Electronically delivered

September 17, 2019

Administrator
Franklin Rehabilitation & Healthcare Center
900 3rd Street South
Franklin, MN 55333

RE: Project Number H5273037C

Dear Administrator:

On August 5, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 3, 2019.

Also on August 5, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy(ies):

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

On August 26, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 14 2019. We have determined, based on our visit, that your facility has corrected as of August 26, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 3, 2019 be rescinded as of August 26, 2019. (42 CFR 488.417 (b))

In our letter of August 5, 2019, 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), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 3, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 26, 2019, 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 Therefore, the NATCEP prohibition is rescinded however, this does not apply to or affect any previously imposed NATCEP loss.

In addition, this Department recommended to the CMS Region V Office the following the remedies:

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2019

Administrator
Franklin Rehabilitation & Healthcare Center
900 3rd Street South
Franklin, MN 55333

Re: Reinspection Results - Complaint Number **H52573037C**

Dear Administrator:

On August 26, 2019 an investigator from the Minnesota Department of Health, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on July 14, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 5, 2019

Administrator
Franklin Rehabilitation & Healthcare Center
900 3rd Street South
Franklin, MN 55333

RE: Project Numbers H52573037C, H5273038C

Dear Administrator:

On July 15, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 3, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 3, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 3, 2019.

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 3, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Franklin Rehabilitation & Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 3, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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 [January 15, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245273	A. BUILDING _____ B. WING _____	C 07/15/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 7/9-715/19, an abbreviated survey was completed to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H52573037C In addition, the following complaint was found NOT to be substantiated: H5273038C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/14/19

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

Electronically Signed | 08/14/2019

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

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F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an comprehensive assessment and monitoring of their physical condition following a surgical procedure for 1 of 1 resident (R1) whom had a surgical procedure. As a result of this, R1 died unexpectedly at the facility the same day she returned from the procedure causing actual harm. Findings include: R1's 5/7/19, quarterly Minimum Data Set (MDS) assessment identified diagnoses of gall bladder disease with stones, Chronic Obstructive Pulmonary Disease (COPD), a history (Hx) of alcohol dependence, and high blood pressure. R1's cognition was intact, and she was independent with activities of daily living (ADLs), except for eating which required supervision. R1's nursing progress notes identified R1 had been admitted to the facility in October 2018, with the biliary drain in place. R1 had requested the physician remove her biliary drain related to complaints of pain. R1 had requested to have the drain removed resulting in the scheduled procedure which took place on 7/3/19. R1 had left the facility on 7/3/19, at 6:53 a.m. for a medical procedure in Rochester Minnesota. The notes indicated R1 returned 7/4/19, by medical transport van at 1:21 a.m. and complained of "terrible pain". The medication administration record (MAR) indicated nursing staff administered an as needed (PRN) pain medication and R1 evening medications when R1 returned to the facility.	F 684	F684 Quality of Care All nurses have been educated by 7/18/19 on Pre/Post-surgical monitoring, upon return to the facility. All nurses are expected to perform pre-and post-surgical comprehensive assessments, and follow medical provider monitoring orders upon return. All facility residents who may have procedures in the future and return to the facility could have the potential to be affected by the non-compliant practice. Upon return from hospital stay monitoring orders are to be entered the EMAR for nurse monitoring and documentation. Weekly audits x2 will be completed ensuring compliance, then monthly x2, and then quarterly audits. To be reviewed with the QAPI team monthly. DON/designee will monitor for compliance. Completion Date: 8/14/19	

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F 684	Continued From page 2 R1's 7/3/19, post operative (post-op) discharge instructions given to the R1 at the time of hospital discharge identified facility staff were to call R1's surgeon if: 1. R1 experienced a temperature over 100.4 degrees Fahrenheit 2. Foul smelling pus-like drainage, 3. Increased abdominal pain, 4. Wound swelling, bleeding, redness form the incision sites, 5. Nausea or vomiting, 6. Pain not relieved by medication, 7. Frequent, painful, or inability to urinate. Wound and dressing care: The wound was packed post operatively. Change the packing daily until the tract heals. Check the incision and surrounding area daily for any redness, swelling discoloration, heavy drainage or separation of the skin. 8. Start taking Tramadol 50 milligrams (mg) tablet (ULTRAM); Change: Gabapentin 800 mg (NEURONTIN)-another medication with the same name was removed. Continue taking this medication, and follow the direction you see here. Stop taking: acetaminophen 500 mg capsule (TYLENOL). Further review of the discharge summary identified the last set of vitals signs (VS) recorded on 7/3/19 were at 7:10 p.m., prior to discharge. 1. Pulse rate- 86 (A normal is 60 to 100 beats per minute); 2. Respiratory rate (RR) 23 breaths per min (bpm) (The normal RR is 12 to 20). 3. Blood Pressure (BP) 92/77 millimeters of mercury (mm/hg) (normal is 120/80 mm/hg). 4. Oxygen saturation (SpO2) was 88%, (Normal	F 684		

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F 684	Continued From page 3 is 95 to 100 %). The facility progress notes on: (1) 7/4/19, indicated R1 had 4 dressings on her abdomen that needed to stay in place for 48 hours. Nursing staff identified they had reviewed hospital discharge orders. R1 was not to shower for 2 days and was not to strain for a bowel movement. R1 had 8 pills upon her return, and had taken one en-route back to the facility. R1 had complained of "bad indigestion" upon her return and Maalox (an antacid) and MOM (milk of magnesia- a laxative) had also been given. (2) 7/4/19 at 9:01 a.m., R1 was administered Tramadol (narcotic pain medication) and identified her pain as a 3 of 10, (1-10 pain scale, identifying 1 as minimal and 10 being excruciating pain) but did not identify where the pain was located. There was no assessment of R1's physical condition, pain, or vital signs to monitor R1's after her surgical procedure, even though R1 returned from the hospital 8 hours 23 minutes earlier. A late entry progress note dated 7/4/19, at 7:49 p.m. identified at approximately 5:00 p.m., R1 was found not breathing, and had no pulse. Staff initiated resuscitative measures and EMS (emergency medical services) was activated. Interview and review of the 7/4/19, sheriff's report with the sheriff on 7/10/19 at 10:11 a.m., identified R1 was deceased upon his arrival approximately at 6:00 p.m. on 7/4/19. At: 1.) 1:00 a.m. on 7/4/19, R1 returned to the facility. 2.) 8:27 a.m. R1 received her morning medications passed by licensed practical nurse	F 684		

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F 684	Continued From page 4 (LPN)-A. 3.) 9:15 a.m., R1 got up from bed and went out to smoke and advised the nurse aide (NA)-A she had vomited all her 8:27 a.m. medications and requested more pain medication. there was no documentation to support NA-A had notified nursing staff of R1's vomiting. 4.) 12:00 p.m., R1 had refused her noon meal. 5.) 1:00 p.m., R1 was witnessed going outside to smoke by RN-A. 6.) 4:00 p.m. LPN-A indicated she looked into R1's room, which was dark. LPN-A thought she was sleeping. 7.) R1 had not gone to the dining room for her 5:00 p.m. supper meal. The dietary manager had mentioned this to RN-A. RN-A then proceeded to R1's room to check on her condition. 7.) 5:01 p.m. RN-A entered R1's room and found R1 not breathing and pulseless, a large large amount of a dark red blood-like substance on her bedding and pillow. An emesis basin was observed by RN-A at the bedside and contained what she believed to be dark red blood. EMS was immediately activated and resuscitative measures initiated. 8.) 5:45 p.m., staff documented the time of death, following contact with the medical examiner and authorization to release R1's body to the funeral home. 9.) 7:19 p.m., staff had made contact with family members to alert them to R1's passing. Review of the 7/4/19, faxed communication to the medical director on 7/4/19, identified CPR had been performed on R1 with no effect. On 7/5/19, the medical director faxed back communication stating "unfortunate. Any autopsy to be done? Post-op complication concerns?" There was no	F 684		

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F 684	Continued From page 5	F 684		

indication the faciltiy had investigated events leading up to R1's death to determine what occurred.

During an interview and document review, with the director of nursing (DON) and facility administrator on 7/9/19 at 5:04 p.m., identified prior to R1's surgical procedure, she had been alert, oriented and able to direct her own care. Their understanding was R1's appointment was to remove a drain in her abdomen. The administrator and DON were unaware R1 had a cholecystectomy in addition to an abdominal drain removal. Both were unaware of details of the surgical procedure R1 had on 7/3/19. Their expectation was nursing staff should have performed a comprehensive physical assessment upon arrival back to the facility and routine post-op monitoring. There was no indication a physical assessment was completed or communication with the physician when R1 was vomiting and increased pain.

The dietary manager (DM) was interviewed on 7/10/19, at 11:08 a.m. and stated she had noticed R1 was not in the dining room and asked RN-A if R1 was coming to the dining room for supper. RN-A stated she was going to go to R1's room to check on her. The DM heard staff yelling for help. Upon arrival at R1's room, R1 had been placed on the floor by staff and cardiopulmonary resuscitation (CPR) was performed. The ambulance was called. RN-A utilized the automated emergency defibrillator (AED) in an attempt to further resuscitate R1. The AED advised no shock was indicated. CPR continued until emergency medical services (EMS) arrived and took over resuscitative measures. Following

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F 684	Continued From page 6	F 684		

3 unsuccessful attempts to revive R1, EMS contacted the medical director and received the order to discontinue resuscitative measures at 5:45 p.m.

RN-A was interviewed on 7/10/19, at 11:47 a.m. and confirmed she had been working on 7/4/19, from 6:00 a.m. - 6:00 p.m. RN-A confirmed she had received report on 7/4/19, and had been informed R1 had arrived back from her medical apt at 1:00 a.m. on 7/4/19. LPN-A who was on duty when R1 returned, but there was no mention of any assessment being completed or monitoring in place. RN-A also verified she had not completed a post operative assessment or checked VS. R1's usual pattern was to not get up for breakfast, and come out of her room for her morning medications around 9:30 - 10:00 a.m. and following that, go outside to smoke. Since this was the usual routine for R1, she didn't question when R1 didn't come for breakfast. R1 had been notified R1 complained of pain, but made no attempt to perform a comprehensive assessment post-operatively. RN-A was advised by TMA-A that R1 didn't come out for her noon meal and had stated she wasn't hungry. Staff observed R1 going out to smoke at 1:00 p.m. R1 had been observed lying in bed, watching TV after returning to her room after smoking. R1 had a history of napping during the afternoon and became upset if she was disturbed. RN-A indicated when she was notified by the DM R1 hadn't come for her supper meal, she went to check on her. R1's lights were off in her room. R1 was lying on her right side, facing the door. R1 didn't respond to RN-A, so she walked over to the bed and noticed "something dark" on R1's blanket and pillow. RN-A turned on the light, and

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	245273	A. BUILDING _____ B. WING _____	C 07/15/2019

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

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F 684	Continued From page 7	F 684		

observed R1's face with a dark blood-like substance around her nose, cheeks, mouth, and large amounts on both the pillow and bedding. R1 was pale, her lips were dark and she was neither breathing nor had a heartbeat. R1's advanced directive was for resuscitative measures so she called for help and initiated CPR. EMS was activated and the AED was obtained and utilized per instructions. No shock was advised and CPR continued. EMS arrived and took over CPR. The paramedic on the scene contacted the medical director and received orders to discontinue resuscitative attempts. The sheriff's department was contacted by EMS personal and responded to the scene. Family members were contacted after multiple attempts in addition to the primary provider. The sheriff arrived on scene, conducted his investigation and contacted the medical examiner who authorized release of R1's body to the funeral home. The director of nursing (DON) was notified of the occurrence and indicated she would notify the facility administrator.

TMA-A was interviewed on 7/10/19, at 12:24 p.m. and confirmed she had also been working on 7/4/19. She indicated she was providing medication pass on her shift and R1 had turned on her call light on around 8:30 a.m. and requested her morning medications and pain medication. (R1 did not indicate where she was having pain), but was observed cringing when she moved, and required assistance to sit up in bed. TMA-A indicated R1 usually got up without assistance and came to the medication cart to request/receive her medication. TMA-A indicated she knew this was not R1's usual pattern of behavior but didn't provide any additional

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F 684	Continued From page 8	F 684		

investigation. R1 requested 2 narcotic pain medication. TMA-A explained to R1 that she could not have both per RN-A's direction. RN-A had not followed up to identify why R1 wanted additional medication. R1 then took the offered medication and laid back down in bed. TMA-A indicated approximately 1/2 to 3/4 of an hour later, R1 got out of bed and transported herself outside to smoke. R1 informed TMA-A she had thrown up and was requesting additional narcotic pain medication. TMA-A had advised RN-A of R1's vomiting and request for additional medication. RN-A denied the medication request. TMA-A was unaware if RN-A had gone to R1 to perform an assessment. She indicated she had checked on R1 through her doorway periodically during the day. She saw R1 lying in bed with the lights off and window curtains drawn. TMA-A made no attempt to rouse or physically check R1 due to her hx of not wanting to be bothered while sleeping. Around 4:00 p.m. TMA-A had looked in through R1's doorway. R1 was in bed, facing the door, and appeared to be sleeping. TMA-A indicated it was shortly after 5:00 p.m., RN-A went into R1's room, discovered R1 was unresponsive and called for help.

TMA-B was interviewed on 7/10/19, at 1:17 p.m. and also confirmed she had worked on 7/4/19. TMA-B indicated she was not aware of a problem with R1 until she was summoned to come and assist during the emergency. Upon her arrival in the room, she observed R1 lying in bed, with blood on her face, nose and mouth. R1's skin color was blue, and she was not breathing. CPR was initiated and EMS was notified.

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F 684	Continued From page 9 R1's surgeon was interviewed on 7/11/19, at 12:30 p.m. and confirmed he had performed a laparoscopic cholecystectomy, and drain removal on 7/3/19, at 1:57 p.m. The surgeon stated the procedure was uncomplicated, however, there had been a small tear to the liver made during the operation, but was controlled with electro-cautery. R1 had received screening in the clinic that same day, prior to her procedure and had no identified concerns. The surgeon also verified there had been no concern with the resident's intubation (tube to assist in breathing during general anesthesia). R1 had not left the hospital to transfer back to the facility until later in the evening. The surgeon had not been called at any time regarding R1's post-op condition from her arrival at the facility until after R1 had died. His expectation was staff were to have followed discharge instructions as ordered. He was surprised an autopsy had not been requested due to the unexplained cause of death. Although R1 had a medical procedure on 7/3/19 and returned to the faciltiy on 7/4/19 at 1:21 a.m., there was no indication the facility completed a physical assessment, vital signs, or pain monitoring to determine if any medical interventions needed to be implemented even though R1 identified she had "terrible pain" and was vomiting. The facility made no attempts to contact the physician, and follow R1's discharge instructions even though the instructed directed staff to call if there was vomiting and increased pain. As a result R1's became unresponsive on 7/4/19 at 5:00 p.m., 12 hours and 21 minutes after she returned from the hospital and died. There was no policy or professional standards of	F 684		

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F 684	Continued From page 10 practice reference provided related to post-op monitoring or comprehensive assessment guidelines for staff to follow for any resident post-operatively if there were concerns or questions.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 5, 2019

Administrator
Franklin Rehabilitation & Healthcare Center
900 3rd Street South
Franklin, MN 55333

Re: State Nursing Home Licensing Orders - Complaint Numbers H52573037C, H5273038C

Dear Administrator:

A complaint investigation was completed on July 15, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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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: From July 9-15, 2019, an abbreviated survey was conducted to determine compliance with State licensure. A correction order was issued. The following complaint was found to be substantiated: H5273037C	2 000		

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2 000	Continued From page 1 The following complaint was found to be unsubstantied: H5273038C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide an comprehensive assessment and monitoring of their physical condition following a surgical procedure for 1 of 1 resident (R1) whom had a surgical procedure. As a result of this, R1 died unexpectedly at the facility the same day she returned from the procedure causing actual harm.	2 830	Tag 0830 Adequate and Proper Nursing Care All nurses have been educated by 7/18/19 on Pre/Post-surgical monitoring, upon return to the facility. All nurses are expected to perform pre-and post-surgical comprehensive assessments, and follow	8/14/19

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2 830	Continued From page 2 Findings include: R1's 5/7/19, quarterly Minimum Data Set (MDS) assessment identified diagnoses of gall bladder disease with stones, Chronic Obstructive Pulmonary Disease (COPD), a history (Hx) of alcohol dependence, and high blood pressure. R1's cognition was intact, and she was independent with activities of daily living (ADLs), except for eating which required supervision. R1's nursing progress notes identified R1 had been admitted to the facility in October 2018, with the biliary drain in place. R1 had requested the physician remove her biliary drain related to complaints of pain. R1 had requested to have the drain removed resulting in the scheduled procedure which took place on 7/3/19. R1 had left the facility on 7/3/19, at 6:53 a.m. for a medical procedure in Rochester Minnesota. The notes indicated R1 returned 7/4/19, by medical transport van at 1:21 a.m. and complained of "terrible pain". The medication administration record (MAR) indicated nursing staff administered an as needed (PRN) pain medication and R1 evening medications when R1 returned to the facility. R1's 7/3/19, post operative (post-op) discharge instructions given to the R1 at the time of hospital discharge identified facility staff were to call R1's surgeon if: 1. R1 experienced a temperature over 100.4 degrees Fahrenheit 2. Foul smelling pus-like drainage, 3. Increased abdominal pain, 4. Wound swelling, bleeding, redness form the incision sites,	2 830	medical provider monitoring orders upon return. All facility residents who may have procedures in the future and return to the facility could have the potential to be affected by the non-compliant practice. Upon return from hospital stay monitoring orders are to be entered the EMAR for nurse monitoring and documentation. Weekly audits x2 will be completed ensuring compliance, then monthly x2, and then quarterly audits. To be reviewed with the QAPI team monthly. DON/designee will monitor for compliance. Completion Date: 8/14/19	

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2 830	Continued From page 3 5. Nausea or vomiting, 6. Pain not relieved by medication, 7. Frequent, painful, or inability to urinate. Wound and dressing care: The wound was packed post operatively. Change the packing daily until the tract heals. Check the incision and surrounding area daily for any redness, swelling discoloration, heavy drainage or separation of the skin. 8. Start taking Tramadol 50 milligrams (mg) tablet (ULTRAM); Change: Gabapentin 800 mg (NEURONTIN)-another medication with the same name was removed. Continue taking this medication, and follow the direction you see here. Stop taking: acetaminophen 500 mg capsule (TYLENOL). Further review of the discharge summary identified the last set of vitals signs (VS) recorded on 7/3/19 were at 7:10 p.m., prior to discharge. 1. Pulse rate- 86 (A normal is 60 to 100 beats per minute); 2. Respiratory rate (RR) 23 breaths per min (bpm) (The normal RR is 12 to 20). 3. Blood Pressure (BP) 92/77 millimeters of mercury (mm/hg) (normal is 120/80 mm/hg). 4. Oxygen saturation (SpO2) was 88%, (Normal is 95 to 100 %). The facility progress notes on: (1) 7/4/19, indicated R1 had 4 dressings on her abdomen that needed to stay in place for 48 hours. Nursing staff identified they had reviewed hospital discharge orders. R1 was not to shower for 2 days and was not to strain for a bowel movement. R1 had 8 pills upon her return, and had taken one en-route back to the facility. R1 had complained of "bad indigestion" upon her return and Maalox (an antacid) and MOM (milk of	2 830		

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2 830	Continued From page 4 magnesia- a laxative) had also been given. (2) 7/4/19 at 9:01 a.m., R1 was administered Tramadol (narcotic pain medication) and identified her pain as a 3 of 10, (1-10 pain scale, identifying 1 as minimal and 10 being excruciating pain) but did not identify where the pain was located. There was no assessment of R1's physical condition, pain, or vital signs to monitor R1's after her surgical procedure, even though R1 returned from the hospital 8 hours 23 minutes earlier. A late entry progress note dated 7/4/19, at 7:49 p.m. identified at approximately 5:00 p.m., R1 was found not breathing, and had no pulse. Staff initiated resuscitative measures and EMS (emergency medical services) was activated. Interview and review of the 7/4/19, sheriff's report with the sheriff on 7/10/19 at 10:11 a.m., identified R1 was deceased upon his arrival approximately at 6:00 p.m. on 7/4/19. At: 1.) 1:00 a.m. on 7/4/19, R1 returned to the facility. 2.) 8:27 a.m. R1 received her morning medications passed by licensed practical nurse (LPN)-A. 3.) 9:15 a.m., R1 got up from bed and went out to smoke and advised the nurse aide (NA)-A she had vomited all her 8:27 a.m. medications and requested more pain medication. there was no documentation to support NA-A had notified nursing staff of R1's vomiting. 4.) 12:00 p.m., R1 had refused her noon meal. 5.) 1:00 p.m., R1 was witnessed going outside to smoke by RN-A. 6.) 4:00 p.m. LPN-A indicated she looked into R1's room, which was dark. LPN-A thought she was sleeping.	2 830		

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2 830	Continued From page 5 7.) R1 had not gone to the dining room for her 5:00 p.m. supper meal. The dietary manager had mentioned this to RN-A. RN-A then proceeded to R1's room to check on her condition. 7.) 5:01 p.m. RN-A entered R1's room and found R1 not breathing and pulseless, a large large amount of a dark red blood-like substance on her bedding and pillow. An emesis basin was observed by RN-A at the bedside and contained what she believed to be dark red blood. EMS was immediately activated and resuscitative measures initiated. 8.) 5:45 p.m., staff documented the time of death, following contact with the medical examiner and authorization to release R1's body to the funeral home. 9.) 7:19 p.m., staff had made contact with family members to alert them to R1's passing. Review of the 7/4/19, faxed communication to the medical director on 7/4/19, identified CPR had been performed on R1 with no effect. On 7/5/19, the medical director faxed back communication stating "unfortunate. Any autopsy to be done? Post-op complication concerns?" There was no indication the faciltiy had investigated events leading up to R1's death to determine what occurred. During an interview and document review, with the director of nursing (DON) and facility administrator on 7/9/19 at 5:04 p.m., identified prior to R1's surgical procedure, she had been alert, oriented and able to direct her own care. Their understanding was R1's appointment was to remove a drain in her abdomen. The administrator and DON were unaware R1 had a cholecystectomy in addition to an abdominal drain removal. Both were unaware of details of	2 830		

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2 830	Continued From page 6 the surgical procedure R1 had on 7/3/19. Their expectation was nursing staff should have performed a comprehensive physical assessment upon arrival back to the facility and routine post-op monitoring. There was no indication a physical assessment was completed or communication with the physician when R1 was vomiting and increased pain. The dietary manager (DM) was interviewed on 7/10/19, at 11:08 a.m. and stated she had noticed R1 was not in the dining room and asked RN-A if R1 was coming to the dining room for supper. RN-A stated she was going to go to R1's room to check on her. The DM heard staff yelling for help. Upon arrival at R1's room, R1 had been placed on the floor by staff and cardiopulmonary resuscitation (CPR) was performed. The ambulance was called. RN-A utilized the automated emergency defibrillator (AED) in an attempt to further resuscitate R1. The AED advised no shock was indicated. CPR continued until emergency medical services (EMS) arrived and took over resuscitative measures. Following 3 unsuccessful attempts to revive R1, EMS contacted the medical director and received the order to discontinue resuscitative measures at 5:45 p.m. RN-A was interviewed on 7/10/19, at 11:47 a.m. and confirmed she had been working on 7/4/19, from 6:00 a.m. - 6:00 p.m. RN-A confirmed she had received report on 7/4/19, and had been informed R1 had arrived back from her medical apt at 1:00 a.m. on 7/4/19. LPN-A who was on duty when R1 returned, but there was no mention of any assessment being completed or monitoring in place. RN-A also verified she had not completed a post operative assessment or	2 830		

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	00934	A. BUILDING: _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 7	2 830		

checked VS. R1's usual pattern was to not get up for breakfast, and come out of her room for her morning medications around 9:30 - 10:00 a.m. and following that, go outside to smoke. Since this was the usual routine for R1, she didn't question when R1 didn't come for breakfast. R1 had been notified R1 complained of pain, but made no attempt to perform a comprehensive assessment post-operatively. RN-A was advised by TMA-A that R1 didn't come out for her noon meal and had stated she wasn't hungry. Staff observed R1 going out to smoke at 1:00 p.m. R1 had been observed lying in bed, watching TV after returning to her room after smoking. R1 had a history of napping during the afternoon and became upset if she was disturbed. RN-A indicated when she was notified by the DM R1 hadn't come for her supper meal, she went to check on her. R1's lights were off in her room. R1 was lying on her right side, facing the door. R1 didn't respond to RN-A, so she walked over to the bed and noticed "something dark" on R1's blanket and pillow. RN-A turned on the light, and observed R1's face with a dark blood-like substance around her nose, cheeks, mouth, and large amounts on both the pillow and bedding. R1 was pale, her lips were dark and she was neither breathing nor had a heartbeat. R1's advanced directive was for resuscitative measures so she called for help and initiated CPR. EMS was activated and the AED was obtained and utilized per instructions. No shock was advised and CPR continued. EMS arrived and took over CPR. The paramedic on the scene contacted the medical director and received orders to discontinue resuscitative attempts. The sheriff's department was contacted by EMS personal and responded to the scene. Family members were contacted after

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2 830	Continued From page 8 multiple attempts in addition to the primary provider. The sheriff arrived on scene, conducted his investigation and contacted the medical examiner who authorized release of R1's body to the funeral home. The director of nursing (DON) was notified of the occurrence and indicated she would notify the facility administrator. TMA-A was interviewed on 7/10/19, at 12:24 p.m. and confirmed she had also been working on 7/4/19. She indicated she was providing medication pass on her shift and R1 had turned on her call light on around 8:30 a.m. and requested her morning medications and pain medication. (R1 did not indicate where she was having pain), but was observed cringing when she moved, and required assistance to sit up in bed. TMA-A indicated R1 usually got up without assistance and came to the medication cart to request/receive her medication. TMA-A indicated she knew this was not R1's usual pattern of behavior but didn't provide any additional investigation. R1 requested 2 narcotic pain medication. TMA-A explained to R1 that she could not have both per RN-A's direction. RN-A had not followed up to identify why R1 wanted additional medication. R1 then took the offered medication and laid back down in bed. TMA-A indicated approximately 1/2 to 3/4 of an hour later, R1 got out of bed and transported herself outside to smoke. R1 informed TMA-A she had thrown up and was requesting additional narcotic pain medication. TMA-A had advised RN-A of R1's vomiting and request for additional medication. RN-A denied the medication request. TMA-A was unaware if RN-A had gone to R1 to perform an assessment. She indicated she had checked on R1 through her doorway periodically during the day. She saw R1 lying in bed with the	2 830		

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2 830	Continued From page 9	2 830		

lights off and window curtains drawn. TMA-A made no attempt to rouse or physically check R1 due to her hx of not wanting to be bothered while sleeping. Around 4:00 p.m. TMA-A had looked in through R1's doorway. R1 was in bed, facing the door, and appeared to be sleeping. TMA-A indicated it was shortly after 5:00 p.m., RN-A went into R1's room, discovered R1 was unresponsive and called for help.

TMA-B was interviewed on 7/10/19, at 1:17 p.m. and also confirmed she had worked on 7/4/19. TMA-B indicated she was not aware of a problem with R1 until she was summoned to come and assist during the emergency. Upon her arrival in the room, she observed R1 lying in bed, with blood on her face, nose and mouth. R1's skin color was blue, and she was not breathing. CPR was initiated and EMS was notified.

R1's surgeon was interviewed on 7/11/19, at 12:30 p.m. and confirmed he had performed a laparoscopic cholecystectomy, and drain removal on 7/3/19, at 1:57 p.m. The surgeon stated the procedure was uncomplicated, however, there had been a small tear to the liver made during the operation, but was controlled with electro-cautery. R1 had received screening in the clinic that same day, prior to her procedure and had no identified concerns. The surgeon also verified there had been no concern with the resident's intubation (tube to assist in breathing during general anesthesia). R1 had not left the hospital to transfer back to the facility until later in the evening. The surgeon had not been called at any time regarding R1's post-op condition from her arrival at the facility until after R1 had died. His expectation was staff were to have followed

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2 830	Continued From page 10 discharge instructions as ordered. He was surprised an autopsy had not been requested due to the unexplained cause of death. Although R1 had a medical procedure on 7/3/19 and returned to the faciltiy on 7/4/19 at 1: 21 a.m., there was no indication the facility completed a physical assessment, vital signs, or pain monitoring to determine if any medical interventions needed to be implemented even though R1 identified she had "terrible pain" and was vomiting. The facility made no attempts to contact the physician, and follow R1's discharge instructions even though the instructed directed staff to call if there was vomiting and increased pain. As a result R1's became unresponsive on 7/4/19 at 5:00 p.m., 12 hours and 21 minutes after she returned from the hospital and died. There was no policy or professional standards of practice reference provided related to post-op monitoring or comprehensive assessment guidelines for staff to follow for any resident post-operatively if there were concerns or questions. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to assessment following return from a surgical procedure including proper assessment and intervention. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	2 830		

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2 830	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		