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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Restorative Care Center	900 3rd Street South Franklin, MN 55333

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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure physician orders were followed for pressure ulcer (PU) wound care for 3 of 3 resident (R1, R4, and R5) reviewed for wound care. Findings include: Stage II pressure ulcer: partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage III pressure ulcer: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage IV pressure ulcer: full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. R1's Face Sheet dated 3/1/23, indicated R1 had paraplegia, stage IV pressure ulcer of sacral region, and protein-calorie malnutrition. R1's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R1 was cognitively intact, needed supervision with cares, and had one stage III and one stage IV pressure ulcers. R1's care plan dated 9/6/23, indicated R1 had a stage IV pressure ulcer on his coccyx and a stage III pressure ulcer on his left ankle. Interventions included the facility would administer treatments as ordered and monitor for effectiveness. R1's provider orders dated 4/1/25 through 4/30/25, indicated R1 had the following orders: - right heel pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to surrounding skin, collagen (natural fibrous protein) to wound bed, and dressing would be applied daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- sacrum pressure ulcer would be cleansed with wound cleanser, skin prep would be applied to peri wound, iodosorb gel (inhibits growth of microorganisms) to wound bed, lightly soak kerlix with vashe (wound cleanser) wound solution, pack the wound, and cover with a dressing two times a day. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's right heel pressure ulcer lacked documentation that dressing changes was completed on 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's treatment administration record dated 4/1/25 through 4/30/25, indicated R1's sacrum pressure ulcer lacked documentation that dressing change was completed on day shift on 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/16/25, 4/19/25, and 4/22/25. R1's sacrum pressure ulcer lacked documentation that dressing change was completed on evening shift 4/13/25 and 4/30/25. R4's Face Sheet dated 9/28/23, indicated R4 had adult failure to thrive and muscle weakness. R4's significant change MDS assessment dated [DATE], indicated R4 was cognitively intact, needed extensive assistance with bed mobility and personal hygiene, and had a stage III pressure ulcer. R4's care plan dated 9/20/24, indicated R4 had a stage II pressure ulcer on her coccyx. Interventions indicated the facility would follow policies and protocols for skin breakdown. R4's provider orders dated 4/1/25 through 4/30/25, indicated R4 had the following orders: - right glute wound would be cleansed with wound cleanser, packed with vasche soaked gauze, and covered with adhesive foam dressing daily. - left ischial tuberosity would be cleansed with wound cleanser, skin prep applied around edges, and a bordered silicone dressing would be applied every two days. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R4's right glute wound lacked documentation that dressing changes was completed on 4/4/25, 4/6/25, 4/8/25, 4/10/25, 4/11/25, 4/16/25, 4/19/25, and 4/24/25. R4's treatment administration record dated 4/1/25 through 4/30/25, indicated R's left ischial tuberosity wound lacked documentation that dressing change was completed on 4/22/25 and 4/24/25. R5's Face Sheet dated 1/4/25, indicated R5 had type 2 diabetes mellitus. R5's significant change MDS assessment dated [DATE], indicated R5 was cognitively intact, had a stage III pressure ulcer, and needed extensive assistance with cares. R5's care plan dated 3/31/25, indicated R5 had a pressure ulcer to his left elbow. Interventions indicated the facility would follow policies and protocols for skin breakdown and would monitor left elbow dressing. R5's provider orders dated 4/1/25 through 4/30/25, indicated R5 had the following orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- left elbow stage III pressure ulcer would be cleansed with wound cleanser and covered with foam adhesive bandage daily R5's treatment administration record dated 4/1/25 through 4/30/25, indicated R5's left elbow stage III pressure ulcer lacked documentation that dressing changes was completed on 4/2/25, 4/5/25, 4/6/25, 4/7/25, 4/8/25, 4/10/25, 4/11/25, 4/12/25, 4/15/25, 4/19/25, and 4/22/25. During an interview on 4/30/25 at 11:18 a.m., R1 stated there had been several times in the last month that his dressings have not been changed. He stated he was not sure what dates or why, but the nurse never came to complete them, and he did not ask for his dressings to be changed. During an interview on 4/30/25 at 3:14 p.m., R5 stated staff do the best they can to get dressings done but it does not happen every day. R5 stated he was not sure what dates his dressings were not completed in the last month. During an interview on 5/1/25 at 9:52 a.m., R4 stated there have been several times her dressings have not been completed but she was not sure what dates or why. During an interview on 5/1/25 at 11:32 a.m., licensed practical nurse (LPN)-A stated if she did a resident's dressings she would have documented the completion in the record. She stated there has been several times in the last month that she was not able to complete dressing changes for the residents, but she reported this to the director of nursing (DON). LPN-A stated she was not sure if the dressing changes were completed on those days. She stated she does not recall the dates or who the residents were that did not get their dressings changed. During an interview on 5/1/25 at 11:57 a.m., LPN-B stated if she did not document in the residents' records that a dressing was completed, she would not have done it. She stated there were times she was unable to get wounds done but she would report to the DON when she was not able to complete the dressings. There were days where wounds were just not done for the residents, but I always told the DON. During an interview on 5/1/25 at 12:38 p.m., infection preventionist (IP)-A stated she if she was in charge of completing dressing orders for the day, she would have charted the ones she completed in the residents' medical record if she had completed them. IP-A stated she was not sure why dressing orders were not completed on several occasions in the last month. During an interview on 5/1/25 at 1:33 p.m., registered nurse (RN)-A stated when she has worked at the facility, she was never in charge of completing dressing changes. She stated if she were to do a dressing change, she would have documented in the resident's medical record. During an interview on 5/1/25 at 1:55 p.m., interim DON stated staff were expected to follow provider orders when it came to wound care. Facility wound treatment management policy reviewed 2/2025, indicated wound treatments would be completed according to physician orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during wound care for 2 of 3 residents (R4 and R5) reviewed for wound care. Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R4's provider orders dated 4/17/25, indicated R4 had a dressing order to cleanse R4's laceration on her left lower buttock with wound cleanser, apply skin barrier prep around edges, and apply a bordered silicone dressing every 2 days. R5's significant change MDS dated [DATE], indicated R5 was cognitively intact and needed extensive assistance with bed mobility and personal hygiene. R5's provider orders dated 2/18/25, indicated R5 had a dressing order to cleanse R5's left elbow with wound cleanser and cover with foam adhesive bandage daily. During an observation on 4/30/25 at 10:47 a.m., the infection preventionist (IP)-A entered R4's room after sanitizing her hands. IP-A applied gown and gloves. IP-A explained to R4 that IP-A was going to complete R4's dressing changes. IP-A removed soiled dressing from R4's left lower buttock with a small amount of pink colored drainage. IP-A cleansed the left lower buttock with wound cleanser and gauze. IP-A did not remove her gloves and wash her hands. IP-A applied a clean bordered silicone dressing to R4's left lower buttock wound. IP-A removed her gloves and gown, sanitized her hands, and left the room. During an observation on 4/30/25 at 1:53 p.m., IP-A entered R5's room and explained to R5 she would be completing his dressing to his left elbow due to the dressing falling off. IP-A washed her hands with soap and water and applied gown and gloves. IP-A cleansed R5's left elbow with wound cleanser and gauze. IP-A did not remove her gloves and wash her hand. IP-A removed a border foam dressing from its packaging and applied it to R5's left elbow wound. IP-A removed her gown and gloves and washed her hands with soap and water. During an interview on 4/30/25 at 2:04 p.m., IP-A stated when she provides wound care she was expected to remove gloves and wash hands after any dirty tasks such as removing a soiled dressing and cleansing a wound. IP-A stated she did not do that with R4 or R5 when changing their dressings. IP-A stated she should have taken off her gloves and washed her hands after cleansing R4 and R5's wounds. During an interview on 5/1/25 at 1:55 p.m., the interim director of nursing (DON) stated staff were expected to wash their hands before a dressing change, after removing the soiled dressing, after cleansing the wound, and after placing a new dressing on the wound. The facilities Hand Hygiene policy reviewed 2/2025, indicated hand hygiene would be completed before and after handling clean or soiled dressings and when moving from a contaminated body site to a clean body site.