risk factors measured by the risk assessment tool; medications, psychological, cognitive status, or recent change in functional status. - Provide additional interventions as directed by the resident’s assessment, including but not limited to: increased frequency of rounds, sitter, if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, therapy services referral, etc. - When a fall occurred, the facility was expected to assess the resident, complete a post-fall assessment and an incident report, notify the physician and family, review the care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of an injury. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on expected fall processes; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one days			20830			08/12/2026