

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3rd Street South Franklin, MN 55333	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</p> <p>Based on interview, observation, and document review the facility failed to thoroughly investigate falls, establish adequate fall prevention interventions, and follow care planned fall interventions for 2 of 3 residents (R1 and R5) reviewed for falls. This resulted in actual harm when R1 fell and required a visit to the emergency department resulting in a fractured left tenth rib.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 9/30/24, indicated R1 had hemiplegia affecting her right dominant side, dementia, disorientation, and muscle weakness.</p> <p>R1's Fall Risk assessment dated [DATE], indicated R1 was a high risk for falls.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment, had two or more falls without injury, and needed limited assistance with transfers, toilet use, and bed mobility.</p> <p>R1's care plan undated, indicated R1 was at high risk for falls and to ensure R1 was wearing appropriate footwear: non-skid socks or tennis shoes when ambulating or mobilizing in wheelchair. Other interventions included to educate R1 not to stand without assistance, anticipate needs, ensure call light was within reach, encourage call light usage, prompt response to all requests for assistance, and therapy would evaluate and treat as ordered.</p> <p>R1's unwitnessed fall document dated 12/20/24, indicated R1 was found on the floor next to her wheelchair due to trying to self-transfer to the bathroom. No interventions were identified on the document.</p> <p>R1's witnessed fall document dated 2/4/25, indicated R1 had fallen trying to stand from wheelchair alone. No interventions were identified on the document.</p> <p>R1's unwitnessed fall document dated 2/27/25, indicated R1 had fallen from her wheelchair when trying to stand alone. Intervention indicated R1 was re-educated not to stand up alone.</p> <p>R1's progress note dated 3/22/25 at 6:34 a.m., indicated R1 had fallen as she was trying to use the bathroom at 5:15 a.m., with no injury noted.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3rd Street South Franklin, MN 55333	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress note dated 3/22/25 at 10:00 a.m., indicated R1 was crying in pain at her left lower rib and left hip area. R1 was sent to the emergency department for evaluation.</p> <p>R1's progress note dated 3/22/25 at 1:43 p.m., indicated R1 had a nondisplaced tenth left rib fracture.</p> <p>R1's investigation report undated, indicated R1 would have a call don't fall sign placed in room, care plan would be updated, and staff would be educated on call light times and anticipating the needs of residents who are at risk for falls.</p> <p>R1's care sheet undated, lacked any fall interventions.</p> <p>R1's medical record lacked IDT review, root cause analysis, or appropriate fall interventions after each fall.</p> <p>R5's Face Sheet dated 1/17/23, indicated R1 has Alzheimer's disease, dementia, mild neurocognitive disorder, and muscle weakness.</p> <p>R5's fall risk assessment dated [DATE], indicated R1 was at high risk for falls.</p> <p>R5's significant change MDS dated [DATE], indicated R5's memory was not assessed, had 2 or more falls with no injury, and one fall with minor injury. R1 needed extensive assistance with toileting.</p> <p>R5's care plan dated 1/17/23, indicated R1 was at moderate risk for falls. Interventions included anticipate residents needs, currently on hospice to manage end of life care, wear appropriate footwear such as rubber soled skid- free shoes, slippers, or non skid socks when ambulating.</p> <p>R5's unwitnessed fall document dated 3/9/35, indicated R1 missed his chair when attempting to sit down and fell . No interventions were identified on the document.</p> <p>R5's witnessed fall document dated 3/19/25, indicated R1 slid out of his wheelchair and was on the floor. No interventions were identified on the document.</p> <p>R5's fall with suspected head injury document dated 3/29/25 at 12:00 a.m., indicated R1 was found on the floor next to his bed with bowel movement in his brief. Had an injury to the top of his scalp. No interventions were identified on the document.</p> <p>R5's unwitnessed fall dated 3/29/25 at 2:40 a.m., R1 was found on the floor next to his bed. No interventions were identified on the document.</p> <p>R5's care sheet undated, lacked any fall interventions.</p> <p>R5's medical record lacked IDT review, root cause analysis, or appropriate fall interventions after each fall.</p> <p>During an observation on 4/2/25 at 11:18 a.m., R1 did not have a call don't fall sign in her room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 3rd Street South Franklin, MN 55333	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/3/25 at 8:29 a.m., R1 was in the common area with blue star socks on that did not have grip on the bottoms of them and no shoes on.</p> <p>During an interview on 4/3/25 at 8:40 a.m., nursing assistant (NA)-A stated residents fall interventions would be on the resident care sheets or care plans. NA-A stated she was not aware of what the current interventions were for R1 or R5.</p> <p>On 4/3/25 at 9:10 a.m., NA-B stated fall interventions for R1 and R5 were on the care sheet NA-B keeps in her pocket. NA-B stated currently there were no fall interventions in place for R1 or R5 according to the care sheets. NA-B stated she was not aware of any fall intervention in place for R1 or R5 at this time.</p> <p>On 4/3/25 at 9:15 a.m., licensed practical nurse (LPN)-A stated she assisted R1 and R5 with cares the morning of 4/3/25 but had not looked at their care plans to see what fall interventions are currently in place. LPN-A stated she put socks on R1 and thought they were gripper socks but was not aware they are not. LPN-A stated R1 should have had gripper socks or shoes on. LPN-A stated there was a process issue with who was responsible for producing interventions after a residents fall. LPN-A stated the director of nursing (DON) and interdisciplinary team (IDT) are the ones who would assign the interventions and put them in the care plans. LPN-A stated she was not sure why interventions had not been put into place after residents had fallen.</p> <p>On 4/3/25 at 10:10 a.m., registered nurse-(RN)-A stated the DON used to be the one who put fall interventions in the care plans, but she was not sure who would be responsible for that now. R1 was expected to have shoes or gripper socks on when she was in her wheelchair. RN-A stated she was not sure why fall interventions were not being put into place or care planned.</p> <p>On 4/3/25 at 10:29 a.m., the DON stated RN-A was expected to update the care plans with fall interventions for R1 and R5. Staff were expected to look at the care plans to find fall interventions. DON stated she was not sure why fall interventions were not being put into place after every fall, but she expected this to be completed. DON stated there were no fall interventions care planned for R1 or R5's falls.</p> <p>On 4/3/25 at 12:20 p.m., the medical director (MD)-A stated he was concerned there were no interventions care planned for R1 and R5 after their falls. MD-A stated he would have expected interventions to be put into place right after the fall. If R1 had interventions in place after prior falls the potential for falls could have been decreased and could have helped prevent her fracture. The facility should have followed the facility policy in regard to falls.</p> <p>The facility Fall Prevention Program policy reviewed 8/2024, indicated when a resident experienced a fall the facility would review and update the care plan as needed and document all assessments and actions. Interventions would be monitored for effectiveness.</p>		