Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 23, 2025

Administrator

Franklin Restorative Care Center

900 3RD STREET SOUTH

FRANKLIN, MN 55333

RE: CCN: 245273

Cycle Start Date: May 1, 2025

Dear Administrator:

On June 13, 2025, we notified you a remedy was imposed.

On July 29, 2025, 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 July 11, 2025.

As authorized by CMS the remedy of:

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

In our letter of June 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 1, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 11, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Your request for a 24-hour RN waiver has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 23, 2025

Administrator
Franklin Restorative Care Center

900 3RD STREET SOUTH
FRANKLIN, MN 55333

Re: Reinspection Results
Event ID: 1FSG12

Dear Administrator:

On June 30, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

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

RE: CCN: 245273
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 2025, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 1, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 1, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1FSG11

Dear Administrator:

The above facility was surveyed on April 30, 2025, through May 1, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/30/25 through 5/1/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52733768C (MN00112620) H52733828C (MN00110532) H52733827C (MN00111171) a deficiency was issued at F686. An unrelated deficiency was issued at F880. 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.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		5/25/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician orders were followed for pressure ulcer (PU) wound care for 3 of 3 resident (R1, R4, and R5) reviewed for wound care. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage III pressure ulcer: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage IV pressure ulcer: full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. R1's Face Sheet dated 3/1/23, indicated R1 had paraplegia, stage IV pressure ulcer of sacral region, and protein-calorie malnutrition.	F 686	1.Corrective actions taken for affected residents: Physician orders for RI, R4, and R5 were immediately reviewed. The orders were reviewed and updated in resident's treatment record to reflect accurate and current treatments for wounds. Attending physician and responsible parties were notified of the omissions and the corrective actions taken. 2.Identification of other residents with potential to be affected: An audit of residents with current wound care orders was conducted to identify any additional discrepancies. Any identified issues were corrected, and wound care treatments are now in compliance with physician orders. 3. Measures and systemic changes to ensure compliance: Licensed nursing staff were re-educated on the importance of following physician orders, documentation standards, and wound care protocols. A wound documentation tips tool was provided during nurse education. Charge nurses will verify wound care completion daily, and any concerns will be escalated to the Director of Nursing. 4. Monitoring and quality assurance: The Director of Nursing or designee will conduct weekly audits of wound care orders and treatment records for 5 residents per week for 3 months. Findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2 R1's annual Minimum Data Set (MDS) assessment dated 2/23/25, indicated R1 was cognitively intact, needed supervision with cares, and had one stage III and one stage IV pressure ulcers. R1's care plan dated 9/6/23, indicated R1 had a stage IV pressure ulcer on his coccyx and a stage III pressure ulcer on his left ankle. Interventions included the facility would administer treatments as ordered and monitor for effectiveness. R1's provider orders dated 4/1/25 through 4/30/25, indicated R1 had the following orders: - right heel pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to surrounding skin, collagen (natural fibrous protein) to wound bed, and dressing would be applied daily. - sacrum pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to peri wound, iodosorb gel (inhibits growth of microorganisms) to wound bed, lightly soak kerlix with vashe (wound cleanser) wound solution, pack the wound, and cover with a dressing two times a day. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's right heel pressure ulcer lacked documentation that dressing changes was completed on 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's sacrum pressure ulcer lacked documentation that dressing change was completed on day shift on 4/6/25, 4/8/25,	F 686	will be reviewed during monthly QAPI meetings. Continued non-compliance will result in further corrective action and retraining.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 3 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's sacrum pressure ulcer lacked documentation that dressing change was completed on evening shift 4/13/25 and 4/30/25. R4's Face Sheet dated 9/28/23, indicated R4 had adult failure to thrive and muscle weakness. R4's significant change MDS assessment dated 4/7/25, indicated R4 was cognitively intact, needed extensive assistance with bed mobility and personal hygiene, and had a stage III pressure ulcer. R4's care plan dated 9/20/24, indicated R4 had a stage II pressure ulcer on her coccyx. Interventions indicated the facility would follow policies and protocols for skin breakdown. R4's provider orders dated 4/1/25 through 4/30/25, indicated R4 had the following orders: - right glute wound would be cleansed with wound cleanser, packed with vasche soaked gauze, and covered with adhesive foam dressing daily. - left ischial tuberosity would be cleansed with wound cleanser, skin prep applied around edges, and a bordered silicone dressing would be applied every two days. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R4's right glute wound lacked documentation that dressing changes was completed on 4/4/25, 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/16/25, 4/19/25, and 4/24/25. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R's left ischial tuberosity wound lacked documentation that dressing change was completed on 4/22/25 and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 4 4/24/25. R5's Face Sheet dated 1/4/25, indicated R5 had type 2 diabetes mellitus. R5's significant change MDS assessment dated 3/7/25, indicated R5 was cognitively intact, had a stage III pressure ulcer, and needed extensive assistance with cares. R5's care plan dated 3/31/25, indicated R5 had a pressure ulcer to his left elbow. Interventions indicated the facility would follow policies and protocols for skin breakdown and would monitor left elbow dressing. R5's provider orders dated 4/1/25 through 4/30/25, indicated R5 had the following orders: - left elbow stage III pressure ulcer would be cleansed with wound cleanser and covered with foam adhesive bandage daily R5's treatment administration record dated 4/1/25 through 4/30/25, indicated R5's left elbow stage III pressure ulcer lacked documentation that dressing changes was completed on 4/2/25, 4/5/25, 4/6/25, 4/7/25, 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/19/25, and 4/22/25. During an interview on 4/30/25 at 11:18 a.m., R1 stated there had been several times in the last month that his dressings have not been changed. He stated he was not sure what dates or why, but the nurse never came to complete them, and he did not ask for his dressings to be changed. During an interview on 4/30/25 at 3:14 p.m., R5 stated staff do the best they can to get dressings done but it does not happen every day. R5 stated	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 5 he was not sure what dates his dressings were not completed in the last month. During an interview on 5/1/25 at 9:52 a.m., R4 stated there have been several times her dressings have not been completed but she was not sure what dates or why. During an interview on 5/1/25 at 11:32 a.m., licensed practical nurse (LPN)-A stated if she did a resident's dressings she would have documented the completion in the record. She stated there has been several times in the last month that she was not able to complete dressing changes for the residents, but she reported this to the director of nursing (DON). LPN-A stated she was not sure if the dressing changes were completed on those days. She stated she does not recall the dates or who the residents were that did not get their dressings changed. During an interview on 5/1/25 at 11:57 a.m., LPN-B stated if she did not document in the residents' records that a dressing was completed, she would not have done it. She stated there were times she was unable to get wounds done but she would report to the DON when she was not able to complete the dressings. There were days where wounds were just not done for the residents, but "I always told the DON". During an interview on 5/1/25 at 12:38 p.m., infection preventionist (IP)-A stated she if she was in charge of completing dressing orders for the day, she would have charted the ones she completed in the residents' medical record if she had completed them. IP-A stated she was not sure why dressing orders were not completed on several occasions in the last month.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 6 During an interview on 5/1/25 at 1:33 p.m., registered nurse (RN)-A stated when she has worked at the facility, she was never in charge of completing dressing changes. She stated if she were to do a dressing change, she would have documented in the resident's medical record. During an interview on 5/1/25 at 1:55 p.m., interim DON stated staff were expected to follow provider orders when it came to wound care. Facility wound treatment management policy reviewed 2/2025, indicated wound treatments would be completed according to physician orders.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		5/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during wound care for 2 of 3 residents (R4 and R5) reviewed for wound care. Findings include: R4's significant change Minimum Data Set (MDS) dated 4/7/25, indicated R4 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R4's provider orders dated 4/17/25, indicated R4 had a dressing order to cleanse R4's laceration on her left lower buttock with wound cleanser, apply skin barrier prep around edges, and apply a bordered silicone dressing every 2 days. R5's significant change MDS dated 3/7/25, indicated R5 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R5's provider orders dated 2/18/25, indicated R5 had a dressing order to cleanse R5's left elbow with wound cleanser and cover with foam adhesive bandage daily. During an observation on 4/30/25 at 10:47 a.m., the infection preventionist (IP)-A entered R4's	F 880	1.Corrective actions taken for affected residents: The staff member involved in wound care for R4 and R5 was re-educated on proper hand hygiene procedures per CDC and facility policy. R4 and R5 were assessed for any signs of infection; none were identified. No adverse outcomes were noted, and responsible parties and physicians were notified. 2.Identification of other residents with potential to be affected: A review of wound care practices for all residents receiving wound treatments was conducted. Observations and chart audits were completed to identify any further breaches in hand hygiene. Any issues found were addressed immediately with retraining and corrective action as needed. 3.Measures and systemic changes to ensure compliance: Staff were re-educated on hand hygiene policies, with an emphasis on moments requiring handwashing during wound care (before, after glove use, and between resident contact). Visual reminders were posted in treatment areas, and supervisory staff will reinforce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 room after sanitizing her hands. IP-A applied gown and gloves. IP-A explained to R4 that IP-A was going to complete R4's dressing changes. IP-A removed soiled dressing from R4's left lower buttock with a small amount of pink colored drainage. IP-A cleansed the left lower buttock with wound cleanser and gauze. IP-A did not remove her gloves and wash her hands. IP-A applied a clean bordered silicone dressing to R4's left lower buttock wound. IP-A removed her gloves and gown, sanitized her hands, and left the room. During an observation on 4/30/25 at 1:53 p.m., IP-A entered R5's room and explained to R5 she would be completing his dressing to his left elbow due to the dressing falling off. IP-A washed her hands with soap and water and applied gown and gloves. IP-A cleansed R5's left elbow with wound cleanser and gauze. IP-A did not remove her gloves and wash her hand. IP-A removed a border foam dressing from its packaging and applied it to R5's left elbow wound. IP-A removed her gown and gloves and washed her hands with soap and water. During an interview on 4/30/25 at 2:04 p.m., IP-A stated when she provides wound care she was expected to remove gloves and wash hands after any dirty tasks such as removing a soiled dressing and cleansing a wound. IP-A stated she did not do that with R4 or R5 when changing their dressings. IP-A stated she should have taken off her gloves and washed her hands after cleansing R4 and R5's wounds. During an interview on 5/1/25 at 1:55 p.m., the interim director of nursing (DON) stated staff were expected to wash their hands before a	F 880	expectations during daily rounds. 3.Monitoring and quality assurance: The Infection Preventionist or designee will conduct random observations of wound care procedures for proper hand hygiene on 5 wound treatments weekly for 1 month, then monthly for 3 months. Audit results will be reviewed in QAPI meetings. Patterns of non-compliance will result in further retraining and disciplinary action, if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 dressing change, after removing the soiled dressing, after cleansing the wound, and after placing a new dressing on the wound. The facilities Hand Hygiene policy reviewed 2/2025, indicated hand hygiene would be completed before and after handling clean or soiled dressings and when moving from a contaminated body site to a clean body site.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/30/25 through 5/1/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H52733768C (MN00112620) H52733828C (MN00110532) H52733827C (MN00111171) a licensing order was issued at 4658.0525 Subp. 3 An unrelated licensing order was issued at 4658.0800 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician orders were followed for pressure ulcer (PU) wound care for 3 of 3 resident (R1, R4, and R5) reviewed for	2 900	Corrected	5/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 3 wound care. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage III pressure ulcer: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage IV pressure ulcer: full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. R1's Face Sheet dated 3/1/23, indicated R1 had paraplegia, stage IV pressure ulcer of sacral region, and protein-calorie malnutrition. R1's annual Minimum Data Set (MDS) assessment dated 2/23/25, indicated R1 was cognitively intact, needed supervision with cares, and had one stage III and one stage IV pressure ulcers.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 4 R1's care plan dated 9/6/23, indicated R1 had a stage IV pressure ulcer on his coccyx and a stage III pressure ulcer on his left ankle. Interventions included the facility would administer treatments as ordered and monitor for effectiveness. R1's provider orders dated 4/1/25 through 4/30/25, indicated R1 had the following orders: - right heel pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to surrounding skin, collagen (natural fibrous protein) to wound bed, and dressing would be applied daily. - sacrum pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to peri wound, iodosorb gel (inhibits growth of microorganisms) to wound bed, lightly soak kerlix with vashe (wound cleanser) wound solution, pack the wound, and cover with a dressing two times a day. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's right heel pressure ulcer lacked documentation that dressing changes was completed on 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's sacrum pressure ulcer lacked documentation that dressing change was completed on day shift on 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's sacrum pressure ulcer lacked documentation that dressing change was completed on evening shift 4/13/25 and 4/30/25. R4's Face Sheet dated 9/28/23, indicated R4 had adult failure to thrive and muscle weakness.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 5 R4's significant change MDS assessment dated 4/7/25, indicated R4 was cognitively intact, needed extensive assistance with bed mobility and personal hygiene, and had a stage III pressure ulcer. R4's care plan dated 9/20/24, indicated R4 had a stage II pressure ulcer on her coccyx. Interventions indicated the facility would follow policies and protocols for skin breakdown. R4's provider orders dated 4/1/25 through 4/30/25, indicated R4 had the following orders: - right glute wound would be cleansed with wound cleanser, packed with vasche soaked gauze, and covered with adhesive foam dressing daily. - left ischial tuberosity would be cleansed with wound cleanser, skin prep applied around edges, and a bordered silicone dressing would be applied every two days. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R4's right glute wound lacked documentation that dressing changes was completed on 4/4/25, 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/16/25, 4/19/25, and 4/24/25. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R's left ischial tuberosity wound lacked documentation that dressing change was completed on 4/22/25 and 4/24/25. R5's Face Sheet dated 1/4/25, indicated R5 had type 2 diabetes mellitus. R5's significant change MDS assessment dated 3/7/25, indicated R5 was cognitively intact, had a stage III pressure ulcer, and needed extensive assistance with cares.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 R5's care plan dated 3/31/25, indicated R5 had a pressure ulcer to his left elbow. Interventions indicated the facility would follow policies and protocols for skin breakdown and would monitor left elbow dressing. R5's provider orders dated 4/1/25 through 4/30/25, indicated R5 had the following orders: - left elbow stage III pressure ulcer would be cleansed with wound cleanser and covered with foam adhesive bandage daily R5's treatment administration record dated 4/1/25 through 4/30/25, indicated R5's left elbow stage III pressure ulcer lacked documentation that dressing changes was completed on 4/2/25, 4/5/25, 4/6/25, 4/7/25, 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/19/25, and 4/22/25. During an interview on 4/30/25 at 11:18 a.m., R1 stated there has been several times in the last month that his dressings have not been changed. He stated he is not sure what dates or why, but the nurse never came to complete them, and he did not ask for his dressings to be changed. During an interview on 4/30/25 at 3:14 p.m., R5 stated staff do the best they can to get my dressings done but it does not happen every day. R5 stated he was not sure what dates his dressings were not completed in the last month. During an interview on 5/1/25 at 9:52 a.m., R4 stated there have been several times her dressings have not been completed but she is not sure what dates or why. During an interview on 5/1/25 at 11:32 a.m., licensed practical nurse (LPN)-A stated if she did	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 a resident's dressings she would have documented the completion in the record. She stated there has been several times in the last month that she was not able to complete dressing changes for the residents, but she reported this to the director of nursing (DON). LPN-A stated she was not sure if the dressing changes were completed on those days. She stated she does not recall the dates or who the residents were that did not get their dressings changed. During an interview on 5/1/25 at 11:57 a.m., LPN-B stated if she did not document in the residents' records that a dressing was completed, she would not have done it. She stated there were times she was unable to get wounds done but she would report to the DON when she was not able to complete the dressings. There were days where wounds were just not done for the residents, but I always told the DON. During an interview on 5/1/25 at 12:38 p.m., infection preventionist (IP)-A stated she if she was in charge of completing dressing orders for the day, she would have charted the ones she completed in the residents' medical record if she had completed them. IP-A stated she is not sure why dressing orders were not completed on several occasions in the last month. During an interview on 5/1/25 at 1:33 p.m., registered nurse (RN)-A stated when she has worked at the facility, she was never in charge of completing dressing changes. She stated if she were to do a dressing change, she would have documented in the resident's medical record. During an interview on 5/1/25 at 1:55 p.m., interim DON stated staff were expected to follow provider orders when it came to wound care.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 Facility wound treatment management policy reviewed 2/2025, indicated wound treatments would be completed according to physician orders. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding treatments. The DON or designee could provide education on these policies and procedures to all staff who provide wound care. The DON or designee could and establish a system to monitor wound dressing changes are completed per orders then report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper and hand hygiene was performed during wound care for 2 of 3 (R4 and R5) residents reviewed for wound care. Findings include:	21375	Corrected	5/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 9 R4's significant change Minimum Data Set (MDS) dated 4/7/25, indicated R4 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R4's provider orders dated 4/17/25, indicated R4 had a dressing order to cleanse R4's laceration on her left lower buttock with wound cleanser, apply skin barrier prep around edges, and apply a bordered silicone dressing every 2 days. R5's significant change MDS dated 3/7/25, indicated R5 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R5's provider orders dated 2/18/25, indicated R5 had a dressing order to cleanse R5's left elbow with wound cleanser and cover with foam adhesive bandage daily. During an observation on 4/30/25 at 10:47 a.m., the infection preventionist (IP)-A entered R4's room after sanitizing her hands. IP-A applied gown and gloves. IP-A explained to R4 that IP-A was going to complete R4's dressing changes. IP-A removed soiled dressing from R4's left lower buttock with a small amount of pink colored drainage. IP-A cleansed the left lower buttock with wound cleanser and gauze. IP-A did not remove her gloves and wash her hands. IP-A applied a clean bordered silicone dressing to R4's left lower buttock wound. IP-A removed her gloves and gown, sanitized her hands, and left the room. During an observation on 4/30/25 at 1:53 p.m., IP-A entered R5's room and explained to R5 she	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 10 would be completing his dressing to his left elbow due to the dressing falling off. IP-A washed her hands with soap and water and applied gown and gloves. IP-A cleansed R5's left elbow with wound cleanser and gauze. IP-A did not remove her gloves and wash her hand. IP-A removed a border foam dressing from its packaging and applied it to R5's left elbow wound. IP-A removed her gown and gloves and washed her hands with soap and water. During an interview on 4/30/25 at 2:04 p.m., IP-A stated when she provides wound care she is expected to remove gloves and wash hands after any dirty tasks such as removing a soiled dressing and cleansing a wound. IP-A stated she did not do that with R4 or R5 when changing their dressings. IP-A state she should have taken of her gloves and washed her hands after cleansing R4 and R5's wounds. During an interview on 5/1/25 at 1:55 p.m., the interim director of nursing (DON) stated staff were expected to wash there hands before a dressing change, after removing the soiled dressing, after cleansing the wound, and after placing a new dressing on the wound. The facilities Hand Hygiene policy reviewed 2/2025, indicated hand hygiene would be completed before and after handling clean or soiled dressings and when moving from a contaminated body site to a clean body site. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding hand hygiene. The DON or designee could provide education on these policies and procedures to all staff who provide direct care. The DON or	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11 designee could and establish a system to monitor staff for infection control practices including hand hygiene then report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		