Electronically delivered

February 18, 2020

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

RE: CCN: 245273
Cycle Start Date: January 31, 2020

Dear Administrator:

On January 31, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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" 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

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 April 30, 2020 (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 July 31, 2020 (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) / 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
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 01/31/2020

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 On 1/31/20, an abbreviated survey was completed at your facility 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: H5273053C 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		3/6/20

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

Electronically Signed | 02/20/2020

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 01/31/2020

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure resident to ensure 3 of 3 residents (R3, R4, and R5) were kept safe from 1 of 3 resident (R2) to prevent resident-to-resident abuse by identifying and implementing appropriate interventions. Findings include: Review of the 1/11/20, report to the State Agency (SA) identified R3 went to bed on the evening of 1/9/20. On the morning of 1/10/20, he was found with a black eye. The facility assessed the injury and determined no additional treatment was needed. On 1/10/20, an internal investigation was initiated. Nursing assistant (NA)-A approached by R2 in the hallway. R2 stated he said hello to R3. R3 punched him. R2 stated he hit R3 in defense. The dietary manager (DM) stated he was getting R2 coffee the morning of 1/10/20. The DM asked R2 if he hit R3. R2 confirmed he had struck R3 after he had entered R2's room and wouldn't leave. An observation of R3 identified a large bruise around his left eye. R2 was unable to report the incident due to dementia. R2 stated he suffered from memory loss, and was unable to recall hitting R3, but it could have happened. R2 stated if he had hit R3, he would have told staff. R2 had a small mark near his knuckle. R2 was unable to identify how it got there. it was believed R2 had assaulted R3 because R2 admitted to two staff members he had hit R2, had a small scabbed area by his knuckle, and R3 had a large bruise on his left	F 600	It is the policy of Franklin Rehab & Healthcare to ensure all residents are free and safe from abuse and neglect. F600 R2's care plan was updated to reflect history of physical and verbal aggression. R2 has been on 15-minute checks since 1/28/19 and continues to be to ensure the facility minimizes the potential for R2 to cause harm to other residents. Activities have provided staff with a copy of resident's preferred activities to help keep R2 occupied. R2 is being moved to a room closer to the nurse's station to ensure staff can monitor him closer. R2 saw the rounding psychiatrist on 2/1/20 and also had a Tapestry telehealth visit on 2/4/20 which resulted in a medication change to help with behaviors. R3 was placed on 15-minute checks for 72 hrs. and was discontinued after no further instances were found. R2 is being monitored on 15-minute checks to ensure he does not intervene with R4 or other residents by relocating them in their wheelchairs. Residents with histories of physical and verbal aggression or that have a history of resident to resident altercations have the potential to be affected. An audit will be completed to ensure their care plans are	

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 01/31/2020

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 600	Continued From page 2 eye. R2's 1/14/20, quarterly Minimum Data Set (MDS) identified R2 had moderate cognitive impairment. He walked independently, and was able to provide cares independently. His diagnoses included dementia, alcohol dependence, traumatic brain injury (TBI), and chronic obstructive pulmonary disease (COPD). R2 had verbal behaviors 1-3 days. R2's previous 10/14/19, quarterly MDS identified R2 had no physical abuse identified. R2's facility incident report logs identified the following: verbal aggression on verbal aggression on 1/1/20, and on 1/11/20, a resident to resident altercation on 9/9/19; and a sexual abuse allegation on 11/18/19. R2's 1/30/20, care plan identified on 9/18/19, R2 was at risk for abuse and neglect due to alcohol induced dementia, provoking other residents, and verbal outbursts. R2 was placed on 15 minute checks on 1/28/20. R2 had a stop sign placed across his doorway on 1/16/20. Staff were to keep others who disturbed him away form his room and away from him in the dining room. Staff were to remove him from an unsafe environment. R2 had behavioral problems related to dementia. R2 had a history of being verbally aggressive, and threatening when agitated. R2 was manipulative, and had history of verbal altercations with other residents. Staff were to separate R2 from other residents when verbal altercations escalated. If resident was assisting peers, staff were to evaluate if assistance was appropriate. R2's care plan made no mention he had a history of physical aggression towards other residents.	F 600	current and reflect appropriate interventions. All staff will be educated on keeping residents safe, preventing abuse, and Relias training on de-escalation practices. Daily audits will be completed for 3 weeks, then weekly for 1 week, then monthly for 2 months by the Administrator or designee ensuring that residents with verbal or physical aggression remain safe, that staff intervene appropriately, and that care plan interventions are in place and reported to agency when warranted. All audits will be discussed with the QAPI committee to determine compliance and further need for continuing monitoring. Date of compliance: 3/6/2020	

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 01/31/2020

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 600	Continued From page 3 R2's 12/27/19, Nurse Note identified R2 had a verbal altercation with R5, and stated "if you ever talk to me like that again, I'll bop you." R2's 12/28/19, Nurse Note identified R2 was upset regarding smoking times. R2 began pounding on the door stating he was going to bang on everyone's door to wake everyone up. R2 "stormed" up and down the hallway yelling and banging on doors. R2 attempted to bargain with staff, and when he was declined a cigarette, he resumed yelling and banging on the doors. R2's 1/2/20, Nurse Note identified R2 was calling names and pushed an unidentified resident who was in his wheelchair. R2 was playing cards at the time of the incident. Staff reminded R2 not to push other residents and to keep his opinions to himself. R2's 1/7/20, Nurse Note identified R2 was playing cards. R4 was making rude comments and calling people stupid. R2 rose from his chair and was pushing R4 out of the dining room while R4 was screaming. Staff intervened and told him to return to playing cards. R2 and R4 continued to make negative comments to each other. R2's 1/11/20, Nurse Note identified R2 began arguing with and unidentified female resident at lunch. R2 swore at the resident and threw a butter container. R2's 1/14/20, Quarterly Nurse Note, note stated R2 had behaviors of being rude to staff an peers, rejection of care, and verbal aggression. An interview on 1/30/19, at 4:02 p.m. nursing	F 600		

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 01/31/2020

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 600	Continued From page 4 assistant (NA)-A identified she worded the night of the alleged resident to resident altercation. She was exiting a residents room. R2 was standing in the hallway, and it felt as if he waited for her to leave the room. R2 admitted to her he punched R3. He told her if I saw anything on R3's face it was from him. R2 stated R3 punched him first. NA-A neither saw nor heard any discord during the night. R2 told her if anything happened, he had hit R3. R2 had also admitted he had hit other people. R2 had memory problems and is belligerent. When he became upset, there was no talking him out of it. R2 moved to the locked unit about a month ago, and was angry and took thing out on staff and residents. R3 had a history of wandering into other resident rooms. During the night, R3 was wandering in the activity room, and in the hallways. In the morning, R3 was found with a headache and a black eye. Interview on 1/30/20, at 2:29 p.m. with law enforcement officer (LE), identified he had been to the facility to investigation the altercation between R2 and R3. R2 was avoidant when interviewed. LE felt he was withholding information. R3's eye had a large bruise. Photos were obtained. LE stated he believed there was enough information to determine R2 had an altercation with R3. An interview on 1/30/20, at 5:24 p.m. the social service designee (SSD) identified the facility had daily interdisciplinary meetings (IDT) all incident reports were reviewed and resident care plans were updated. If a resident had an actual history of physical altercations, it was to be documented in the care plan.	F 600		

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 01/31/2020

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 600	Continued From page 5 Interview on 1/30/20 at 3:30 p.m., with the administrator (A) identified she felt R2 had not struck anyone, and R2's story was inaccurate. To her knowledge, R2 had no prior history of actual physical altercations with other residents. R2 never disclosed to her he had hit R3 and he was not an accurate reporter. The A indicated R2 was not physical with R4 on 1/7/20. R4 had behaviors, and R2 wanted R4 to leave the area and he pushed him out of the activity area because he was having behaviors R4 was in a wheelchair, and R2 was assisting staff. R4 always yelled out when people approached him. An incident report dated 9/9/19 identified R2 was involved in a resident to resident altercation. The administrator continued to state R2 had no history of physical abuse towards other residents. The administrator agreed to provide only R2's incident report on 1/10/20. R2's additional reports were requested, and the administrator declined to provide additional documentation. R2's care plan did not identify R2 had a history of being physically aggressive, and made not mention of potential to become physically aggressive. The 10/1/19, Abuse Policy and Procedure made no mention of resident-to-resident altercations. Its purpose was to prevent resident abuse, staff were to assess, care plan, and monitor residents with symptoms of behavior problems and develop and implement care plans to address behavioral issues. Staff were to be educated to understand and manage residents verbal and physical aggression. Staff were to report all allegations of abuse to facility management immediately.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2020

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

Re: Event ID: OFTV11

Dear Administrator:

The above facility survey was completed on January 31, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

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 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	**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 1/31/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5273053C. No correction orders were issued. The facility is enrolled in the electronic Plan of	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 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN REHABILITATION & HEALTHCARE	**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 Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt.	2 000		