Electronically delivered
April 14, 2020

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

RE: CCN: 245273
Cycle Start Date: March 13, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 13, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 June 13, 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 September 13, 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

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 03/13/2020

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FRANKLIN REHABILITATION & HEALTHCARE CENTER	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

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F 000	INITIAL COMMENTS On 3/12/20 through 3/13/20, 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 complaints were found to be SUBSTANTIATED: H5273054C, with a deficiency issued at F Tag 740. 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 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		4/24/20

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

Electronically Signed | 04/22/2020

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.

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F 740	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate behavior management and consultation occurred to manage physical behaviors for 3 of 3 residents (R1, R2, R3). Findings include Review of the 3/4/20, report filed to the State Agency (SA) identified at 5:30 p.m. a resident-to-resident altercation between R2 and R3 occurred in the locked unit dining room over a coffee mug. R2 grabbed a coffee mug and hit resident R1 in the face with the mug, causing the mug to break. R2 pushed R1 from his chair, causing R1 to fall to his left side on the floor. Staff assisted resident R1 out of the dining room and attempted to redirect R2 out of the dining room, R2 was not responsive to redirection. The 3/9/20, 5-day investigation report of the 3/4/20 incident, submitted to the SA identified R1 and R2 had an altercation. R2 struck R1 with a coffee mug. R1 was not injured and the residents were separated. R2 was transferred to the emergency department (ED). R2 returned the next morning with an order for Depakote 500 milligrams (mg). R2 was placed on 15-minute checks. R1 was relocated to the unsecured wing of the facility with a wander guard placed and was monitored every 15-minutes for safety. R2 returned from the hospital the following day, and placed on one-to-one supervision when he went outside his room. Staff were educated to ensure R2 was in staff line of sight at all times when out of his room to intervene when R2 became verbal	F 740	POC: H5273054C It is the policy of Franklin Rehab & Healthcare to ensure that residents needing behavioral health services receive the services in order to maintain the highest practicable physical, mental, and psychosocial well-being. Cited Residents: R1-Was transferred to the non-secured unit. The care plan was reviewed and revised as needed. R2-Resident□s care plan has been reviewed and revised as needed. Consulting psychiatrist completed visit; reviewed history, behavior concerns and medications. Resident received multiple medication changes to address agitation and aggression. Consulting psychiatrist continues to be involved in ongoing evaluation of resident. R3- Resident□s care plan has been reviewed and revised as needed. Consulting psychiatrist will be contacted for further recommendations. At Like Residents: Resident with behavioral management issues have the potential to be affected. Resident with behavioral management issues /outbursts will have their care plans reviewed and revised. The primary physician and first party contact will be notified. The consulting psychiatrist will be contacted per primary MD and or IDT□s recommendations. IDT will review	

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F 740	Continued From page 2 to prevent physical altercations. Review of the 3/6/20, report filed to the SA identified at 8:30 a.m. R2 and R3 were in the locked unit dining room having a snack. R3 was requesting more food. R2 told R3 he had just eaten. R3 told R2 to shut up. R2 entered R3's personal space and told R3 not to talk to him like that. R2 struck R3 on the left side of his face, and grabbed R3's shirt to attempt to pull R3 out of his wheelchair. Staff intervened, and removed R3 from the dining room and assisted him to the unlocked unit east dining room. R3 sustained no injury. R2 was transported to the ED for a mental evaluation. Review of the 3/9/20, 5-day investigation report for the 3/6/20 incident, submitted to the SA identified the dining room was left unsupervised when R2 was out of his room. Changes were made to ensure anytime residents with histories of verbal and physical aggression were out of their rooms, staff were to be present to ensure all residents were safe. On 3/7/20, R2 returned to the facility with orders for Seroquel and had one-to-one supervision when he was out of his room. R3 had no injuries. The facility continued to seek alternative long-term care placement for R2. The report made no mention of changes made to ensure residents had supervision when they were out of their rooms R1's 2/18/20, quarterly Minimum Data Set (MDS) identified R1 had short-term and long-term memory problems. R1's decision-making skills were severely impaired. R1 had inattention and disorganized thinking. R1's mood assessment identified R1 had little interest or pleasure doing	F 740	residents with behavior management issues and verbal/physical outbursts daily and as needed. The team will review/discuss incidents, identify potential triggers/root cause analysis to the behaviors. The primary physician will be notified. The consulting psychiatrist will be notified per primary MD and or IDT□s recommendations. Resident care plans will be reviewed and revised as needed. The non-transparent adhesive on the nursing station window has been removed, allowing for visual observation. Cameras have been installed down each hallway and in the secured unit dining room allowing for visual monitoring of residents. Education: All staff education on Behavior Management and Resident to Resident Altercations was completed on 3/25/20. Audits: Audits will be completed by Administrator or designee, checking for adherence to Behavior Management Guidelines and Resident to Resident Altercations to ensure resident safety. Line of Sight and Radio/Headset audits were done from 3/18/20-3/22/20 and will be done randomly on a weekly basis for 3 months to ensure compliance. Audits to ensure appropriate behavioral health consultation and behavior management will be done by daily by reviewing incidents of verbal/physical outburst with the IDT team. The Administrator will be	

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F 740	Continued From page 3 things, had trouble falling asleep, concentrating, and had slowed speech, and was short-tempered and easily annoyed. R1 had behaviors not directed towards others. R1 was able to eat independently and walk throughout the facility independently. He required extensive assistance of two staff to perform hygiene, dress, and toilet. R1's diagnoses included Alzheimer's disease, aphasia, non-Alzheimer's dementia, bipolar disorder, psychotic disorder, paranoid personality disorder, and type two diabetes. R1 used antidepressants and antipsychotics daily. R1's 3/12/20, care plan identified R1 used antidepressant and antipsychotic medications. Staff were to monitor R1's target behaviors included inappropriate comments towards staff, combativeness with cares, and verbal altercations with other residents. Staff were to separate R1 from other residents immediately when verbal or physical aggression occurred. Staff were to refer to R1's psychiatrist for medication and behavior intervention recommendations as needed. R1 was independent with ambulating throughout the facility, and required assistance of one staff for personal cares. R1 had impaired speech and had difficulty making himself understood. Staff were to anticipate R1's needs, and provide a calm unhurried environment. R1 made poor decisions and was unable to make safe choices. Staff were to provide 15-minute checks for 72 hours, provide cues and reminders as needed, and to separate R1 from other residents known to agitate R1. Staff were to provide redirection when R1 wandered into other residents' rooms, and remove R1 from potentially dangerous situations.	F 740	responsible for compliance.	

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F 740	Continued From page 4	F 740		

R1's psychiatric progress notes identified R1 received psychiatric care on an as needed (PRN) basis. R1's 2/18/20, visit identified R1 had no new problems and no medication changes. The notes made no mention R1's psychiatrist was notified of R1's 3/4/20, resident-to-resident altercation.

R1's 2/10/20, physician visit note identified R1's medications were reviewed, No additional documentation or physician recommendations were included in R1's physician notes following the altercation with R2.

R1's 15-minute check documentation were requested and not provided.

R2's 1/14/20, quarterly (MDS) identified R2's had moderately impaired cognition. R2 had physical and verbal behaviors directed towards others. R2 was independent with all personal cares, and was able to walk throughout the locked unit independently. R2's diagnoses included non-Alzheimer's dementia, traumatic brain injury (TBI), depression, adjustment disorder, nicotine dependence, alcoholic polyneuropathy.

R2's medications included Celexa (anti-depressant) 40 milligrams (mg) daily for adjustment disorder with depressed mood; Depakote 500 mg twice daily for adjustment disorder started on 3/5/20; Seroquel 25 mg daily for alcohol dependence with alcohol induced persisting dementia started on 3/9/20.

R2's 3/2/20, care plan identified R2 had behavior problems related to dementia with behavioral

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F 740	Continued From page 5 disturbance, and had a history of verbal and physical aggression, invading or provoking residents, and assisting residents without their permission. R2 also had a history of stealing smoking materials behind the nurse station. Staff were to intervene and separate residents when R2 was provoked or was provoking other residents; monitor and document target behaviors; provide praise when R2 had improvements in behaviors and encourage participation in activities. Staff were to separate R2 and other residents when verbal or physical altercations occurred. Staff were to discuss and provide education to R2 about behaviors when he was reasonable. Staff were to explain all procedures to R2 to allow him to adjust to changes. R2 used Nicotrol inhalers to use when having urges to smoke. Staff were to encourage him to use the inhaler and remind R2 the locked unit is a non-smoking unit. Staff were to walk away and provide time for R2 to deescalate when he had agitation related to smoking. Staff were to provide non-pharmaceutical interventions to decrease target behaviors, and refer to the psychiatrist for medication and behavioral interventions as needed. Staff were to report behavior changes to the physician. R2's care plan made no mention of R2's diagnoses of TBI. R2's undated nursing assistant (NA) care sheet identified R2 was independent with mobility, toileting and transfers. R2 required supervision in the dining room. R2 was on 15- minute checks and was 1:1 when out of his room. R2 had poor cognition and had inappropriate behaviors. Staff were provide constant reminders and to redirect R2 when behaviors occurred if possible.	F 740		

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F 740	Continued From page 6 R2's 3/4/20, and 3/6/20, ED and hospital documents were requested, but not provided. R2's physician communication records for 3/4/20, and 3/6/20 were requested, but not provided. R2's 1/9/20, physician visit note identified R2 had increased verbal aggression and wandering issues. R2 had smoking urges during the night. R2 was worsening, but no behavioral medication changes or behavior modification interventions were made during the visit. Staff were to continue redirecting R2 and monitor for improvement. R2 was under the care of a psychiatrist, and plan was to see what suggestions the psychiatrist had regarding behavioral concerns. There was no mention staff had followed up with the psychiatrist. R2's 2/1/20 psychiatric note identified staff reported R2 had been more irritable. R2 started taking Depakote 250 mg three times daily. No changes were made to R2's medications. No additional recommendations were provided, and the note made no mention of R2's verbal and physical aggression with other residents on 3/4/20, and 3/6/20. R2's Resident Location Charting (15-minute checks) identified R2 was placed on 15-minute checks between 2/1/20, and 2/7/20. R2's checks had lines drawn through many check times and made no mention of where R2's location was during the checks. R3's 2/4/20, quarterly MDS indicated that R3 had moderate cognitive impairment. R3 had severe depression symptoms. R3 had frequent	F 740		

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F 740	Continued From page 7	F 740		

behavioral symptoms directed towards others. R3 ate independently, and walked independently in his room. R3 used a wheelchair to motivate independently in the hallways, and required staff supervision when moving throughout the facility. R3's diagnoses included Alzheimer's disease, anxiety, Wernicke's (alcohol-induced) encephalopathy, intermittent explosive disorder, unspecified mood affective disorder, history of alcohol dependence, confusional arousals, altered mental status, history of stroke and nicotine dependence.

R3's care plan identified R3's behaviors included cursing, shouting, wandering into other resident's rooms, making repetitive requests, and combativeness and refusal of cares. R3 had a history of verbal altercations with other residents. R3 lacked safety awareness, and was at risk for abuse. Staff were to keep R3 safe by explaining provision of care. Staff were to intervene and remove R3 from verbal altercations immediately, and were not to place R3 near others known to disturb him.

R3's physician notes were requested. R3's last visit documented in R3's paper chart occurred on 12/9/20. No additional notes were provided as evidence R3's behaviors were addressed following altercations on 2/5/20, 2/12/20, 3/4/20, and 3/6/20.

R3's 2/1/20, psychiatric note identified R3's Seroquel was discontinued in October, 2019. R3 had no increased in problems. No changes occurred with R3's treatments. There was no documentation to identify the psychiatrist was made aware of R3's yelling out or of R3's

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F 740	Continued From page 8 altercations on 2/5/20, 2/12/20, 3/4/20, and 3/6/20. Review of reports submitted to the SA identified the facility had 10 resident-to-resident abuse allegations during the past 4 months. Review of February, 2020 and March, 2020, incident reports identified the following resident to resident incidents: (1) On 2/4/20, R1 was in the hallway near R5. R5 reached out to touch R1. R1 grabbed R5's arms and pulled them forcibly behind R5's back. Staff intervened and separated the residents. R1 was placed on 15-minute checks for 72 hours. R5 had no injuries. (2) On 2/5/20, a verbal and physical altercation occurred between R2 and R3. R3 was in the hallway with staff yelling out for coffee. R2 approached R3 and poured water over his head. R2 was redirected from the area. R3 was dried off and returned to the dining room. The interdisciplinary team (IDT) review on 2/11/20, identified no further incidents were observed, and R3 resumed normal activities. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist. (3) On 2/5/20, an altercation occurred between R4 and an unidentified resident. R4 was in the hallway near a resident she did not like and poured water on his head. R4 stated she did not like the resident. R4 was placed on 15-minute checks for 72 hours. R4 was evaluated by the psychiatrist and diagnosed with unspecified psychosis. There was no mention the behavior	F 740		

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(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 740	Continued From page 9	F 740		

interventions had been addressed or reviewed by the psychiatrist.

(4) On 2/12/20, a verbal altercation occurred when R2 and R3 were left unsupervised in the dining room. Staff responded to R2 yelling and cursing into R3's ear telling him to shut up. R2 and R3 were separated. R3 was assisted to the unlocked dining area to watch TV under staff supervision. R2 left the dining room and went to his room. IDT review on 1/13/20, identified R3 was placed on 15-minute checks. Staff were to continue to monitor R2 for anxiety and behaviors and intervene with future incidences. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist.

(5) On 3/4/20, a verbal and physical altercation occurred between R2 and R3 at 12:50 a.m., in the locked unit hallway. Staff responded R2 yelling and cursing at R3. R3 standing in front of his wheelchair in a puddle of water the hallway with wet clothing. R2 stated he had thrown water at R3 because he yelling. R2 was unable to be redirected and continued yelling at R3 and staff. Staff removed R3 from the locked unit for supervision. R2 returned to his room following the altercation. An 3/9/20, IDT note identified R2's care plan was updated to reflect he had a history of throwing water onto other residents. There was no mention the behavior interventions had been addressed or reviewed by the psychiatrist.

Interview on 3/13/20, at 10:40 a.m. with registered nurse (RN)-A identified she had computer based training, but was unable to recall when she last had behavior training at the facility.

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	245273	A. BUILDING _____ B. WING _____	C 03/13/2020

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F 740	Continued From page 10 An interview on 3/13/20, at 1:45 p.m. with the director of nursing (DON) identified she had computer based training from a previous job, but had not received training from the facility prior to starting her position on 3/1/20. The DON expected staff to make resident and staff safety a number one priority. Staff needed to separate the residents and to use de-escalation techniques to prevent resident altercations and minimize behaviors. Staff were expected to be able to anticipate and identify potential situations before it happens and intervene before altercations occurred. The facility had assigned a computer based de-escalation technique training video. Not all staff had completed the on-line training. There was no resident specific training provided to staff. The DON agreed training on behavior modifications should be resident specific and include recommendations from the psychiatrist. An interview on 3/12/20, at 1:54 p.m. with physician (MD)-A, (primary care physician (PCP)) identified he was the PCP for many of the residents at the facility under his care. During rounds at the facility, MD-A would speak with the nurse regarding resident behaviors and ensured medications were at an appropriate dose and were used according to diagnoses. When a psychotropic or antipsychotic medications were prescribed by the psychiatrist, MD-A would not adjust the dosages. Psychotropic and antipsychotic medications were ordered for newly admitted residents when a psychiatric consultation was not completed prior to admission, or when psychiatric services were not able to address in a timely manner. Overall,	F 740		

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F 740	Continued From page 11 MD-A identified psychiatric services were difficult to obtain in this area due to past closures of regional and local psychiatric hospitals. Finding placement for residents with behaviors was difficult because of associated complex behavior management. MD-A was not involved in the IDT because he was not the medical director. He had not discussed non-pharmacological care with the facility. MD-A noticed an increase of admissions to the ED for residents from the facility with behaviors on weekends and when new staff and pool staff worked. MD-A usually had not addressed non-pharmacological interventions with facility staff and had not provided oversight on behavioral management of his patients with behaviors as he would expect the resident's psychiatrist to address those concerns. He was unaware of any discussions between the psychiatrist and PCP's regarding resident behaviors to ensure continuity of care. Interview and document review on 3/13/20, at 2:30 p.m. with the administrator identified he started his position on 2/17/20, and the DON started on 3/2/20. He agreed the facility had not ensured resident behaviors were adequately managed. Staff lacked skills and education to manage difficult resident behaviors. The administrator confirmed staff documentation of 15-minute checks was not adequate to ensure staff were monitoring residents every 15-minutes. No audits were initiated to ensure staff maintained line of sight supervision of residents, especially on the evening and night shifts. The Administrator identified interventions were in the process of implementation. Staff were provided radios with headsets to communicate. Additionally, a video camera system was ordered	F 740		

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F 740	Continued From page 12	F 740		

and were to be installed after 3/16/20. No audits for radio use were documented, but he had come to the facility on off hours to ensure staff were utilizing the radios. Additionally, the non-transparent adhesive covering on the nurse station window was planned to be removed, and replaced with see-through Plexiglas to enable the nurse at the nurse station to observe the hallway of the locked unit. Staff training was scheduled for 3/25/20, to address resident behaviors, but no behavior training had occurred to address R2's frequent altercations with other residents, and no resident-specific training was provided regarding behavior management for other residents with behaviors. Review of the staff schedule with the administrator identified he acknowleged the facility was not adequately staffed on the locked unit to ensure residents received line of sight supervision to reduce resident altercations. His goal was to have two NAs and one trained medication aid (TMA) or nurse on the locked unit on all shifts due to increase supervision. The facility was attempting to recruit new staff. Physicians were notified of behavioral issues, but were not yet included in review of resident behavioral management practices at the facility. The psychiatrist was not involved in non-pharmacological behavioral management practices at the facilty. He acknowleged facility staff had not received adequate training to be equipped enough to manage residents requiring behavioral management. He had not yet reviewed the facility assessment to ensure it reflected what services the facility was able to provide, but had stopped taking new admissions in order to develop a plan and provide training for staff to care for the residents residing at the facility. The Quality Assurance Performance

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F 740	Continued From page 13 Improvement (QAPI) program was needing to be improved. He had started an interdisciplinary team (IDT) meeting daily, which as done after stand-up in the mornings. Behaviors were addressed in IDT. IDT included the DON, the assistant director of nursing, the social services designee, the new activity director, and the dietary manger when they were available. No NAs were included in IDT team meetings as required. An IDT tool was being developed to use at the meetings to ensure review of interventions to ensure they were appropriate and effective. No policy had been developed yet to address behavior management.	F 740		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2020

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

Re: Event ID: 40B311

Dear Administrator:

The above facility survey was completed on March 13, 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

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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: On 3/12/20 through 3/13/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5273054C. No correction orders were issued. The facility is enrolled in the electronic Plan of	2 000		

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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 of the electronic documents.	2 000		