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	05/28/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain informed consent, including risks and benefits, for 4 out of 4 residents (R8, R15, R22, R27) reviewed for use of psychotropic medications. Findings include: R8's quarterly minimum data set (MDS) dated [DATE], indicated R8 was admitted [DATE], was moderately cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (high level of fat content in the bloodstream), dementia, and depression. R8's order report summary dated 5/20/25, indicated R8 was currently prescribed mirtazapine (antidepressant) with a start date of 4/23/2025, and Olanzapine (antipsychotic) start date 9/5/2024. R8's Order recap report dated 5/21/25, indicated original start dates for the Mirtazapine was 11/3/2023, and olanzapine was 7/2/2024. Additionally, R8 has a discontinued order for lorazepam (benzodiazepine) start date 7/12/2024 end date 9/5/2024 and paroxetine (antidepressant/anti-panic) original start date 11/3/23 and discontinue date 5/1/24. R8's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed. R15's admission MDS dated [DATE], indicated R15 was admitted on [DATE], was moderately cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed alprazolam (benzodiazepine) with a start date of 2/14/2025, and Zoloft (antidepressant) start date 5/13/25. R15's order recap report dated 5/21/25, indicated original start dates for alprazolam was 2/4/25, original start date for Zoloft was 3/19/25. Additionally, R15 has a discontinued order for duloxetine (antidepressant) start date 2/14/25 end date 3/18/25. R15's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's significant change MDS, dated [DATE], indicated R22 was cognitively intact, and diagnoses included major depressive disorder, generalized anxiety disorder, and hoarding disorder. During the review period, R22 was taking the following high-risk drug classes: antidepressant, diuretic, opioid, and hypoglycemic. R22's order summary report, dated 5/20/25, indicated R22 was currently prescribed the following psychotropic medications: Trazodone (antidepressant) 50mg by mouth at bedtime with a start date of 2/26/25, Venlafaxine (antidepressant) 37.5 mg by mouth every morning with a start date of 4/11/25, and Venlafaxine (antidepressant) 75 mg by mouth two times a day (BID) with a start date of 8/28/24. R22's record lacked evidence R22 had been informed of the risks and benefits and obtained informed consent for prescribed psychotropic medications. R27's significant change MDS dated [DATE], indicated R27 was admitted on [DATE], was severely cognitively impaired, and has the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety. R27's order summary report date 5/20/25, indicated R27 was currently prescribed buspirone (psychotropic) with a start date of 11/27/24, and haloperidol (antipsychotic) start date 3/21/25, Lexapro (antidepressant) start date 8/6/24, and olanzapine (antipsychotic) start data 3/21/25. R27's order recap report dated 5/21/25, indicated original start date for buspirone was 5/25/23, original start date for haloperidol was 12/4/24, original start date for Lexapro was 1/18/23, original start date for olanzapine was 3/14/25. Additionally, R27 has discontinued orders for lorazepam (benzodiazepine) start date 12/15/24 end date 2/19/25, Namenda (psychotropic) start date 3/13/25 end date 3/20/25, risperidone (antipsychotic) start date 8/15/24 end date 8/19/24, and Seroquel (antipsychotic) start date 2/19/25 end date 3/14/25. R27's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications being completed. On 5/19/25 at 4:47 p.m., the regional director of nursing (O)-E, stated they do not have any consents for psychotropics, they had not been completed, and whatever was provided for information was all they had. On 5/28/25 at 1:56 p.m., consulting pharmacist (PharmD) stated the facility was expected to obtain consent for all psychotropic medication, and it was important for residents/resident representatives to be informed of the risks and potential side effects prior to initiating the psychotropic. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated staff were expected to obtain consent after residents/resident representatives were informed of the risk and benefits before a psychotropic medication was administered. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Use of Psychotropic Medications policy, last reviewed 3/5/25, indicated prior to initiating or increasing the psychotropic medication, the resident, family and/or resident representative, must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medication, in advance of such an initiation or increase. The resident had the right to accept or decline the initiation or increase of a psychotropic medication. The facility will document the resident or resident representative was informed in advance of the risk and benefits of the purpose are, the treatment alternatives, or other options, and the preferred options to accept or decline in a format that facility deems to use i.e.; consent forms, or narrative notes.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 residents (R24) observed with medications at their bedside. Findings include: R24's quarterly MDS, dated [DATE], indicated R24 was cognitively intact, and diagnoses included diabetes, heart failure, and chronic obstructive pulmonary disease (COPD). On 5/20/25 at 7:39 a.m., licensed practical nurse (LPN)-B was observed setting up R24's morning medications but was unable to locate R24's fluticasone-salmeterol (Advair) inhaler in the medication cart. Trained medication assistant (TMA)-A suggested LPN-B look on R24's bedside table to see if the inhaler had been left in R24's room the previous night. On 5/20/25 at 7:59 a.m., when LPN-B entered R24's room to administer his medications, R24's Advair discus was observed on R24's bedside table and was within R24's reach. When LPN-B asked R24 about the Advair discus, R24 stated, yeah, they never put that away last night. R24's order summary report, dated 5/20/25, indicated an order with a start date of 4/4/24, for Advair 500-50 mcg/act 1 puff inhale orally two times a day related to COPD. R24's self-administration of medications (SAM) assessment dated [DATE], indicated R24 was safe to self-administer Bio Freeze and nicotine gum as needed (PRN), and would be left at bedside table for resident to take. However, the SAM assessment did not indicate R24 was determined to safely self-administer Advair. R24's care plan report printed 5/20/25, indicated R24's safety was at risk and there was a potential for abuse due to current medical condition, use of medications, need for assistance with cares and mobility. On 5/28/25 at 3:54 p.m., the director of nursing (DON) confirmed R24's SAM did not indicate it was safe for R24 to keep Advair at bedside to self-administer. DON stated the only medications that were to be left at bedside were those a SAM identified as safe to do so after a nurse evaluation. DON stated she expected staff to store all medication appropriately for the safety of the resident and other residents. The facility's Person-Centered Medication Administration policy, dated 2024, indicated residents had the right to choose the medication goals and preferences, and the facility would determine if the residents' choices presented a risk or safety challenge to the resident or other residents.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN-CMS-10055) was provided to 1 of 3 residents (R143) reviewed for beneficiary notification. Findings include: R143's discharge minimum data set (MDS) dated [DATE], indicated R143 was admitted on [DATE] and discharged on 3/27/2025, and their Medicare part A services ended on 2/19/2025. R143's SNFABN-CMS-10055 signed on 2/19/25, informed them services would end on 2/19/2025. However, this notice was given outside of the 48 hours prior to services ending requirement, and was provided the same day as services ending. On 5/19/25 at 2:41 p.m., the office manager (OM) stated they were responsible for completing the Medicare SNFABN-0CMS-10055 forms, and they were expected to provide them to the resident 48 hours prior to the end of services. OM stated they were typically informed by therapies or the MDS nurse when someone's services were ending. OM confirmed R143 was given their SNFABN-CMS-10055 outside of the required 48 hours prior to end of services. OM stated the SNFABN-CMS-10055 were important to provide to the resident so they were aware they will need to cover the cost of services at that time. On 5/22/25 at 10:054 a.m., the administrator stated their expectation was for the staff member responsible to complete and provide the notices to the resident and to follow the guidelines of their policy related to the time frame. The administrator stated it was important to provide these notices because it was part of the Medicare process. The facility policy dated 2024, indicated to ensure the resident or representative has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare part A stay or when all of Part B therapies are ending.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and document review, the facility failed to ensure resident living areas were free from unwanted noise for 3 of 4 residents (R3, R14, R22) reviewed for uncomfortable sound levels. This had the potential to affect residents in surrounding rooms, visitors and facility staff. Findings include: R3's annual Minimum Data Set (MDS), dated [DATE], indicated R3 was cognitively intact, and diagnoses included schizophrenia, anxiety disorder, major depressive disorder, bipolar disorder, and delusional disorders. R14's significant change MDS, dated [DATE], indicated R14 was cognitively intact, and diagnoses included major depressive disorder, mood affective disorder, and diabetes. R22's quarterly MDS, dated [DATE], indicated R22 was cognitively intact, and diagnoses included chronic tension-type headache, major depressive disorder, and anxiety disorder. On 5/20/25 at 7:39 a.m., during a medication administration observation, a continuous, loud, high-pitched, obstructive noise was heard repeatedly for long lengths of time in the hallway outside the residents' rooms. Trained medication aide (TMA)-A stated the noise was from the call light system that was located at the nurses' station. The nurses' station was in the center of the building, between the 3 resident hallways, and adjacent to the resident common area. It was noted that the noise could be heard down the length of the resident hallways. The call light system was activated for long periods of time, frequently, throughout the survey period. A sample of activation time lengths were as follows: On 5/20/25 at 10:39 a.m., the noise from the call light sounded non-stop for 24 minutes. On 5/20/25 at 1:21 p.m., the noise from the call light sounded non-stop for 20 minutes. On 5/21/25 at 11:48 a.m., the noise from the call light sounded non-stop for 34 minutes. On 5/21/25 at 3:10 p.m., the noise from the call light sounded non-stop for 19 minutes. On 5/22/25 at 2:29 p.m., the noise from the call light sounded non-stop for 9 minutes. On 5/22/25 at 3:02 p.m., the noise from the call light sounded non-stop for 19 minutes. On 5/27/25 at 2:32 p.m., the noise from the call light sounded non-stop for 8 minutes. On 5/28/25 at 8:35 a.m., the noise from the call light sounded non-stop for 13 minutes. On 5/28/25 at 2:46 p.m., the noise from the call light sounded non-stop for 18 minutes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 10:32 a.m., R22 stated the call light alarms go off a lot for long periods of time until a staff person turns them off. The noise was irritating. R3 and R14 agreed with R22's statement. R14 stated the call light noise occurred even at night and the loud noises affected sleep. On 5/22/25 at 1:31 p.m., registered nurse (RN)-A and licensed practical nurse (LPN)-C stated they have been frustrated because it was hard to work with the noise from the call light system and they found it incredibly hard to focus on what they were doing. RN-A stated residents have complained about the noise and have yelled, shut that [expletive] thing up. RN-A stated the frequent noise has caused more severe negative resident behaviors, and it has been a concern the entire time RN-A has worked at the facility. RN-A and LPN-C stated they had reported the concern about the noise level's effect on residents, but were told nothing can be done. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated an environment that was not calm could contribute to challenging resident behaviors and had identified loud noises as a trigger for residents. DON stated concern the frequent call light noise throughout the day and night in common areas and rooms negatively affected resident quality of life. DON acknowledged the constant distraction from the loud noise could negatively affect staff performance and their ability to concentrate. DON stated a call light system was required for safety, but a quieter sounding alarm would be better for the residents. On 5/28/25 at 5:31 p.m., the administrator stated background noise could be difficult for residents with dementia to sort out, too much noise could be overstimulating, and it was important to maintain a calm environment. The facility's call light system is old, and the board, located at the nursing station, rings until the call is answered and shut off. The facility's General Information document, undated, provided with the facility's admission packet, indicated quiet hours were from 10:00 p.m. to 6:00 a.m., and to be considerate of the rights of other residents, including noise control. The facility's Resident Rights policy, dated 2024, indicated the resident has a right to a safe, clean, comfortable and homelike environment. The facility's Resident Environmental Quality policy, dated 2024, indicated the facility would be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure ordered as needed (PRN) antipsychotic medications were limited to a 14-day time period and clinical rational indicated continuation past the 14-day time period. Additionally, the facility failed to ensure a gradual dose reduction (GDR) or appropriate indication for use for medications was documented for 2 of 4 residents (R15, and R27) reviewed for unnecessary medications. Findings include: R15's admission MDS dated [DATE], indicated R15 was admitted on [DATE], was moderately cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed alprazolam (benzodiazepine) 0.5 mg (milligrams)-give two tablets by mouth every 6 hours PRN, with a start date of 2/14/2025. R15's medical record lacks any evidence of clinical indication or rational to continue past the required 14-day time frame. R15's monthly pharmacy reconciliation for March 2025, indicated the pharmacist requested the clinical rational for surpassing the 14-day time frame. R15's medical record lacked any evidence of a rationale, or any evidence the facility responded to the pharmacist request. R27's significant change MDS dated [DATE], indicated R27 was admitted on [DATE], was severely cognitively impaired, and had the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety. R27's order summary report date 5/20/25, indicated R27 was currently prescribed the following medications: 1. Haloperidol (antipsychotic) inject 0.25 ml intramuscularly (IM) every 24 hours PRN, with a start date 3/21/25. 2. Lexapro (antidepressant) give 10 mg my mouth daily with a start date of 8/6/24. 3. Olanzapine (antipsychotic) give 10 mg three times daily (TID) and every 4 hours PRN with a start date of 3/21/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Morphine (analgesic) give 5 mg by mouth every 4 hours PRN with the indication of dementia. R27's medical record lacks any evidence of clinical indication or rational to continue past the 14-day time frame for both Haloperidol and/or Olanzapine. Furthermore, R27's medical record lacked any evidence of a GRD being completed or attempted for Lexapro. R27's monthly pharmacy reconciliation for January 2025, indicated the pharmacist requested the clinical rational for Haloperidol surpassing the 14 days, for a second time. R27's medical record lacked any evidence of the facility responded to the pharmacist request. R27's monthly pharmacy reconciliation for April 2025, indicated the pharmacist requested the clinical rationale for Olanzapine, a third request for the rationale for Haloperidol, and requested a GDR for Lexapro. R27's medical record lacked any evidence of the rationale, the GDR, or if the facility responded to the pharmacist requests. R27's monthly pharmacy reconciliation for May 2025, indicated the pharmacist had send a fourth request for haloperidol clinical rationale, and a second request for Olanzapine clinical rational. R27's medical record lacked any evidence the facility responded to the pharmacist request. On 5/28/25 at 1:56 p.m., the consulting pharmacist (O)-D stated their expectation was if the psychotropic medication needed to be continued, the provider should have provided a clinical rational explaining why and a duration. The pharmacist confirmed both R15 and R27's medical records lacked any clinical rational to support the continuance of their above listed medications. The pharmacist stated their expectation for a GDR was to be completed within 6 months after starting the medication and then yearly. The pharmacist stated the importance of completing GDR's, as the side effects of these meds can be harmful and it was important to keep them on the lowest effective dose. The Pharmacist reviewed the indication of R27's morphine order, and confirmed dementia was not an acceptable indication for this medication. Lastly, the pharmacist confirmed they had attempted to address all of the above issues in R15 and R27's monthly pharmacy reviews, however they had not received any response from the facility. On 5/28/25 at 3:54 p.m., the director of nursing (DON) confirmed R15 and R27 did not have documented clinical rational to continue use of PRN medications beyond 14 days. The DON stated their expectation was the clinical rational be documented in the residents medical records. The DON confirmed no GDR had been attempted for R27's Lexapro, and the DON expected one to have been completed within 6 months of starting the mediation, and then yearly, GDR's were important to keep the resident on the lowest possible does as some of these medications have a black box warning. The DON confirmed the indication for R27's morphine of dementia was not appropriate and should have been more personalized. Lastly, the DON confirmed they were unsure who was responsible for completing the monthly pharmacy reviews for the facility. The previous DON had left unexpectedly, and the current DON stated they assumed the pharmacy reviews had been sent to the previous DON and now they were unsure who was completing them,. The DON stated the importance of responding and following up on pharmacy's recommendations to ensure safe medication usage and ensuring the residents were getting their appropriate mediations for the right reasons. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Use of Psychotropic medications last reviewed 3/5/25, indicated PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days unless the physician believe it appropriate to extend beyond 14 days. The medical record should include documentation from the physician for the rationale for the extended time period and indicate a specific duration. Residents who use psychotropic medication shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. Lastly, the residents medical record shall include documentation of the rationale for chosen treatment options.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to update the care plan for 1 of 2 residents (R31) reviewed for pressure ulcer interventions. Findings include: R31's significant change minimum data set (MDS) dated [DATE], indicated R31 was cognitively intact and had the following diagnoses: osteoporosis (deterioration of bone structure), thyroid disorder, malnutrition, and depression. R5's care plan last reviewed 4/21/25, indicated R31 has the potential for nutrition/hydration problems and an intervention listed was Arginaid Oral packet (Nutritional Supplements) give one packet by mouth two times daily to aid with wound healing. R5's physician orders accessed 5/27/25, indicated following order: Arginaid Oral Packet (Nutritional Supplements) give 1 packet by mouth two times daily was stated on 2/14/2024 and discontinued on 8/26/2024. On 5/27/25 at 1:48 p.m., the licensed practical nurse (LPN)-A stated the charge nurse on duty was responsible for updating the care plans when necessary. LPN-A stated there was no set schedule of when to complete the updates but they typically happened the same day or as soon as possible after. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated their expectation was the care plans should be updated at least quarterly and with all changes of condition. The DON confirmed they would have expected R31's care plan to have been updated prior to present day as the order was discontinued in August of 24'. The DON stated the importance of updating care plans to provide consistent and current care for the residents. The facility policy was requested and not provided.

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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 record review and interview the facility failed to accurately implement physician orders for 1 of 1 resident (R5) reviewed for weekly weight monitoring. Findings include: R5's annual minimum data set (MDS) dated [DATE], indicated R5 was cognitively intact, and had the following diagnoses: neurogenic bladder, paraplegia (has lost use of some of their limbs), malnutrition, and depression. R5's physician order list accessed 5/22/25, indicated a physician order which started on 12/27/23 indicated weekly weights and vitals on bath day as an active order. R5's care plan last reviewed 3/14/25, indicated R5 was at risk for potential nutrition/hydration problems, and to monitor weights per MD order and/or facility policy. R5's electronic medical administration record (eMAR) and treatment administration record (TAR) were reviewed from December 2024 through May 2025, and the last documented weight for R5 was on 12/25/24. On 5/27/25 at 1:48 p.m., licensed practical nurse (LPN)-A stated the nurse on duty was responsible for collecting weights which need to be completed, or when appropriate delegating the task to a certified nursing assistant (CNA). LPN-A stated the weights to be completed, show up in the MAR and TAR, or they will receive and email from the dietician or dietary requesting one. LPN-A confirmed there were no further weights charted since December 2024 and was unsure why they were not completed. LPN-A further noted the R5 was agreeable to taking their weight and stated it would not be charted in any other locations. On 5/28/25 at 3:54 p.m., the Director of nursing (DON) stated they expected weights to be collected based on each resident's specific physician orders or at a minimum monthly, until deemed not necessary. The DON confirmed the no weights had been charted or completed since December 2024 for R5. The DON stated it was important to follow physician orders because it was the facility's responsibility to complete, was in the nurse's scope of practice to complete or explain why it was not completed and was part of the care plan. The facility policy Weight Monitoring dated 2023, indicated the facility will ensure all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range.

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Franklin Restorative Care Center	900 3rd Street South Franklin, MN 55333

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. I'm not sure if this is correct, I used other surveyors tags as guidiance, and their tag from last year. Let me know if you want me to change anything. Based on interview and document review the facility failed to ensure a registered nurse (RN) was scheduled for at least 8 consecutive hours a day, seven days a week. This had the potential to affect at 35 residents who reside in the facility. Findings include: The Facility's PBJ Staffing report 1705D dated quarter 1 2025 October 1st-Decemeber 31st, indicated the facility had triggered the following staffing concerns: 1. One star staffing rating. 2. Excessively low weekend staffing. 3. No RN hours. Review of the facility's license staff schedule for May 10th, 2025, and May 24th, 2025, confirmed they was no consecutive eight hours of RN coverage in the facility. The Daily Timecards Log dated 5/6/25 -5/10/25, listed punch in and outs times for licensed employees from 5/6/25 -5/10/25, and 5/23/25-5/26/25. These logs confirmed there was no RN coverage on 5/10/25, and 5/24/25. On 5/28/25 at 9:59a.m., the administrator and health unit coordinator (HUC) stated both were responsible for and completed the schedule. They attempt to conduct block scheduling when possible and have been struggling with call ins for scheduled shifts. On an average day they aim to have one charge nurse, 2-trained medication administrators (TMA), 2-3 nursing assistants, and on nights 1-2 nurses, and 1-2 aides. The administrator and HUC confirmed they attempt to check and verify they have RN coverage by reviewing the schedule and time cards, however they confirmed sometimes it did not happen. The Administration confirmed they did not have consecutive RN coverage on 5/10/25 and 5/24/25. Furthermore, the administrator stated it was important to have RN coverage in the facility because it was a requirement of skilled nursing. A Staffing policy was requested, and none was provided.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interviews, the facility failed to ensure all required data were included on the nurse staffing information posted daily. This had the potential to affect all 35 residents residing in the facility and their visitors who may wish to view the information. Findings include: The Facility's PBJ Staffing report 1705D dated quarter 1 2025 October 1st-December 31st, indicated the facility had triggered the following staffing concerns: 1. One star staffing rating. 2. Excessively low weekend staffing. 3. No RN hours. The staff schedule and posting documentation dated from October 2024 through May 2025, was reviewed and the following dates failed to include any or all of the following requirements for the daily staff posting: 1. Facility name. 2. Current date. 3. Facility Census. 4. Total number and actual hours worked by licensed staff. 5. Total number of licensed staff, and their designation or title. October 2024: 10/5/24, 10/12/24,10/13/24, 10/15/24,10/19/24, 10/20/24, 10/24/24, 10/28/24 (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	December 2024: 12/19/24, 12/31/24 February 2025: 2/6/25, 2/17/25, 2/23/25, 2/24/25 March 2025: 3/2/25, 3/3/25, 3/9/25, 3/1025, 3/16/25, 3/17/25, 3/23/25, 3/24/25, 3/3025, 3/31/25 April 2025: 4/6/25, 4/7/25, 4/13/25, 4/14/25, 4/16/25 through 4/30/25. May 2025: 5/1/25 through 5/16/25, and 5/18/25 through 5/28/25. On 5/28/25 at 9:59 a.m., the administrator and the health unit coordinator (HUC) stated the HUC prepared the staff posting and the night nurses were responsible for listing any staff changes, and posting it in the morning. The administrator and the HUC stated they believed the posting was required to have the name of the facility, census, name of staff, the shift they worked, and the hours they worked. The administrator and the HUC confirmed the above listed staff postings were missing some or all of the required information. The administrator stated the importance of posting all of the correct information, so the facility and residents were aware of how many staff were working. A staff posting policy was requested and none was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and document review, the facility failed to implement a system to monitor stored narcotics to prevent diversion. This had the potential to affect all 16 residents prescribed Schedule II-V medications. Findings include: On 5/21/25 at approximately 11:00 a.m., assistant director of nursing/infection preventionist (ADON/IP) confirmed the following: 1. The facility's West Individual Narcotic Record's Index page indicated the last narcotic entered on the Index page was Lyrica entered on page 55. However, the narcotic book had medications documented through page 127. 2. The facility's East Individual Narcotic Record's Index page indicated the last narcotic entered on the Index page was Lyrica entered on page 55. However, the narcotic book had medications documented through page 127. On 5/28/25 at 11:07 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-C were observed completing a medication cart narcotic count. LPN-C had the narcotic book. RN-A unlocked the narcotic box in the medication cart, pulled out the first card, called out the number noted at the top of the card, LPN-C turned to the corresponding page in the narcotic book, LPN-C stated the number of remaining doses listed in the narcotic book, RN-A held up the card and both nurses verified that the number of doses that remained in the medication card matched the number indicated in the narcotic book. The nurses stated they followed the same procedure for each narcotic, and after the procedure was completed, they both signed and dated the task was completed in the back of the narcotic book. On 5/28/25 at 11:12 a.m., RN-A stated a C was noted in the resident's medication administration record (MAR) which indicated that medication was a controlled substance and needed to be secured in the locked narcotic drawer and the count maintained in the narcotic book. RN-A stated narcotic counts were completed at every shift change. RN-A stated the facility no longer used the Index pages located at the front of each book to log when a new medication was received and place in the locked narcotic drawer, and they did not use the Index pages to determine which pages to review during each shift change narcotic count. RN-A stated staff knew what medications should be maintained the drawer from repetition and we would just know if a narcotic card was missing. On 5/28/25 at 3:54 p.m., director of nursing (DON) confirmed the facility did not use the index pages at the front of the narcotic books to track and monitor each narcotic, and no other method or list was maintained that indicated what medications should be kept in each locked narcotic drawer. DON stated records needed to be maintained to account for every narcotic that entered the facility. DON stated the facility did not have a clearly refined system in place to monitor stored narcotics to prevent diversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's handwritten Controlled Medications document, undated, provided on 5/28/25, indicated 9 controlled medications for 6 residents were in the facility's East medication cart, and 14 controlled medications for 10 residents were in the facility's [NAME] medication cart. However, the document failed to indicate the corresponding narcotic book page number for each medication listed. The facility's Controlled Substance Administration and Accountability policy, dated 2024, indicated the facility would have safeguards in place to prevent loss or diversion of controlled substances.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure pharmacist consultant recommendations were acted upon for 5 of 5 residents (R8, R15, R22, R24, R27) reviewed for unnecessary medications. Findings include: R8's quarterly minimum data set (MDS) dated [DATE], indicated R8 was admitted [DATE], was moderately cognitively impaired, and had the following diagnoses: hypertension (HTN) (high blood pressure), hyperlipidemia (HLD) (high level of fat content in the bloodstream), dementia, and depression. R8's order report summary dated 5/20/25, indicated R8 was currently prescribed the following medications: 1. Mirtazapine (antidepressant) take 2 tablets by mouth daily, and take 1 tablet 7.5 mg by mouth daily 2. Olanzapine (antipsychotic) 2.5 mg by mouth twice daily (BID) R8's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. April 2025-Pharmacist requested laboratory work up for Olanzapine, as none had been completed since 2024. 2. May 2025- Pharmacist requested order clarification for Mirtazapine, order stated dosage as two tabs, but order also listed one tab, and no change has been made to the order. R8's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. R15's admission MDS dated [DATE], indicated R15 was admitted on [DATE], was moderately cognitively impaired, and had the following diagnoses: anemia (low iron count in the bloodstream), heart failure (failure of the heart to pump blood efficiently), renal insufficiency (kidneys inability to filter blood efficiently), diabetes, HLD, and anxiety. R15's order summary report dated 5/20/25, indicated R15 was currently prescribed the following medications: 1. Alprazolam (benzodiazepine) 0.5 mg (milligrams)-give two tablets by mouth every 6 hours PRN 2. Sertraline (Antidepressant) 50 mg by mouth once daily. R15's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. March 2025- Pharmacist requested clinical rational for Alprazolam, it was overdue for 14-day review. 2. April 2025- Pharmacist requested a second request for rationale for Alprazolam, and Sertraline, both were over the 14-day review mark. 3. May 2025- Pharmacist requested a third request for rationale for Alprazolam, and a second request for Sertraline R15's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. R22's significant change MDS, dated [DATE], indicated R22 was admitted on [DATE], was cognitively intact, and diagnoses included diabetes, PVD, and pancreatic insufficiency. R22's order summary report, dated 5/20/25, indicated R22 was currently prescribed the following medications: 1. Nystatin cream (used to treat fungal or yeast infections) 100000 unit/gm topically BID 2. Atorvastatin (used to lower cholesterol levels) 40 mg by mouth daily R22's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. March 2025-pharmacist recommended Nystatin cream be changed from scheduled BID to PRN. 2. May 2025-pharmacist noted R22's last lipid panel in 2024 was within normal limits (WNL), recommended another lipid panel and discontinue (d/c) atorvastatin if the lipid panel results were still WNL to reduce interactions and effects of polypharmacy. R22's record lacked evidence the facility updated the physician regarding the 3/13/25 and 5/7/25 pharmacist recommendations. R24's quarterly MDS, dated [DATE], indicated R24 was admitted on [DATE], was cognitively intact, and diagnoses included diabetes, heart failure, and chronic obstructive pulmonary disease (COPD). R24's order summary report, dated 5/20/25, indicated R24 was currently prescribed the following medications: 1. Calcipotriene cream (used to treat psoriasis) 0.005% topically BID 2. Lantus (long-acting insulin) 100 unit/mL - inject 18 unit subcutaneously daily 3. Humalog (rapid-acting insulin) 100 unit/mL - inject 5 units subcutaneously with meals 4. Humalog (rapid-acting insulin) 100 unit/mL - inject as per sliding scale subcutaneously before meals (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Hydrocodone-Acetaminophen (used to treat moderate to severe pain) 5-325 mg by mouth three times R24's monthly pharmacy reconciliations dated 4/11/25, indicated the following: 1. Pharmacist recommended the 2/11/25 order for calcipotriene cream be changed from scheduled BID to PRN. 2. Pharmacist noted R24 was receiving long-acting [NAME] and had a continuous glucose monitor. Beer's criteria high risk drug: sliding scale insulin produces high rates of hypoglycemia without adequate control of blood sugars or outcome benefit. Pharmacist recommended an increased dose of basal insulin and d/c sliding scale to establish control and outcome benefit. 3. Pharmacist recommended reducing Hydrocodone frequency or changing to PRN. R24's record lacked evidence the facility updated the physician regarding the 4/11/25 pharmacist recommendations. R27's significant change MDS dated [DATE], indicated R27 was admitted on [DATE], was severely cognitively impaired, and has the following diagnoses: peripheral vascular disease (PVD) (inability of the blood vessels and capillaries in the extremities to constrict enough to send the blood back to the heart), arthritis, Alzheimer's, and anxiety. R27's order summary report date 5/20/25, indicated R27 was currently prescribed the following medications: 1. Haloperidol (antipsychotic) inject 0.25 ml intramuscularly (IM) every 24 hours PRN, with a start date 3/21/25. 2. Lexapro (antidepressant) give 10 mg my mouth daily with a start date of 8/6/24. 3. Olanzapine (antipsychotic) give 10 mg three times daily (TID) and every 4 hours PRN with a start date of 3/21/25. R27's monthly pharmacy reconciliations were reviewed for the last 6 months. Of those, the corresponding months had the following recommendations: 1. January 2025- pharmacist requested the clinical rational for Haloperidol surpassing the 14 days, for a second time. 2. April 2025- Pharmacist was requesting the clinical rationale for Olanzapine, a third request for the rationale for Haloperidol, and requested a gradual dose reduction (GDR) for Lexapro. 3. May 2025- Pharmacist had send a fourth request for haloperidol clinical rationale, and a second request for Olanzapine clinical rational. R27's medical record lacked any evidence the facility ever responded to or updated the physician regarding the pharmacist recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/28/25 at 1:56 p.m., the consulting pharmacist (PharmD) stated the facility was expected to resolve monthly medication review recommendations prior to the next monthly pharmacist visit. PharmD stated the facility was responsible for ensuring the recommendations were reviewed by the providers. On 5/28/25 at 3:54 p.m., the director of nursing (DON) stated the regional director of nursing had to contact the consulting pharmacist to obtain the pharmacist recommendations that were missing, and confirmed that R8, R15, R22, R24, and R27's pharmacist recommendations had not been acted upon by the facility. DON stated staff were expected to manage pharmacist recommendation prior to the next consulting pharmacist visit (one month), and it was important to ensure resident medication safety. The facility's Medication Regimen Review, dated 2024, indicated the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medications, and facility staff would act upon all recommendation according to procedures for addressing medication regimen review irregularities.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to maintain separately locked and permanently affixed compartments for storage of controlled medications in the medication room refrigerator reviewed for medication storage. Findings include: On 5/20/25 at 10:00 a.m., a vial of Lorazepam Oral Concentrate USP 2 mg/ml (2 milligrams of medication/per milliliter of liquid) a schedule IV (four) controlled Substance was observed in the door of the refrigerator outside of the double lock box. The lock box was not permanently secured to the refrigerator and had a key in the lock. Licensed practical nurse (LPN)-B stated they were agency staff and confirmed the unaffixed lock box, with key, had been there since they had started working in the facility. LPN-B confirmed the key was always left in the box. LPN-B confirmed the Ativan should have been stored and locked in the lock box. Next, writer and LPN-B went to confirm the Ativan medication count in the narcotic box, which was correct, and the Director of nursing (DON) passed by. At 10:14 a.m., the DON came into the medication room and confirmed the Ativan was inappropriately stored and not locked in the refrigerator door and confirmed it should have been double locked in the locked box. The DON confirmed the box had the key stored in the lock and stated it should have been locked at all times with the key having been kept with the charge nurse, and not left in the box. On 5/28/25 at 1:56 p.m., the consultant pharmacist (O)-D stated their expectation was Lorazepam Oral Concentrate USP should be stored double locked in an affixed structure/compartment within a refrigerator. On 5/28/25 at 3:54 p.m., the DON stated their expectation was Lorazepam Oral Concentrate should have been double locked and stored in affixed structure/compartment within the refrigerator. The DON stated the importance of storing narcotics properly to prevent misappropriation and have a process for safe medication storage in place. The facility Medication Policy dated 2024, indicated schedule II (two) drugs and back-up stock of schedule III (three), IV (four), and V(five) medications are stored under double-lock and key. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure dishwasher temperatures were within the manufactures minimum temperatures to ensure resident dishes were sanitized. In addition, the facility failed to ensure temperatures were monitored in 4 of 4 refrigerators and 2 of 2 freezers reviewed for the kitchen. This had the potential to affect all 35 residents who resided in the facility. Findings include: On 5/18/25 at 1:50 p.m., during the initial walk through of the kitchen the dishwashing machine was being used by a nursing assistant (NA)-A, the machine was labeled a [NAME] Temp star Dishwasher with temperature requirements as follows: wash temperature 150 degrees Fahrenheit (F), and rinse temperature of 180 degrees F. The actual temperatures observed were as follows: 1. 2:02 p.m., wash -165 degrees F, rinse -170 degrees F 2. 2:03 p.m., wash -164 degrees F, rinse -168 degrees F 3. 2:04 p.m., wash -165 degrees F, rinse -170 degrees F 4. 2:05 p.m., wash -154 degrees F, rinse -160 degrees F NA-A confirmed the temperatures for the rinse were not reaching the required 180 degrees F, and stated they were responsible for checking the machines temperatures were within range each mealtime or at least three times a day. NA-A confirmed they had conducted the temperature check when they arrived to work, and it had been working correctly. However, had not noticed the low temperatures until they were pointed out by surveyor. NA-A then notified their supervisor unprompted, and stated they would use paper material until the machine could be repaired. On 5/18/25 at 2:08 p.m. the certified dietary manager (CDM) arrived onsite and confirmed the dishwasher was not reaching the required temperatures and stated maintenance had been updated and confirmed they would be using paper products until the issue had been resolved, which was confirmed by observation at the next meal time. The [NAME] Warewashing Systems: Tempstar series installation, operation, and service manual last revised 11/30/15, indicated the facility's machine was a Tempstar S Steam Heated Model with the follow minimum temperature requirements: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Wash temperature (minimum): 150 degrees F 2. Rinse temperature (minimum): 180 degrees F On 5/21/25 at 1:12 p.m., the maintenance director (M)-A stated the machine had maintenance conducted on 4/30/25 and had been in working order since then. The refrigerator and freezer temperature logs were reviewed from March through May for the 2 freezers, and 4 refrigerators in the kitchen. The logs information showed the following: 1. Small Freezer: a. March: 15/62 opportunities were documented. b. April: 40/60 opportunities were documented. c. May: 21/44 opportunities were documented. 2. Big Freezer a. March: 14/62 opportunities were documented. b. April: 36/60 opportunities were documented. c. May: 20/44 opportunities were documented. 3. (continued on next page)

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 05/28/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refrigerator Number 2: a. March: 12/62 opportunities were documented. b. April: 38/60 opportunities were documented. c. May: 23/44 opportunities were documented. 4. Refrigerator Number 3: a. March: 13/62 opportunities were documented. b. April: 41/60 opportunities were documented. c. May: 21/44 opportunities were documented. 5. Refrigerator Number 4: a. March: a March log was requested for refrigerator number 4; however, none was provided. b. April: 41/60 opportunities were documented. c. May: 21/44 opportunities were documented. 6. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refrigerator Number 5: a. March: 13/62 opportunities were documented. b. April: 42/60 opportunities were documented. c. May: 23/44 opportunities were documented. On 5/22/25 at 10:03 a.m., the CDM stated their expectation was for the dishwasher wash cycle to meet 150 degrees F and the rinse cycle to meet 180 degrees F, and it was important to ensure the dishwasher was functioning properly, so all of the items were sanitized properly. Furthermore, the CDM confirmed the four refrigerator logs, and two freezer logs were missing information. The CDM stated the cooks were typically responsible for completing them, and they were expected to be done in the morning and the evening, and it was important to store food appropriately and keep the food safe. On 5/22/25 at 10:05 a.m., the administrator stated they expected the dishwasher to be meeting manufacturers temperature requirements, and it was important to ensure the safety of the residents and proper sanitation of the dishes. Furthermore, they expected the refrigerator and freezer temperature logs to be completed daily, and it was important to ensure the safety of the food they are giving the residents. The facility Dishwashing Machine Use policy revised march of 2010, indicated dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: 150 degrees F and dishwashing machines that use hot water sanitation rinse may not be more than 194 degrees F or less than 180 degrees F. The facility Refrigerators and Freezers policy last revised 2014, indicated food service supervisors or designated employee will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program effectively sustained ongoing compliance related to repeat citations from past surveys regarding immunizations. This had the potential to affect all 35 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 4/16/25, indicated the facility was cited F883 for influenza and pneumococcal immunizations on the survey exited 3/28/24. See F883: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R10, R27, R31) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). The facility's Quality Assessment and Assurance (QAA) committee meeting minutes from April 2024 through May 2025 lacked ongoing data related to the above repeat citation. On 5/28/25 at 5:31 p.m., the administrator acknowledged the importance of continued monitoring of prior Performance Improvement Projects (PIPS). The facility's Quality Assurance and Performance Improvement policy, dated 2024, indicated the facility monitors the effectiveness of its performance improvement activities to ensure improvements are achieved and sustained.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 3 of 5 residents (R10, R27, R31) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 10/24, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R10's significant change Minimum Data Set (MDS), dated [DATE], indicated R10 was [AGE] years old and diagnoses included dementia, diabetes, rheumatoid arthritis, epilepsy. R10's immunization report, dated 5/21/25, indicated R10 received PPSV23 on 3/22/10, and PCV13 on 3/2/16. R10's immunization consent form indicated R10's guardian signed consent to receive the pneumococcal vaccine on 4/25/24. However, R10's record lacked evidence R10 received PCV20 or PCV21. R27's significant change MDS, dated [DATE], indicated R27 was [AGE] years old and diagnoses included Alzheimer's disease, anxiety disorder, and peripheral vascular disease (PVD). R27's immunization report, dated 5/21/25, indicated R27 received PCV15 on 8/12/22. R27's immunization consent form indicated R27's guardian signed consent to receive pneumococcal vaccine on 4/24/24. However, R27's record lacked evidence R27 received PPSV23, PCV20 or PCV21. R31's significant change MDS, dated [DATE], indicated R31 was [AGE] years old and diagnoses included adult failure to thrive, depression, and osteoporosis. R31's immunization report, dated 5/21/25, indicated R31 had not received any pneumococcal vaccinations. However, R31's record lacked evidence R31 was offered or received PCV15, PCV20, or PCV21. On 5/28/25 at 3:54 p.m., director of nursing (DON) verified the facility failed to administer R10 and R27 requested/consented pneumococcal vaccinations. Additionally, DON verified R31 had not been offered the pneumococcal vaccine. The DON stated it was important to keep resident immunizations up to date to prevent the spread of infection. The facility's Pneumococcal Vaccine policy, reviewed 5/2024, indicated the facility offered residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and document review, the facility failed to ensure 1 of 5 residents (R26) reviewed for immunizations were offered and/or provided the COVID-19 vaccine to help reduce the risk of associated infection(s). Findings include: R26's annual Minimum Data Set (MDS), indicated R26 diagnoses included mild cognitive impairment, transient ischemic attack (TIA) and cerebral infarction (stroke), and aortic valve stenosis. R26's immunization report, dated 5/21/25, indicated R26 had not received any COVID-19 vaccinations. R26's immunization consent form indicated R26 was offered and signed consent to receive the COVID-19 vaccine on 4/26/24. However, R26's record lacked evidence the facility provided the requested COVID-19 vaccine. On 5/28/25 at 3:54 p.m., director of nursing (DON) verified R26's clinical record lacked evidence the facility provided the COVID-19 vaccine to R26. DON stated the COVID-19 vaccine was important to prevent the spread of infection and staff were expected to review and offer immunizations upon admission and quarterly at care conferences. The facility's COVID-19 Vaccination Policy and Procedure, revised 5/2024, indicated it is the policy of the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering COVID-19 vaccination to our residents and staff members.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on document review, interview, and observation the facility failed to ensure shared resident refrigerator 1 of 1 was kept in sanitary conditions and 2 of 2 (shared resident refrigerator and medication refrigerator) reviewed for temperature control were monitored. Findings include: On 5/19/25 at 11:03 a.m. a shared resident refrigerator was observed to contain multiple open, and undated bottles, and a container of milk. Two bottles of pepsi, a bottle of flavored water, and a container of chocolate milk. All opened and undated in the refrigerator. In the freezer, there was a large box of orange popsicles with had melted. There was a large amount of sticky orange substance on the floor of the freezer which encompassed a Tupperware container containing an unknown item. The container was affixed to the floor of the refrigerator by the orange substance. The certified dietary manager (CDM) confirmed the residents used this refrigerator and freezer. Both were unsanitary and unappealing. The CDM was unsure of the last time the refrigerator had been cleaned. The temperature logs of the shared refrigerator were reviewed and the CDM confirmed the temperature log for May of 2025 was missing significant amounts of information, and they were unsure who was responsible for checking and maintaining the temperatures. The temperature log for the shared resident refrigerator dated May 2025, indicated there was no temperature information noted for 9/20 days listed. The monthly deep cleans log dated January 2025, indicated the shared resident refrigerator cleaning schedule, there was no date listed to indicate the last time the refrigerator was cleaned. On 5/20/25 at 1:17 p.m., the administrator provided the above listed temp logs and cleaning schedule, and confirmed they had no evidence of the last time the refrigerator was cleaned. On 5/20/25 at 10:00 a.m., the medication refrigerator in the medication room had five small see-through containers on a shelf, each held insulin pens. The insulin pens were inside of a plastic bag, and then placed in the see through container, each of the 5 containers and bags had water inside the bags and within the containers. The freezer compartment of the refrigerator was covered in a hard block of white ice and was leaking down into the insulin bags and containers. Additionally, the temp log on the refrigerator was reviewed, and was found to be missing significant amounts of information. The Medication/Insulin temperature logs were reviewed for March, April and May of 2025, and the following information was noted: March 2025-26/62 shifts had no temperature noted. April 2025-16/60 shifts had no temperature noted. May 2025-44/62 shifts had no temperature noted. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25 at 10:00 a.m., Licensed practical nurse (LPN)-B confirmed there was water within the bags, and containers and confirmed no water should be in them. LPN-B stated the nurse on duty was responsible for reviewing the temperature logs, and they are expected to complete the logs daily. On 5/20/25 at 10:14 a.m., the Director of nursing (DON) confirmed there should be no water within the bags or containers which store medications, and the refrigerator needed to be defrosted. On 5/28/25 at 1:36 p.m , the consultant Pharmacist stated their expectation was insulin should be stored and temperature controlled between 36 degrees Fahrenheit(F) to 46 degrees F, and the condition listed above was unsanitary and there should be no water within their storage compartments for medications, and temperatures logs should be completed per facility policy. The pharmacist stated it was important to store medications in appropriate conditions and temperatures to ensure effectiveness, and to ensure the product does not breakdown. On 5/28/25 at 3:54 p.m., the DON their expectation was for insulin pens to be stored in sanitary conditions, and temperature logs were to be completed every 24 hours. The DON stated the importance of storing medications in sanitary conditions and completing temperature logs to have safe storage process in place and prevent spoiling of contents of the refrigerator. On 5/22/25 at 10:05 a.m., the administrator stated housekeeping was responsible for weekly cleaning and temperature tracking of the shared resident refrigerator, and confirmed it had not been cleaned since January 2025. It was important to keep the refrigerator clean and the temperature logs maintained to safely store the resident's food. The facility policy Refrigerators and Freezers last revised 2014, indicated food service supervisors or designated employee will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. The facility policy Medication storage dated 2024, indicated temperatures are maintained within 36-46 degrees F. Charts are kept ton each refrigerator and temperature levels are recorded daily by the charge nurse or other designee.