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	06/23/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure call lights were functional and within reach for 3 of 8 residents (R1, R5, and R7) reviewed for call light placement.Findings include:R1's significant change in status Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included schizophrenia, acute respiratory failure with hypoxia, and malnutrition. R1's fall focus care plan identified R1 was at risk for falls related to incontinence, poor communication/comprehension, psychoactive drug use, mental health diagnoses, and behavior of throwing herself backwards. Interventions included be sure call light is within reach and courage her to use it for assistance if needed. During observation and interview on 6/17/26 at 9:34 a.m., R1 was lying in bed and stating she needed to use the bathroom. R1 was unable to locate her call light and when it was given to her, she could not push the button. R1 stated she couldn't hold it anymore and needed to go to the bathroom. Evaluator pushed the call light for her and ADON responded and acknowledged R1 likely did not have the strength to push that button and would get a soft touch call light for her.R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 had moderately impaired cognition and needed staff assistance for toileting, dressing, bed mobility, and transferring. Diagnoses included cervical disc disorder with myelopathy (arthritic condition affect the neck joints), bipolar disorder (mental health disorder that causes extreme mood swings), and chronic obstructive pulmonary disease (lung disease causing breathing problems). R5's fall focus care plan identified R5 was a high risk for falls related to gait/balance problems and safety awareness (history of impulsiveness). Interventions included to be sure R5's call light was within reach and encourage the resident to use it for assistance. R5 needed prompt response to all requests for assistance. During an observation and interview on 6/16/26 at 9:55 a.m., R5 was sitting in his wheelchair watching television. R5 stated he was sitting in his torture chair and had a lot of pain in his bottom, rating his pain a 9 on a 0-10 pain scale. R5 wanted a pain pill but could not reach either of the two call lights in his room and stated he could not move his wheelchair to get to them. Defined himself as being stuck. Both call lights were closed inside his bedside table drawer and were out of reach. One call light cord appeared frayed with exposed wires. At 10:05 a.m., Licensed practical nurse (LPN)-A entered the room with R5's pain pill and acknowledged R5 could not reach his call lights and proceeded to tie the frayed call light cord to the metal handlebar of his wheelchair. Assistant Director of Nursing (ADON) verified call light cord was frayed and replaced it. R7's quarterly MDS dated [DATE], R7 had moderately impaired cognition; had impairment to both legs; used a wheelchair; was dependent on staff for personal hygiene, toileting, bed mobility and transfers.R7's fall focus care plan identified R7 was at high risk for falls related to limited mobility, weakness, cellulitis, history of falls, deconditioning, gait/balance problems, and diagnosis of tremors. The care plan lacked call light placement as an intervention. During observation and interview on 6/16/26 at 12:46 p.m., R7 was sitting in his wheelchair in his room and hollering that he wanted to go to bed. R7's call lights in his room were not within his reach to call staff for assistance. Call light observed clipped to the curtain divider in his room. R7 stated he could not reach them so would just holler until they came. R7 stated (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he was very uncomfortable and needed to get out of his chair while adjusting his weight in the chair. At 12:54 p.m., the ADON entered the room and acknowledged that R7's call light was not within his reach. During an interview on 6/16/26 at 12:54 p.m., the ADON stated all residents should always have call lights within reach, and her expectation would be for all staff to ensure the call lights are placed within their reach and be able to push them.^^^^ Review of the facility's Call Light: Accessibility and Timely Response Policy dated 1/2026, identifiedˆthe purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.ˆPolicy Explanation and Compliance Guidelines included:ˆStaff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations with the resident's room. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly (examples included touch pads, larger buttons, bright colors, etc.).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident representative regarding changes to skin integrity, weight loss, and accidents for 1 of 1 residents (R1) reviewed for change in condition. Findings include:R1's significant change in status Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and needed staff assistance with toileting, transfers, dressing, and bed mobility. Diagnoses included intellectual disability, schizophrenia, acute respiratory failure with hypoxia, malnutrition, and dehydration. The MDS also indicated R1 had no skin issues, had two or more falls without injury, required a mechanically altered diet, and had a significant weight loss. R1's care plan lacked a focus or intervention that related to when and why to contact R1's guardian. There was no documentation of R1 having a guardian. R1's Department of Human Services letter dated 12/5/24, identified R1's guardian was a delegate or designee of the Commission of Human Services through [NAME], may act in the Commissioner's stead as a local guardian of R1. Significant weight loss:R1's weight log identified on 3/19/26 R1 was 166.2 pounds; on 5/5/26 R1 was 124.9 which was a loss of 41.3 pounds. R1's Nutritional Assessment identified a significant weight loss related to weight loss of greater than 6.6 pounds, severe decrease in food intake, severe dementia or depression, and a body mass index (BMI) of less than 19. R1's Progress Notes revealed the following:-5/8/26 at 2:41 p.m. - Dietary Note indicated weight warning for a weight of 124.9 pounds. The medical record lacks evidence of guardian notifications related to weight loss or nutrition concerns. -5/18/26 at 5:03 p.m. current weight of 130 pounds continues to show a significant weight loss from 179 pounds in 12/25. The medical record lacks evidence of guardian notification. Skin: R1's Bath Skin assessment dated [DATE] indicated R1 had an open area to coccyx/sacral area and right knee has scabbed areas with treatments in place. R1 also had bruising on arms.R1's Progress Notes revealed the following:-5/11/26 at 3:40 p.m., R1 noted to have skin tears on her buttocks directly above anus. A note was put in for nurse practitioner to evaluate the next day. R1 has bruising around right eye. No facility incident report related to the skin tears or bruising of right eye and lacked documentation that R1's guardian was notified.-5/15/26 at 1:20 p.m., R1 has open area to inside of anus; wound pictures taken and assessment completed but lacked documentation that R1's guardian was notified.Falls:Facility incident report revealed the following:-2/4/26 at 9:45 a.m., identified R1 had been hitting herself in the face, kicking doors, hitting her head on the wall and had bruising of yes and mid to right shoulder area. The incident report lacked documentation of guardian notification-5/5/26 at 11:30 a.m., R1 had a fall. The incident report lacked documentation of guardian notification. -5/9/26 at 5:30 p.m., R1 fell and had a laceration above her right eyebrow 1 centimeter (cm) x 0.3 cm. The incident report lacked documentation of guardian notification-5/10/26 at 12:55 p.m., R1 fell with no apparent injuries. The incident report lacked documentation of guardian notification-6/12/26 at 8:21 p.m., indicated resident fell with complaints of pain in her right knee; hospice, DON and administrator were notified but the noted lacked documentation that the guardian was informed. There was no facility incident report related to this fall. R1's Personal Safety Plan Worksheet dated 1/16/26, identified trusted supporters and people R1 could to when she needed help included guardian Barb.During an interview on 6/16/26 at 1:21 p.m., R1's guardian indicated she had not been notified of R1's significant weight loss of 50 pounds, was not always notified of R1's falls specifically the fall on the 6/12/26 and was not notified of R1's skin issues. The guardian was surprised at the amount of skin issues R1 received treatment for. During an interview on 6/17/26 at 10:25 a.m., employee (E)-B identified as part of the interdisciplinary team (IDT) and stated all notifications to resident's families, guardians, or responsible party were only to be done by the social worker during business hours. E-B stated any change of condition, fall, incident, new orders should have been communicated to the residents' responsible parties, but the facility had not been making (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	those notifications as they should have. During an interview on 6/17/26 at 12:32 p.m., E-I indicated R1's guardian was not getting notified of condition changes, behaviors, or med changes because there was some confusion in the facility about who R1's guardian was. E-I stated that resident families, responsible parties, guardians should have been notified if there was significant change like weight loss, behaviors, changes with medications or orders. Also stated the prior social worker was supposed to make all those notifications, but the facility process changed, and nurses are supposed to make those notifications. During an interview on 6/17/26 at 2:05 p.m., the social service designee (SSD) stated all family, guardian, responsible party notifications had been made by the social worker but recognized that was an area that they needed to improve in. The SSD further stated nurses should contact residents' responsible parties for emergent situations, and the SSD made the non-emergent notifications. The SSD said he needed to review the facility policies. During an interview on 6/17/26 at 3:58 p.m., the regional clinical consultant (RCC) noticed that the facility lacked documentation of notifications and would expect families, responsible parties, and guardians to be notified according to the facility policy. The facility's undated policy titled, Notification of Changes identified the purpose of the policy was to ensure the facility promptly informs the resident, consults with the resident's physician; and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification and included accidents resulting in injury or potential to require physician intervention; significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial state which may include: life-threatening conditions or clinical complications and circumstances that require a need to alter treatment which may include new treatment, discontinuation of current treatment, transfer or discharge of a resident, change of room or room assignment, and a change in resident rights. For residents incapable of making their own decision, the representative would make any decisions that need to be made, and the resident should still be told what is happening to him or her.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an elopement from the facility was recognized and reported to the state agency (SA) for 1 of 1 resident (R4) reviewed for elopement. Findings include:R4's admission Record indicated he was admitted to the facility on [DATE]. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and indicated he experienced delusions; had acute mental status changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. R4's care plan also identified him as a high fall risk related to diagnoses and ambulation without well-fit gripped footwear. R4's medical record lacked any documentation of an elopement on 6/6/26.Review of the facility's incident reports lacked any documentation of the 6/6/26 elopement incident.The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R4's reported elopement attempts on 6/6/26. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former director of nursing (DON) reported that on 6/6/26, R4 had eloped, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned for R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC)'s direction. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an employee's vehicle, and administration directed not to report or document the elopement. Further, E-B stated R4 had made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported to the SA nor documented in R4's record or a facility incident report completed. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff.During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and two other staff were on duty but were in rooms assisting residents when she heard a beeping noise. At first, she thought the beeping noise was a call light and then investigated and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	realized it was the exit door alarm system, but the zones on the master alarm board were not labeled so she did not know which door had been opened and activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck heading into the dock or delivery bay and recognized the man in the driver's seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked employees' door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver's side of the running truck, but the former DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The former DON was then able to safely assist R4 back into the building without any apparent injuries. The former DON identified the facility is surrounded by a corn field, deep gulch or drop-off, and a road and all posed risks to R4's safety. The former DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The former DON then called the RCC at 12:48 p.m. and was instructed to not chart the incident in R4's medical record, not to do an incident report, and not report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4's medical record, did not do an incident report, nor report it to the SA. The former DON stated she was walked out by the administrator and RCC the day the abbreviated survey began (6/16/26).During an interview on 6/17/26 at 1:27 p.m., E-D indicated she heard the door buzzers but was not sure which door it was. By the time they found out which door had alarmed, the former DON found him in the truck. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements at the beginning of May and now the one in June that prompted R4's move to a more secured home. The SSD stated he was not present during the elopement, but on 6/8/26, the former DON reported R4's elopement incident that occurred on 6/6/26, to him. The former DON reported that R4 had gotten into an employee's vehicle and drove it without staff supervision. The SSD stated he did not report to the SA and did not know what the facility vulnerable adult policy directed. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she observed R4 driving her truck to the delivery/docking bay next to the employee entrance. E-E identified R4 was an elopement risk and had eloped through that front door by the business offices two more times that day after he drove her truck. One time, another resident alerted staff that R4 was outside; however, she was not sure where they found him the second time he eloped. Follow up interview on 6/23/26 at 11:56 a.m., the former DON stated she did not document the elopement in R4's medical record because the RCC and administrator told her not to. The former DON reiterated that on 6/6/26, R4 left the building unsupervised.During an interview on 6/17/26 at 2:40 p.m., the administrator stated on 6/6/26 she was unavailable and did not have cellular service so did not have the details of R4's elopement incident; the former DON did not notify her. The administrator stated, he [R4] was supervised from what I know. The administrator stated it was not reported to the SA because R4 was supervised the whole time he was out of the building on 6/6/26 so it was not considered an elopement and not reportable. The administrator further stated, unless I see it first-hand, I don't report it and there are a lot of differing opinions. The administrator indicated if staff came to her with concerns she would not automatically report. She would request the concern be in writing and then would review the concern to determine if it was reportable or not. The administrator said she is not a nurse and counts on the nursing judgement to decide. Staff was to report concerns to the rapid response team which includes the RCC. During an interview on 6/17/26 at 3:58 p.m., the RCC stated, their system is broke and an elopement is considered neglect and should be reported to the SA. The RCC further stated, I was not notified on 6/6/26 [of R4's elopement], the only thing I know was from reviewing his chart and insisted R4 had direct supervision by staff. The RCC stated she would not tell anyone not to report, that she was an over reporter, and if she had known about R4's elopement, it would have been reported to the SA. The undated facility policy titled, Abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neglect, and Exploitation identified the facility will report all alleged violations to the administrator, state agency, adult protective services and to all other required agencies no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; assure the reporters are free from retaliation or reprisal; promote a culture of safety and open communication in the work environment. The administrator will follow up with government agencies during business hours to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. The undated facility policy titled Elopement and Wandering Residents defines elopement as occurring when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Appropriate reporting requirements to the State Survey agency shall be conducted.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate a report of elopement for 1 of 1 resident (R4). Findings include:R4's admission Record indicated he was admitted to the facility on [DATE]. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and indicated he experienced delusions; had acute mental status changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement care of from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 former director of nurse (DON) reported that on 6/6/26, R4 had eloped, took an employee's car from the employee parking lot, and drove it down the road. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC)'s direction and not investigated any further. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that R4 had gotten into and drove an employee's vehicle on 6/6/26, and administration defined as the RCC and administrator, directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported, investigated, nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff.During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and other staff were in rooms assisting residents when she heard a beeping noise. , She investigated and found that it was the door alarm system, but the zones on the master alarm board were not labeled so she did not know which door was activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck heading into the dock or delivery bay and noted the man in the driver's seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked employees' door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver's side of the running (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	truck, but the former DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The former DON called the administrator and the regional clinical consultant (RCC) and was instructed to not chart the incident in R4's medical record, do an incident report, or report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4's medical record, do an incident report, investigate the elopement, nor report it to the SA. During interview on 6/17/26 at 1:13 p.m., E-C identified on 6/6/26 just before lunch the door alarms went off as they were busy with another resident. The door alarms sounded like call lights, and thus it was hard to tell if it was the call light system or the door alarm. E-C stated they figured it was R4 because he frequently tried to get out, and they were unaware which door he went out. By the time R4 was found, he was coming in the back door by the employee parking lot. E-C denied being asked any questions by administration about the elopement. During an interview on 6/17/26 at 1:27 p.m., E-D indicated she heard the door buzzers but was not sure which door it was. By the time they found out which door had alarmed, the former DON found him in the truck. E-D denied being asked any questions by administration about the incident. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements at the beginning of May and now the one in June that prompted R4's move to a more secured home. The SSD stated he was not present during the elopement, but it was reported on 6/8/26, that R4 had gotten into an employee's vehicle and pulled it forward. The SSD was not aware if the elopement was investigated or not. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she observed R4 driving her truck to the delivery/docking bay next to the employee entrance. R4 got out of the truck, walked around to the employee entrance door, and tried to pull the locked door open. R4 appeared to be talking to someone. Upon further inspection, she saw the former DON met him at the employee entrance, in which R4 then walked back to the running truck and got in the driver's side. At that time, the former DON was able to get into the passenger side of the vehicle, shut the ignition off, and pull the keys out of the ignition. E-E explained her truck was parked approximately 5-6 parking spots from the employee entrance and R4 would have had to back up the truck and drive around other parked vehicles and drive by the garage before pulling into the docking/delivery bay. E-E indicated they notified the administrator and her immediate supervisor and was asked to provide a written statement but then did not have any further conversations with the former DON or the administrator regarding the elopement. R4's medical record was reviewed and lacked any documentation related to the reported elopements.Review of facility incident reports did not include any risk management, incident reports, or investigations related to the reported elopements.The State Agencies Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R4's reported elopement attempts.R4's nurse progress notes lacked any documentation of the elopement on 6/6/26.R4's nursing progress note on 6/7/26 (the day after the elopement) was noted to have a left great toenail almost detached from the nail bed with the nail hanging loosely. On-call provider notified and advised to soak the toe and trim/remove as much detached nail as possible. The medical record lacked any further investigation; the facility lacked any incident report/risk management or investigation regarding R4's injury.During interview on 6/17/26 at 2:40 p.m., the administrator stated she was aware of R4's alleged elopement incident but she did not know the details of the incident and stated she thought he was supervised the whole time. She further indicated she did not have an investigation into R4's alleged elopement because she did not think it was a true elopement. During an interview on 6/17/26 at 3:58 p.m., the RCC stated she was aware of R4's alleged elopement incident and elopement should be investigated and reported. The RCC further denied being notified on 6/6/26 of R4's elopement and the only information she had was by reviewing R4's medical record and it said he had direct supervision. The RCC was a part of an interdisciplinary meeting on 6/9/26 at 10:30 a.m. that discussed R4's elopement incident. During a follow up interview on 6/18/26 at 1:48 p.m., the RCC stated R4's alleged elopement was discussed on 6/8/26 but lacked documentation of further investigation.Review of the facility's (continued on next page)

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	245273	A. Building B. Wing	06/23/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated Rapid Response protocol indicated post elopement documentation should include an incident report/risk management; report DHS (department of human services); timeline of search and actions taken; resident assessment after recovery; notifications; and investigative findings. Follow up should include a root cause analysis and after action summary. Review of the facility's undated policy titled, Abuse, Neglect, and Exploitation defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It defined alleged violation as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigation and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of property. The policy directs an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation and determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, the cause, and proving complete and thorough documentation of the incident. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to monitor, report, and implement timely interventions for 1 of 2 residents (R1) reviewed for significant weight loss.Findings include:R1's significant change in status minimum data set (MDS) dated [DATE], indicated severely impaired cognition. Diagnoses included paranoid schizophrenia, moderate intellectual disabilities, protein-calorie malnutrition, acute respiratory failure with hypoxia, and dysphagia.R1's Nutritional assessment dated [DATE], identified R1 was malnourished, independent with eating after meal set up, did not receive a therapeutic nutritional supplement, did not use dentures as they were poor fitting, had poor meal intakes, was at risk for dehydration due to vomiting. The assessment further identified R1's admission weight 30 days prior was 179 pounds, but current weight was not documented and left blank. There was no change in weight and either no weight loss or gain or unknown if there was a weight loss or gain. R1's total nutritional intakes and supplements met her nutritional needs. Nutritional goals and interventions were updated and in R1's care plan. Dietary was to monitor for any abnormal weight changes. R1's nutrition focused care plan initiated on 5/18/26, identified R1 was at risk for nutrition/hydration problems related to the need for hospice services, dentures not fitting properly, advanced age, compromised appetite due to refusing meals, nausea/vomiting, weakness, refused weights, open areas on bottom, dysphagia, weight loss. Interventions included monitoring weights per MD (medical doctor)/hospice orders and/or facility policy; offer extra fluids between meals for hydration at activities; monitor for signs of dehydration; provide diet per MD/hospice order of a 7 regular diet as tolerated; provide R1 with assistance and cues as needed; safe swallowing strategies; sit upright; limit distractions, and meds crushed. R1's treatment administration record for April 2026, identified an order dated 3/5/26, for weekly weights and vital signs on bath day every Thursday. R1's weight on 4/2/26, was documented as 166.1 pounds; on 4/9/26, not applicable (NA) was documented; on 4/16/26, no documented weight; on 4/23/26, NA was documented; on 4/30/26, NA was documented. R1's treatment administration record for May 2026, identified an order dated 3/5/26, for weekly weights and vital signs on bath day every Thursday. R1's weight on 5/7/26 was not documented and all vital signs left blank; on 5/14/26 weight documented as 130 pounds (loss of 36.1 pounds in 6 weeks). R1's Weight Summary identified on 4/2/26, weight was 166.1 pounds and no other weights documented until 5/5/26, when R1's weight was 124.9 pounds (loss of 41.2 pounds).R1's Care Conference Summary dated 3/25/26, did not contain a dietary summary, nursing summary, and no weight or dietary concerns. R1's dietary progress notes reflected the following:-3/13/26, at 10:50 a.m., R1 had weight loss over time and continued compromised appetite and recommended a house supplement between meals. Dietary was to continue to monitor weights and appetite.-R1's progress notes lacked any dietary note from 3/13/26 to 5/8/26 and no evidence of implementation of nutritional supplement. -5/8/26 at 2:41 a.m., identified weight warning for R1 with a weight of 124.9 pounds and requested a reweigh. -5/13/26 at 10:54 a.m., R1 needed more cues and assistance with meals and provided lipped plate and straws to aide with independence with meals. Weight Note on 6/05/26 at 9:55 a.m., identified weight warning with R1's weight at 121.7 pounds; R1 had decreased meal intakes, was sleeping through meals, and having emesis after most meals causing weight loss. R1 was recently admitted to hospice and per dietician recommendation, fax sent to hospice for a supplement order to aide with nutritional intake due to her compromised appetite. On 6/5/26 at 12:17 p.m., hospice and R1's guardian approved use of a nutritional supplement and order was requested from physician. During interview on 6/16/26 at 1:21 p.m., R1's guardian indicated R1 had always had a bit of an issue with eating but had concerns with the facility's monitoring of R1's weight and had not received any notifications of R1's significant weight loss until she requested a care conference in May. R1 was 178 pounds when she was admitted to the facility on 12/25, and weight had decreased to 120 pounds without any interventions. R1's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guardian also stated that the facility did not try any nutritional supplements or interventions until recently which she felt was after the fact and too late. During an interview on 6/17/26 at 3:58 p.m., the regional clinical consultant (RCC) indicated overall documentation is lacking. The RCC indicated her expectations of the facility nursing staff was to monitor weights, track and trend weights, put interventions in place, and document. During an interview on 6/23/26 at 10:30 a.m., the dietary manager (DM) indicated R1 would have behaviors of throwing up but did eat relatively ok until she went to the hospital in May. The DM further explained the nurses did not get R1's weights so when R1 returned from the hospital, a huge weight loss triggered. The DM stated that nursing is expected to notify her of any residents' weight changes but, some will, and some will not. The facility policy related to monitoring resident weights, reporting weight changes, and implementing interventions was requested but not received.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document reviews, the facility failed to adequately supervise and maintain resident safety when resident (R4), with a history of exiting the facility unsupervised, eloped through the front door of the facility, and drove an employee vehicle in the parking lot. This resulted in an Immediate Jeopardy (IJ) situation for R4. In addition, the facility failed to implement a system to ensure adequate supervision was provided for R4, when the exit alarm system panel was not labeled to alert staff to the exit door that R4 opened. The IJ began on 6/6/2026, when R4, who was assessed to be an elopement risk, was exhibiting exit seeking behavior just prior to the incident, exited through the front door of the facility, was able to enter an employee's vehicle with the keys inside, and drove across the employee parking lot before being observed by staff. The facility Administrator and the regional clinical coordinator (RCC) were notified of the IJ on 6/18/26 at 4:35 p.m. The IJ was removed on 6/8/26 and the deficient practice corrected on 6/11/26, prior to the start of the survey and was therefore past noncompliance. Findings include:R4's admission Record indicated he was admitted to the facility on [DATE]. Diagnoses included Lewy bodies dementia (a progressive brain disorder that affects thinking, memory, movement, sleep, and behavior), depression, hallucinations, anxiety disorder, and bipolar disorder (mental health condition characterized by severe, unusual shifts in mood and energy levels). R4's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and indicated he experienced delusions; had acute mental changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. R4's Elopement Risk Evaluation dated 5/21/26, identified R4 was at risk for elopement with a score of 8.0. Elopement risk identified due to R4 being ambulatory, had a habit/history of wandering or attempts to leave the unit/building; exhibited pacing or agitated behavior; asked to go home or other specific destinations; had a diagnoses of dementia, psychosis, and/or other psychiatric diagnoses; had a history of elopement from this facility or another setting; voiced concern from family that R4 had a tendency to wander or elope; and was taking medication which may cause confusion. Interventions included exit alarm, frequent monitoring, behavior log and analysis, staff were aware of elopement risk, and personalization of room. Analysis and elopement prevention plan and care plan updated sections lacked any additional information. R4's elopement focused care plan updated on 5/19/26, indicated he was at risk for elopement related to dementia with behavioral disturbances, impaired cognition with delusions/disorientation to time and place as evidenced by elopement events and exit seeking from skilled nursing facility. The care plan lacked elopement event dates, circumstances, and triggers. On 5/19/26, interventions of monitoring R4's location every 15 minutes for safety and to document per protocol, and an alarm to double fire doors on E (east wing) to alert staff when opened for prompt immediate assessment of R4's location. R4's care plan also identified him as a high fall risk related to diagnoses and ambulation without well-fit gripped footwear. R4's facility Progress Notes identified the following: 5/17/26 at 11:02 a.m., behavior charting indicated R4 exhibited exit seeking at all doors and agitation. Attempted redirection, distractions, and PRN's (as needed medications) but were ineffective. 5/18/26 at 1:01 p.m., R4 continued to exit seek; was agitated and wanted to go home. R4 was unable to be redirected which led to increased behaviors. The note lacked information related to which behaviors R4 demonstrated. 5/20/26 at 5:22 a.m., during the night R4 was confused and tried to get out the doors, R4 redirected. 5/22/26 at 3:07 p.m., R4's son was notified of R4 wandering out of the building and his attempts at trying to elope after learning the door codes from watching staff. The nature of the call was to discuss possible elopement; the facility provided 15-minute checks. 5/24/26 at 4:45 a.m., R4 wandered into other resident rooms, looked for exits to elope, stated he was going home, and was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aggressive and combative to redirection. R4 refused to take PRN risperidone (antipsychotic medication). 15-minute checks continued. 5/24/26 at 6:46 p.m., R4 had gotten out into the locked courtyard within a minute or two, but staff redirected him back into the building. The administrator and prior DON were notified by phone. The note lacked additional information or interventions to mitigate continued self-entry into the locked courtyard.5/25/26 at 9:15 a.m., R4 continued to exit seek with increased agitation when staff redirected. R4 ignored door alarms and any other devices used to keep him away from doors. The note lacked information on intervention(s) to mitigate R4's increased agitation or decrease his exit-seeking behavior.5/25/26 at 8:49 p.m., R4 was actively exit seeking, wandering, and entering other residents' rooms during the PM (evening) shift, difficult to redirect or reassure; voiced concerns about farm equipment and hogs; asked other residents for a ride just a few miles up the road. Redirection was only successful for a couple of minutes and repeated behaviors. The note lacked information on intervention(s) to mitigate R4's behaviors or decrease his exit-seeking behavior.5/31/26 at 10:42 a.m., R4 was agitated, aggressive, and unstoppable, and headed out through an exit door. An ambulance was called and he was transferred to the emergency department for evaluation. R4 returned at 2:00 p.m. with notes to schedule an appointment with physician to follow up on medication adjustments. 6/2/26 at 10:35 a.m., facility reached out to locked facilities for R4's relocation. 6/3/26 at 9:02 a.m., R4 managed to get out of the locked door by pushing on it for an extended period of time which released the lock's safety feature. R4 immediately tried to re-enter the building. Staff unlocked the door and R4 re-entered. The note lacked information on intervention(s) to mitigate or decrease his exit-seeking behavior.6/3/26 at 3:57 p.m., R4 wandered hallways, attempted to elope through the exterior door by the business offices. R4 wanted to leave the building to go to work and check on the status of his farm. Interventions attempted were 1:1 time with staff, redirection, and activities but were ineffective. 6/6/26 at 11:18 a.m., R4 wandered and was exit seeking. R4 had been walking with conviction all morning since 6:30 a.m. and seemed to be on edge about how hot it is outside and getting the hogs he had loaded to [NAME]. Interventions attempted included removal of departure cues (keys, coats, shoes) from sight, redirection, food, sensory board, socialization with peers and staff but he continued to wander, and exit seek.R4's progress notes, including his medical record, lacked information related to R4's 6/6/26 elopement from the facility and driving an employee's vehicle as evidenced below in staff interviews.6/6/26 at 3:47 p.m., R4 continued to wander, pushed doors, and went into other residents' rooms. R4 stated he just wanted to get out the door. The note lacked information on intervention(s) to mitigate or decrease his exit-seeking behaviors.6/7/26 at 1:03 p.m., R4 exhibited severe agitation, anxiety, and exit-seeking behavior throughout the shift; continued to make attempts to leave despite staff interventions. 6/11/26 at 9:09 p.m., R4 was assigned a 1:1 (one-on-one) staff supervision. 6/12/26 at 9:39 a.m., R4 discharged to an assisted living facility. R4's Resident Location Charting from 5/29/26 to 6/8/26, lacked care planned 15-minute checks documentation at the following times:5/29/26, from 6:45 a.m. to 6:00p.m.5/30/26, from 6:45 a.m. to 6:00 p.m.5/31/26, from 6:30 a.m. to 6:00 p.m.6/1/26, from 9:30 a.m. to 10:30 a.m. and 2:15 p.m. to 6:00 p.m.6/2/26 from 12:15 p.m. to 1:15 p.m.6/4/26 from 5:45 a.m. to 12:00 p.m.6/5/26 from 6:45 a.m. to 6:00 p.m.6/6/26 (day of the elopement), from 6:45 a.m. to 6:00 p.m. 6/7/26 from 7:15 a.m. to 6:00 p.m.6/8/26, from 9:45 a.m. to 12:00 p.m., then identified 1:1 staffing. R4's Every 15-Minute Check Sheet dated 6/8/26 had 15-minute checks crossed out and at all times written in because R4 got outside. This form started at 3:30 p.m. with complete documentation until discharge. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former director of nursing (DON) reported that R4 had eloped on 6/6/26, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned for R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC) direction. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	employee's vehicle, and administration including the RCC and administrator directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse and at approximately 11:20 a.m. to 11:40 a.m., she and two other staff were on duty but were in rooms assisting residents when she heard a beeping noise. At first, she thought the beeping noise was a call light and then investigated and realized it was the exit door alarm system, but the zones on the master alarm board were not labeled so she did not know which door had been opened and activated. She had available staff checking rooms and she went out the East door by the business offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The DON continued across the visitors parking lot and saw a white pickup truck heading into the dock or delivery bay and recognized the man in the driver's seat as R4. Once R4 arrived at the delivery bay area, R4 exited the running truck and tried to get into the locked employees' door, where she was able to intervene. After unsuccessful attempts to get R4 back into the building, R4 then proceeded to get back into the driver's side of the running truck, but the DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The DON was then able to safely assist R4 back into the building without any apparent injuries. The DON identified the facility is surrounded by a corn field, deep gulch or drop-off, and a road and all posed risks to R4's safety. The DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The DON then called the RCC at 12:48 p.m. and was instructed to not chart the incident in R4's medical record, not to do an incident report, and not report it to the State agency (SA). In response to this direction, she confirmed she did not document the event in R4's medical record, did not do an incident report, nor report it to the SA. The DON stated she was walked out by the administrator and RCC the day the abbreviated survey began (6/16/26). The former DON further indicated she was walked out of the building and employment terminated when she told the RCC and administrator that she wanted to talk to the SA surveyor and was not aware of any previous issues with her job performance. During interview on 6/17/26 at 1:13 p.m., E-C identified on 6/6/26 just before lunch the door alarms went off as they were busy with another resident. The door alarms sounded like call lights, and thus it was hard to tell if it was the call light system or the door alarm. E-C stated they figured it was R4 because R4 frequently tried to get out, and they were unaware which door he went out. By the time R4 was found, he was coming in the back door by the employee parking lot. E-C denied seeing R4 drive the vehicle but heard about it. E-C explained she thought R4 was on 15-minute checks on 6/6/26, but indicated they did not have enough staff that day to do the 15 minute checks on R4. On 6/8/26, new door alarms were placed on the doors. During an interview on 6/17/26 at 1:27 p.m., E-D indicated on 6/6/26 at approximately 11:30 a.m., she heard the door buzzers but was not sure which door it was. By the time they found out which door had alarmed, the DON found R4 in the truck. R4 tried to elope a lot and was on 15-minute checks but this was changed to 1:1 staff at all times after the elopement. After the 6/6/26 incident, the zones were labeled on the exit door main panel for staff to know which door was alarming. During an interview on 6/17/26 at 1:51 p.m., social service designee (SSD) indicated R4 had two elopements the beginning of May and now the one in June that prompted R4's move to a more secured home. The SSD stated he was not present during the recent elopement, the former DON reported that R4 had gotten into an employee's vehicle and pulled it forward. He explained the facility front yard sits next to a steep drop off, valley, gulch with trees and brush which put R4 at risk if he were to get too close to the edge and fall down the valley. R4 was on 15-minute checks but after the elopement was changed to 1:1 staffing until his discharge. During an interview on 6/18/26 at 10:06 a.m., E-E identified that on 6/6/26 she parked her truck in the employee parking lot with the keys in the ignition. Just before lunch time, she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	observed R4 driving her truck to the delivery/docking bay next to the employee entrance. R4 got out of the truck, walked around to the employee entrance door, and tried to pull the locked door open. R4 appeared to be talking to someone. Upon further inspection, she saw the DON met him at the employee entrance, in which R4 then walked back to the running truck and got in the driver's side. At that time, the DON was able to get into the passenger side of the vehicle, shut the ignition off, and pull the keys out of the ignition. E-E explained her truck was parked approximately 5-6 parking spots from the employee entrance and R4 would have had to back up the truck and drive around other parked vehicles and drive by the garage before pulling into the docking/delivery bay. E-E did not know how long R4 had driven the truck. She described the weather that day as hot and muggy and R4 was wearing a sweatshirt, sweatpants, and yellow grippy socks that had grass and gravel stuck to them. E-E identified R4 was an elopement risk and had eloped through the front door by the offices two more times the day after he drove her truck. One time, another resident alerted staff that R4 was outside; however, she was not sure where they found him the second time he eloped. Additionally, E-E stated there were a set of double fire doors at the end of the East hall before the actual facility exit doors that were always supposed to be shut and alarmed because he tried to elope so often. The purpose of the double door alarms were to alert staff prior to R4 exiting the building but she had frequently observed that the door alarms were shut off and was told by an un-named charge nurse that the door alarms were shut off because R4 set them off so often, it disturbed the residents. E-E provided two videos of the double fire doors at the end of the hall; one video of the doors alarmed and one that she stated she took on 6/7/26 (after R4's elopement) of the double door alarms not working. E-E stated she took the videos because the facility administration had tried to make R4's elopement on 6/6/26 her fault and she wanted proof that the doors were not alarmed. During interview on 6/22/26 at 12:07 p.m., family member (FM)-A stated R4 did not have a valid driver's license as it was revoked after R4 got into trouble while driving around lost, and when the police tried to pull him over, R4 tried to flee the police officer. FM-A indicated the facility told him R4 tried to get into a vehicle on 6/6/26 but he was not aware that R4 had driven it and further stated, he was not surprised by this because R4 roamed the halls and tried to get out of the facility constantly, FM-A further indicated when he visited R4 on 6/7/26, he learned R4 had just eloped out the back and got away from staff. During an interview on 6/23/26 at 10:04 a.m., E-F indicated she was not present when R4 took an employee's vehicle, but she had observed R4 escape out into the courtyard without staff knowledge many times, and on one occasion, he was in the bushes trying to climb the fence. E-F stated that R4 should have had more supervision because of his history of escaping. During an interview on 6/23/26 at 10:10 a.m., E-G stated she had observed R4 enter the kitchen and was attempting to elope out the door but went down the basement stairs instead. E-G stated she called for nursing, and they responded and redirected him. E-G stated, they should be supervising him more closely.During an observation with E-E on 6/23/26 at 10:55 a.m., and following the route out the door R4 exited, based on interviews where the truck was parked in the employee parking lot and the initial sighting of R4 driving in the vehicle, took a person out the front door by the business offices which has a sharp, wooded, drop off behind a two open rail fence beyond approximately 25 feet of grassy area; he then went East and walked through the visitor parking lot and windows of an unoccupied area of the business offices and physical therapy room; walked [NAME] across the lawn and between the garage and trash dumpsters to the vehicle parked approximately 50-100 feet into the gravel parking lot with other employee vehicles parked in the lot; a corn field and gravel road were adjacent to the parking lot to the south; entered the truck and backed the truck out forward 50-100 feet to the east edge of the employee parking lot and turned the vehicle to the south between the employee's smoking area and facility garage; pulled the vehicle up the docking/delivery bay with approximately 10 feet between the front of the truck and the facility. During a Follow up interview on 6/23/26 at 11:56 a.m., the prior DON stated she did not document the elopement in R4's medical record because the RCC and administrator told her not to. The former DON reiterated that on 6/6/26, R4 left the building (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	unsupervised. The following facility's corrective actions dated 6/11/2026, were verified as implemented prior to the survey: 6/8/26, zones on the door alarm panel were labeled.6/9/26 screamer door alarms were installed on the exit doors.6/9/26 elopement assessments were completed on all in-house residents.6/10/26, the elopement book was reviewed and updated, and care plans were reviewed6/11/26, education completed with all staff on Abuse, Neglect, and Exploitation Policy, Elopements and Wandering Policy, and Accidents and Supervision Policy to include the 15 second egress on all exit doors and Screamers. Additionally, documentation supports 1:1 staff supervision for R4 was initiated. The undated facility policy titled, Elopements and Wandering Residents indicated the facility ensured that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Defines elopement when a resident leaves the premises or safe area without authorization and/or any necessary supervision to do so. The facility is equipped with door locs/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. The undated facility policy titled, Accidents and Supervision, identified the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This included: identifying hazard(s) and risk(s), Evaluating and analyzing hazard(s) and risk(s), Implementing interventions to reduce hazard(s) and risk(s), Monitoring for effectiveness and modifying interventions when necessaryDefinitions: Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident; Environment refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas; Hazards refers to elements of the resident environment that have the potential to cause injury or illness; Risk refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.; Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision; defined by type and frequency; based on the individual resident's assessed needs and identified hazards in the resident environment

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, video/audio recording review and document review, the facility administration directed staff not to report or document a resident elopement. The administration's direction not to report, prevented immediate identification and correction of failures in supervision, alarm response, staff training, and elopement prevention, leaving residents exposed to continued risk of elopement and serious injury and demonstrated a breakdown of the facility's governing systems for resident protection, quality assurance, and promoted an ongoing culture of fear of the facility being shut down, retaliation and regulatory noncompliance. The former director of nursing (DON), regional clinical consultant (RCC), chief operating officer (COO), social service designee (SSD), and owner all failed to ensure allegations of reportable events were reported to the State Agency (SA) and thoroughly investigated to protect a resident (R4) from further occurrence. This noncompliance had the potential to affect all 31 residents that resided at this facility. The IJ began on 6/6/26 when the former DON notified the administrator and RCC that R4 eloped from the facility, entered an employee's vehicle with the keys inside, and drove the vehicle independently to a loading/delivery dock next to the facility. In addition, when the former DON reported the incident internally, the RCC told the former DON not to report to the SA and not to document the reportable elopement event. The immediate jeopardy was identified on 6/18/26 and the administrator, assistant administrator, and the RCC were informed of the IJ on 6/18/23 at 4:53 p.m. The immediate jeopardy was removed on 6/23/26 at 2:20 p.m., but noncompliance remained at the lower scope and severity of F, which is widespread, level 2, indicating no actual harm with potential for more than minimal harm that is not immediate jeopardyFindings Include:Refer to F689, F609, F610R4's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and indicated he experienced delusions; had acute mental changes; behaviors of inattention, disorganized thinking; and physical and verbal behaviors towards others. R4's MDS indicated he ambulated independently without assistive devices on and off the unit and indicated he displayed wandering behaviors daily. During interview on 6/16/26 at 2:01 p.m., employee (E)-A identified that on 6/9/26 the former DON reported that R4 had eloped on 6/6/26, took an employee's car from the employee parking lot, and drove it down the road. E-A was concerned about R4's and other people's safety. E-A also stated the former DON told her that the elopement was not documented in R4's medical record and that it was to look like the elopement never happened per regional clinical consultant (RCC) direction. During an interview on 6/17/26 at 10:25 a.m., E-B revealed that the former DON had reported that on 6/6/26, R4 had gotten into and drove an employee's vehicle, and administration including the RCC and administrator directed not to report or document the elopement. Further, E-B stated R4 should have had more supervision as he has made several attempts to elope with two elopement events since May that they were aware of, in which neither were reported nor documented. E-B indicated R4's elopement events occurred when he was not accompanied by staff, nor were his elopements immediately recognized by staff. E-B indicated knowledge of reporting requirements and identified although the administrator and RCC were notified immediately, they did not report the elopement event to the state agency (SA). E-B further stated the administrator and corporate overall were not reporting reportable events and were threatening staff jobs and licenses if they did report. E-B defined corporate as the administrator and RCC. Further identified nursing staff was not allowed to report any event to the SA and there was a fear of retaliation for going against what corporate advises. E-B also voiced concerns related to adequate staff training. During an interview on 6/17/26 at 11:22 a.m., the former DON stated she had been employed at the facility for about a month. On 6/6/26, she was covering as charge nurse at approximately 11:20 a.m. to 11:40 a.m., she and other staff were in rooms assisting residents when she heard a beeping noise, she investigated and found that it was the door alarm system but the zones on the master alarm board were not labeled so did not know which door was activated. She had (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	available staff check rooms and she went out the east door by the offices and asked a resident who was outside smoking if he had seen anyone leave; he had not. The former DON continued across the visitors parking lot and saw a white pickup truck driving into the dock or delivery bay area and noted the man in the driver's seat as R4. R4 exited the running truck and tried to get into the locked employees' door when she was able to intervene. R4 then proceeded to get back into the driver's side of the running truck but the former DON was able to enter the passenger's side, shut off the truck, and pull the keys out of the ignition. The former DON was then able to safely assist R4 back into the building without any apparent injuries. The former DON also identified the facility is surrounded by a corn field, deep gulch or drop-off, and a road. The former DON called the administrator at 11:57 a.m. and the administrator returned her call at 12:34 p.m. The former DON then called the RCC at 12:48 p.m. per the administrator's direction. The former DON reported she was told, you don't say anything, don't document it, don't report it, like it never happened because they [SA] will shut the building down and it will be all your fault; listen to what I tell you or I will have your license. The former DON confirmed she did not document the event in R4's medical record, do an incident report, investigate the elopement, or report to the SA. The former DON reported there was an interdisciplinary meeting (IDT) on 6/9/26 at 10:30 a.m. and discussed the elopement event and identified the administrator, social service designee (SSD), corporate SSD, owner, RCC, and COO were present at the meeting and again discussed not reporting the elopement incident to the SA. The former DON stated she was walked out by the administrator and RCC the day the abbreviated survey began (6/16/26). The former DON further indicated she was walked out of the building and employment terminated when she told the RCC and administrator that she wanted to talk to the SA surveyor and was not aware of any previous issues with her job performance.During an interview on 6/17/26 at 1:56 p.m., E-H indicated the former DON reported R4's elopement on 6/6/26, but did not know much about the elopement except that it should have been reported and investigated but facility nursing leadership were threatened by the administration defined as RCC and administrator not to report the elopement to the SA and was not sure if R4's elopement was investigated. E-H further stated, there is lots of issues with retaliation threats around here. During an interview on 6/17/26 at 2:40 p.m., the administrator stated on 6/6/26 she was unavailable and did not have cellular service so did not have the details of R4's elopement incident; the former DON did not notify her. The administrator stated, he [R4] was supervised from what I know. The administrator stated it was not reported to the SA because R4 was supervised the whole time he was out of the building on 6/6/26 so it was not considered an elopement and not reportable. The administrator further stated, unless I see it first-hand, I don't report it and there are a lot of differing opinions The administrator indicated if staff came to her with concerns she would not automatically report. She would request the concern be in writing and then would review the concern to determine if it was reportable or not. The administrator said she is not a nurse and counts on the nursing judgement to decide. The administrator added staff were to report concerns to the rapid response team which includes the RCC. She further stated we got chewed out by the medical director at QAPI because they weren't reporting reportable events. And further identified, we need to be more diligent about our risk management and were going to be doing training with the staff today at 5:00 pm. The administrator denied ever telling a staff person not to report to the SA. During a follow-up interview on 6/23/25 at 11:56 a.m., the former DON reviewed her call history log, and it identified the following calls sent and received following R4's elopement on 6/6/26:11:57 a.m. the former DON called the administrator and left a voicemail.12:34 p.m. the administrator returned the DON's call.12:48 p.m. the former DON called the RCC and had a 22-minute conversation,1:11 p.m. the DON called the administrator and had an 18-minute conversation. The former DON stated R4's elopements were discussed during the phone calls. During an interview on 6/17/26 at 3:58 p.m., the RCC stated, their system is broke and an elopement is considered neglect and should be reported to the SA. The RCC further stated, I was not notified on 6/6/26 [of R4's elopement], the only thing I know was from reviewing his chart and insisted R4 had direct supervision by staff during the incident on 6/6/26. The (continued on next page)

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