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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the infection prevention and control program included ongoing surveillance, analysis, and trending of resident and staff infections. Additionally, the facility failed to maintain knowledge of a current list of reportable communicable diseases, including when and to whom communicable diseases, healthcare-associated infections, and potential outbreaks must be reported. This had the potential to affect all 34 residents who resided in the facility. In addition, the facility failed to ensure adherence to enhanced barrier precautions (EBP) when nursing staff failed to wear personal protective equipment (gowns) when providing direct care to 2 of 2 residents (R4, R22) reviewed for pressure wounds. Findings include: INFECTION CONTROL PROGRAM/ COMMUNICABLE DISEASE LIST Review of the Infection Surveillance Report dated 1/1/26–3/31/26 revealed documentation that included resident name, room number, infection onset date, signs and symptoms, status, and pharmacy orders. However, the report contained missing data related to signs and symptoms and lacked evidence of analysis of infections and illnesses, including identification of patterns or trends, implemented interventions, and required precautions. The facility was unable to provide documentation demonstrating analysis, trending, or evaluation of infection data. Review of the Employee Line List printed 4/22/26 included employee name, department, title, date, and symptoms. The documentation lacked evidence of analysis of infections or illnesses, including patterns or trends, interventions implemented, and precautions required. The facility did not provide evidence of trending or analysis of staff infection data. On 4/21/26 at 11:21 a.m., registered nurse (RN)-A, identified as the Infection Preventionist and employed at the facility for approximately one month, stated infections were tracked within the electronic medical record (EMR). RN-A reviewed EMR data for February and March 2026 and confirmed the data did not include comprehensive information such as signs and symptoms and primarily included infections associated with medication orders. RN-A confirmed gaps existed in the infection surveillance process and that some data was missing from tracking logs. RN-A further stated that monthly analysis of infections and illnesses is important to identify trends or patterns and to initiate interventions such as staff education and process improvements. RN-A also confirmed lack of awareness of a current list of reportable communicable diseases and was unable to describe the reporting protocol, including communication with local or state public health officials or identification of reportable outbreaks. On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A stated they were not aware (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of employee illness tracking processes. Both indicated that tracking employee illness would be important to identify symptoms and determine necessary precautions within the facility. The DON acknowledged the facility is expected to follow regulatory requirements related to infection surveillance. RN-A stated it is important for the infection preventionist to track employee illnesses to identify potential correlations with resident infections. On 4/22/26 at 12:32 p.m., the administrator stated the facility maintained a document tracking employee illnesses; however, the information had not been shared with RN-A and confirmed the data was not utilized for trending or analysis of staff infections. The facility Infection Prevention and Control Program Policy dated 3/5/25, indicated : Surveillance: A system of surveillance is utilized for prevention identifying reporting investigating and controlling infections and communicable diseases for all resident, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a civility assessment and accepted national standards. The infection preventionist serves as a leader in surveillance activities, maintains documentation of incidents, findings, and any other corrective actions made by the facility and report surveillance findings to the facilities quality assessment and assurance committee. The RNS and LPNS participate in surveillance through assessment of residents and reporting changes and conditions to the residents physicians and management staff per protocol for notification of changes and in-house reporting of communicable diseases and infections. EBP R4's face sheet provided on 4/22/26, included paraplegia (paralysis causing impairment of motor sensory function of lower extremities), pressure ulcers to right and left buttock and neuromuscular dysfunction of bladder (loss of bladder control due to disease or injury). R4's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. Pressure ulcer to sacral region. Indwelling supra-pubic catheter (tube inserted into bladder through abdominal incision to drain urine). Independent with most activities of daily living. Mobility per motorized wheelchair. R4's provider orders included: 10/31/21: foley catheter 4/22/26: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day. No orders for enhanced barrier precautions (EBP). R4's care plan with revised date of 4/7/26, indicated R4 had a pressure injury stage 4 to coccyx, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that R4's pressure injuries would show signs of healing and remain free from infection by/through review date. Care plan dated 4/21/23, indicated R4 had an indwelling suprapubic catheter with history of chronic infections and had a history of ESBL (a bacteria) resistance in urine. The care plan did not indicate R4 had been in EBP. During an interview on 4/22/26 at 10:36 a.m., observed an EBP sign on R4's door. No cart outside the door containing personal protective equipment (PPE) including gowns. R4 had been lying in bed. When asked for permission to observe his dressing change, R4 stated he wanted to wait. Without asking, R4 stated, Staff don't wear gowns when they empty my catheter or change my dressing – they never do. Observed two large, plastic, three-drawer organizers in R4's room and did not see any gowns. One tall, plastic doffing receptable was observed on top of one of the three-drawer organizers in the corner and hard to reach. Inside the receptable was one non-disposable blue gown. During an interview and observation on 4/23/26 at 8:50 a.m., when asked to observe his dressing change, R4 stated, You won't see anything. When asked what he meant, stated staff will do what they are supposed to do – they will wear gowns. Again, looked around the room and did not see any PPE gowns. The receptible to doff reusable gowns still had only one blue gown in it for the past two days despite staff emptying urinary catheter bag each shift. In addition, the doffing receptable was still on top of the three-drawer supply bin and hard to reach, potentially indicating lack of use. During an interview and observation on 4/23/26 at 9:17 a.m., nursing assistant (NA)-B stated she was aware R4 was in EBP and stated she needed to wear PPE when she emptied R4's urine bag. NA-B could not recall the last time she emptied his bag. When asked where R4's PPE gowns were, NA-B stated they were in his room. Together went into R4's room. NA-B looked around and stated there were none. NA-B stated he was supposed to have a cart outside his room with gowns in it. When asked where staff put gowns when they take them off, NA-B pointed to the receptable on top of the three-drawer organizer and said that shouldn't be there. The receptable was removed and shown to NA-B who confirmed the cloth inside was one, blue reusable PPE gown. NA-B acknowledged there should have been more gowns in the receptable because staff emptied R4's urine bag every shift and changed his dressing every day. During an interview and observation on 4/23/26 at 9:44 a.m., together in R4's room, licensed practical nurse (LPN)-C was asked to locate the PPE gowns used for emptying R4's catheter and changing his dressing. LPN-C looked around the room and stated there were none, adding gowns and gloves should have been available outside R4's door. During an interview and observation on 4/23/26 at 10:02 a.m., together with RN-A who was also the infection preventionist, entered R4's room. RN-A verified R4 had been on EBP and verified a PPE cart had not been located outside of R4's door. RN-A stated residents in EBP should have a PPE cart outside their door and did not know what had happened to R4's. RN-A was asked to locate PPE gowns in the room and stated there were none. RN-A was asked if the doffing receptable was in an appropriate location and stated it was not. R4 who was lying in bed, informed RN-A staff never wore gowns to empty his urine or change his dressing. RN-A admitted to not noticing the lack of a PPE cart outside or R4's room and to not monitoring staff for adherence to EBP guidelines. During an observation on 4/23/2026 at 10:28 a.m., upon exiting R4's room, observed a PPE cart outside of R4's room and a doffing receptable just inside R4's room. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters. R22's face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness, mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated [DATE], indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds. R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's physician's order dated 3/20/26, indicated cleanse coccyx wound. Cover with foam dressing. Replace every other day. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date. Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During interview on 4/20/26 at 3:09 p.m., R22 stated she had a pressure ulcer on her coccyx. R22 stated she did not recall staff wearing gowns when changing her brief or providing wound care. During observation and interview on 4/21/26 at 11:10 a.m., LPN-A completed R22's wound order. LPN-A removed R22's brief, cleansed her wound, and applied foam dressing. LPN-A did not wear a gown while completing wound care. LPN-A stated she was unsure if she needed to wear a gown while completing wound care for R22, and stated she did not see an enhanced barrier precautions (EBP) sign on R22's door or an EBP supply cart outside her room. LPN-A stated she would normally expect to wear a gown while completing a dressing change on a pressure ulcer. During observation on 4/21/26 at 3:15 p.m., R22's door had a new sign indicating EBP should be worn in her room when providing cares and had an EBP cart with gowns placed outside her door. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he would expect EBP to be used for wounds that required a dressing to prevent spread of infection. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review the facility failed to implement and maintain an effective infection prevention and control program specific to antibiotic stewardship. The facility did not have a system to track antibiotic use, culture results, organisms identified, or antibiotic resistance to ensure residents received appropriate treatment, this had the ability to affect all 34 residents. Findings Include:Review of the Infection Prevention and Control (IPC) case list dated 1/1/26-3/31/26, , documentation included resident name, room number, onset date, signs and symptoms, current prescription, prescriber, infection type, organism, diagnosis, and category. However, the log lacked documentation of the date cultures were obtained, organisms identified from culture results, and whether organisms were resistant to prescribed antibiotics.On 4/21/26 at 11:21 a.m., registered nurse (RN)-A , identified as the infection prevention nurse, stated antibiotic use was not tracked. RN-A stated the facility completed a log to monitor possible infections and confirmed antibiotic tracking was identified as a gap to ensure residents were on the correct antibiotic. RN-A stated follow-up of cultures and ensuring residents were prescribed the correct antibiotic was a gap and there was no current process for antibiotic stewardship. RN-A stated providers were responsible for reviewing and tracking culture results to ensure appropriate antibiotics were prescribed. RN-A confirmed the facility did not track antibiotic indications for use, dosage, duration, culture results, or whether antibiotics were discontinued timely. RN-A further stated if a resident had a urinary tract infection and a urine culture was obtained, the provider was expected to track and communicate results to the facility, and the facility did not have a process to ensure culture results were received or addressed.On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A verified infection surveillance related to antibiotic use and resistance was not tracked on the IPC log and confirmed the facility did not have a formal antibiotic stewardship process as expected.Facility Antibiotic Stewardship Program Policy and Procedure dated 1/26, indicated It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.Director of Nursing - establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use.The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners:Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms.Monitoring antibiotic use:Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated, or adjustments should be made (e.g., antibiotic time-out).Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.Monitor each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review as requested by the QAA committee.Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure).Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy).At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data.Nursing will monitor the initiation of antibiotics on residents and conduct an (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents were free from involuntary seclusion when the facility maintained locked exit doors that prevented residents from freely exiting the building, without conducting individualized assessments, clinical justification, or care planning to support the restriction. This deficient practice had the potential to affect 8 of 34 residents (R4, R6, R11, R16, R20, R7, R29, R39) residing at the facility.Findings include: R4's annual Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, very important to go outside to get fresh air when the weather is good, no exhibited behaviors of wandering, utilized a motorized wheelchair independently. R4's care plan printed [DATE], indicated able to use powered wheelchair without any issue, able to wheel w/c (wheelchair) independently throughout and outside facility, independent for going in/out of facility backdoor to courtyard to smoke, not an elopement risk/wanderer, independent with transfers from bed/chair. R4's Elopement Risk Evaluation dated [DATE], indicated R4 was not at risk for elopement. R4's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R4's ability to leave the facility. R6's annual MDS assessment dated [DATE], indicated no cognitive impairment, no exhibited behaviors of wandering, very important to go outside to get fresh air when the weather is good, independent with walking. R6's care plan printed on [DATE], indicated R6 enjoys walking, allowed to walk outside on grounds with notifying nursing staff, not an elopement risk/wanderer, walk independently. supervision assistance in corridors: ambulates without device, steady gait. R6's Elopement Risk Evaluation dated [DATE], indicated R6 was not at risk for elopement. R6's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R11's quarterly MDS assessment dated [DATE], indicated intact cognition, no rejection of care, use of wheelchair, independent with transfers, independent with wheeling 150ft in wheelchair. R11's care plan revised [DATE], indicated resident is able to self-propel in wheelchair as well as walk with walker. R11's Elopement Risk Evaluation dated [DATE], indicated R11 was not at risk for elopement. R11's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R11's ability to leave the facility. R16's quarterly MDS assessment dated [DATE], no cognitive impairment, no exhibited behaviors of (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wandering, and utilized a motorized independently wheelchair. R16's care plan printed [DATE], indicated R16 was independent with mobility via use of his electric wheelchair, able to independently maneuver on and off the unit with his electric W/C, and not an elopement risk/wanderer. R16's Elopement Risk Evaluation dated [DATE], indicated R16 was not at risk for elopement. R16's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R20's quarterly MDS assessment dated [DATE], indicated severely impaired cognition, no exhibited behaviors of wandering, utilized a manual wheelchair independently. R20's care plan printed [DATE], indicated occasionally uses front wheeled walker independently for ambulation in his room, locomotion: able to wheel himself independently in manual wheelchair, 1 assist prn (as needed), uses a w/c when outside of his room, independent for transferring, and not an elopement risk/wanderer. R20's Elopement Risk Evaluation dated [DATE], indicated R20 was not at risk for elopement. R20's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R7's annual MDS assessment dated [DATE], indicated intact cognition, no behaviors, use of walker and wheelchair, independent with transfers and walking and propelling wheelchair. R7's care plan dated [DATE], indicated no risk for elopement, able to propel her own wheelchair to all location. R7's Elopement Risk Evaluation dated [DATE], indicated R7 was not at risk for elopement. R7's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R7's ability to leave the facility. R29's quarterly MDS assessment dated [DATE], indicated intact cognition, rejection of care one to three days, use of wheelchair, independent with transfers and propelling wheelchair. R29's care plan revised [DATE], indicated low risk for elopement, independent with transfers, okay to ambulate with four wheel walker (4WW) independently. R29's Elopement Risk Evaluation dated [DATE], indicated R29 was not at risk for elopement. R29's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R29's ability to leave the facility. R39's discharge return not anticipated Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors or wandering, no rejection of care, wheelchair use, independent with wheeling with manual wheelchair, independent with transfers. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's care plan printed [DATE], indicated indicated activities of daily living (ADL) self-care deficit related to paraplegia. The resident is able to: wheel self independently in manual wheelchair, low risk for elopement. R39's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R39's ability to leave the facility. On [DATE] at 8:30 a.m., the administrator stated the facility doors were locked from the outside and inside for safety and security, and that overrode resident rights. The administrator further stated it was her job to keep everyone safe, and no one was getting hurt or lost on her time. The administrator stated residents still had rights, staff could let them in and out and were always available. In addition, administrator stated residents were not told they were admitting to a locked building, and it was not in their admission packet that the building was locked from the inside. The administrator also stated there were some rules about when residents could go outside based on weather and time of day. The administrator stated residents at the facility were not committed by law to be in a locked facility, did not have a provider's order to be in a locked facility, and did not sign a consent to be in a locked facility. On [DATE] at 8:31 a.m., during further interview the administrator stated only staff had access to the codes to unlock the doors. The administrator confirmed residents, including those who were independent and without cognitive impairment, were unable to leave the building without requesting staff assistance. The administrator stated no individualized assessments, or waivers had been completed to support restricting residents' ability to leave without staff assistance. The administrator further confirmed residents had not been formally educated regarding the locked door system. On [DATE] at 12:49 p.m., activities aide (AA)-A stated all facility doors were locked and only staff possessed the code to open the doors, confirming residents could not independently leave through any door. On [DATE] at 12:52 p.m., R7 stated all doors were locked and only staff had access to the codes, and stated the doors were locked due to concerns about other residents. On [DATE] at 12:52 p.m., health unit coordinator (HUC)-H stated all facility doors were locked from the inside and outside at all times and only staff had access to the codes. HUC-H stated the front door was expected to unlock after applying continuous pressure to the push bar for 15 seconds. During observation, the front door, which was constructed of solid wood with a keypad mounted on the adjacent wall, was pushed continuously for 15 seconds and did not unlock or release. HUC-Confirmed the door should have unlocked after sustained pressure. On [DATE] at 12:55 p.m., during a tour of the facility with maintenance director (MD)-A, the following was observed: On the north side of the building in the dining room an exit sign hung above a metal door with a glass upper panel and a horizontal push bar across the center. A keypad was mounted on the wall next to the door. The push bar was pressed continuously for approximately 30 seconds; however, the door remained locked and did not unlock or open. On the south side of the building, the main entrance door located in the day room area was a solid wood door with a keypad installed next to it and an exit sign above. The door remained locked and did (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not open without entering a code. On the east side of the building, near the administrative offices, there was a full glass, wide door with a metal push bar across the middle and a keypad mounted to the side. There were no visible instructions indicating how long to press the bar to unlock the door. When the push bar was pressed continuously for approximately 15 seconds, the locking mechanism disengaged, and the door unlocked. On the west side of the building in the activity room, there was a metal door with a glass upper panel, a horizontal push bar, a keypad mounted next to the door, and an exit sign posted above. The push bar was pressed continuously for approximately 30 seconds; however, the door did not unlock or open. On [DATE] at 1:07 p.m., MD-A stated the doors were intended to unlock after 15 seconds of continuous pressure on the push bar. MD-A confirmed that, except for the east side door, the doors did not function as intended. MD-A further stated the facility previously had a locked dementia unit, which had been discontinued, and the door system had not been converted to allow unlocking after sustained pressure. MD-A stated the current configuration was consistent with a fully locked system rather than one designed to unlock after delay. On [DATE] at 1:11 p.m., during a telephone interview, the maintenance consultant confirmed the facility previously operated a locked unit requiring physician orders for placement and stated that when the unit was discontinued, the door system should have been changed to allow doors to unlock after sustained pressure. The consultant confirmed the current door function was not consistent with that expectation. On [DATE] at 9:33 a.m., R24 stated they walked without staff assistance and was independently able to perform self-cares, stated all doors were locked, required a code, and residents must ask permission to leave the building. R24 stated almost like jail. During an interview on [DATE] at 8:29 a.m., with the administrator and the regional clinical consultant (RCC)-D, the administrator who had been employed by the facility for two years, stated she didn't know how many years the doors had been locked from the inside, adding it had been that way since she started. The administrator stated she never looked at the doors as being locked, she looked at them as a security measure for residents to be safe from a variety of issues. Issues identified included the facility being located in a remote area, the steep bluff in front of the facility, farm fields around the facility, the opioid epidemic and potential drug seekers. Further, the administrator stated due to their isolation, they were a prime target for potential criminal activity. When that didn't fully explain the rationale for locking doors from the inside, the administrator stated staff were always available to let residents and visitors in and out of the facility, and that family members appreciated the safety the facility provided. The administrator stated they had never considered giving a passcode to residents who were independent and able to come and go freely for fear the code would be shared with others and/or a confused resident would follow a resident or visitor out the door. During the same interview, RCC-D stated the facility was small and staff were always available to let people out. RCC-D stated she did not believe the facility was treating residents as if they were in a secure unit and believed the intent of the regulation pertained to a unit, not a facility. RCC-D stated, This isn't a specialty unit; we see it as a skilled facility where we are keeping residents safe, adding, We are not limiting the ability of residents to get out, we are ensuring we are providing adequate supervision. (continued on next page)

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	245273	A. Building B. Wing	04/23/2026

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The administrator stated, We need to know who is outside, we worry about the cornfields as much as the ravines. With regard to concerns expressed by R39 about being not being able to freely leave the facility when desired, the administrator stated R39 had been in a wheelchair and had not been able-bodied to leave the facility. The administrator stated the facility did not utilize a wander or elopement management system. On [DATE] at 8:41 a.m., during a telephone interview, the medical director stated they were not aware the facility doors were locked in a manner that prevented residents from independently leaving the building. The medical director stated they would expect to be informed if residents did not have the ability to leave the building freely. The medical director stated an individualized assessment should be completed for each resident, including evaluation of elopement risk, cognitive status, physical ability, and decision-making capacity, to determine whether the resident could safely leave the building independently or required supervision. The medical director stated if a resident did not demonstrate an elopement risk and had the ability to safely leave, the expectation would be that the resident could do so without restriction. The medical director further stated that if the facility restricted a resident's ability to leave, there should be clear documentation supporting the rationale, including clinical assessment findings, care planning interventions, and, when appropriate, physician involvement or orders. The medical director stated the determination of safety versus resident rights must be individualized, and one generalized safety concern could not be applied to all residents. The medical director emphasized that without individualized assessment and supporting documentation, restricting all residents from leaving the building would not be appropriate. Facility policy on resident seclusion was requested. In an email dated [DATE] at 2:37 p.m., RCC-D indicated the facility did not have a policy on seclusion. Facility Resident Rights policy, dated 2025, indicated residents had the right to be treated with respect and dignity, including: the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Residents had a right to a safe, clean, comfortable and homelike environment. Facility Accident and Supervision policy dated 2/2023, indicated the facility would establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Process included: 1) Identification of Hazards and Risks - the process through which the facility became aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. 2) Evaluation and Analysis - the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. 3) Supervision was an intervention and a means of mitigating accident risk. The facility would provide adequate supervision to prevent accidents. Adequacy of supervision was defined by type and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment. Facility Elopement and Wandering Residents policy dated 2024, indicated the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements. Alarms were not a replacement for (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. The facility would 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. Facility Outdoor Safety policy dated [DATE], indicated it was the policy of the facility to provide a safe and healthy environment for residents. All residents were allowed and encouraged to enjoy outdoor activities if mentally and physically able to participate and weather conditions deemed safe. Residents were only allowed to participate in outside activities under specific conditions including the resident had been assessed to determine whether they were physically and cognitively safe to be out without supervision or whether they required supervision. If supervision was required, residents were to remain on the patio just outside the main entrance door or the enclosed area outside the activities office. If assessments indicated a resident was safe for outdoor activity independently, they must remain on sidewalks, patio, or enclosed area outside the activities office.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were coded accurately on the Minimum Data Set (MDS) assessments for 2 of 5 residents (R11 and R29) reviewed for unnecessary medications.Findings include:R11's face sheet printed 4/22/26, indicated diagnoses of type two diabetes with complications, alcohol abuse, and weakness.R11's quarterly MDS dated [DATE], indicated intact cognition, no rejection of care, use of wheelchair, independent with dressing and hygiene, and section N identified R11 took an anticoagulant.R11's physician's orders printed 4/22/26, did not include an anticoagulant but did include and order for aspirin oral capsule 81mg by mouth one time a day.R11's care plan revised 4/16/26, did not include mention of an anticoagulant medication.R29's face sheet printed 4/22/26, indicated diagnoses of chronic respiratory failure, repeated falls, and systolic heart failure.R29's quarterly MDS dated [DATE], indicated intact cognition, rejection of care one to three days, use of wheelchair, partial assistance with hygiene, substantial assistance with lower body dressing, and section N identified R29 took an anticoagulant.R29's physician's orders printed 4/22/26, included an order for aspirin oral tablet delayed release 81mg by mouth one time a day, but did not include an order for an anticoagulant medication.R29's care plan revised 4/7/26, did not include mention of an anticoagulant medication.During interview on 4/21/26 at 9:29 a.m., registered nurse (RN)-A stated she thought the aspiri taken by both R11 and R29 could be counted as an anticoagulant medication on the MDS assessment. RN-A stated she would clarify with the person who trained her. After clarification, RN-A stated aspirin should be coded as an antiplatelet medication, not an anticoagulant medication. RN-A further stated the MDS was coded incorrectly and she would submit corrections.During interview on 4/22/25 at 2:08 p.m., interim director of nursing stated he would expect the MDS to be coded correctly based on the resident assessment instrument (RAI) directions to ensure accurate representation of resident needs.Facility Conducting an Accurate Resident Assessment policy dated 1/2026, stated accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status using the appropriate RAI instructions.

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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 observation, interview and document review, the facility failed to report elevated blood glucose levels per provider order for 1 of 1 residents (R5) reviewed for insulin. In addition, the facility failed to calibrate blood glucose monitors according to manufacturer instructions for 1 of 1 residents (R5) reviewed for insulin. Further, the facility failed to ensure monitoring of skin wounds for 1 of 1 resident (R22) reviewed for non-pressure skin conditions. Findings include: ELEVATED BLOOD GLUCOSE AND CALIBRATION OF MONITOR R5's face sheet received on 4/22/26, included diagnoses of diabetes with hyperglycemia (elevated blood sugar). R5's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R5 was independent with most activities of daily living, did not walk and could propel wheelchair independently. R5's provider order dated 7/31/25, indicated blood sugar checks two times a day. Order dated 6/21/21, indicated staff were to notify provider if BS (blood sugar) was <70 or >400. R5's care plan dated 8/16/21, indicated R5 had diabetes and his blood sugars would remain within normal limits through next review. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of R5's electronic medical record (EMR) indicated in March and April 2026, two of R5's fingerstick blood sugars had been in excess of 400 mg (milligram)/dl (deciliter) without documentation that a provider had been notified. On 3/31/26 at 9:00 a.m., blood sugar had been 536 mg/dl On 4/3/26 at 4:40 p.m., blood sugar had been 421 mg/dl A provider note dated 3/17/26, (prior to documentation of the elevated blood sugars) indicated R5 had presented for evaluation of type 2 diabetes. Recent A1c (blood test that measures average blood sugar levels over the past two or three months) was 8.8% (normal = 5.7%). Minor adjustments to diabetes medications had been made and R5 would continue to be monitored closely. During an interview on 4/23/26 at 10:30 a.m., regional clinical consultant (RCC)-D looked in R5's EMR and verified the two blood sugars greater than 400 mg/dl. RCC-D also verified there had not been an order for a sliding scale (where insulin dosages were adjusted based on blood sugar levels), nor had there been documentation nursing staff notified a provider of the blood sugars greater than 400 mg/dl. RCC-D stated she would have expected nursing staff to follow provider orders, inform the provider of the elevated blood sugars and potentially receive new orders. Further, RCC-D was informed nursing staff did not know if glucometers were being calibrated per manufacturer instructions, something that would be considered with abnormally high blood sugars checks. RCC-D stated she would expect glucometers to be calibrated and would check on it. At 10:41 a.m., RCC-D stated she could not see evidence glucometers where being calibrated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/26 at 10:45 a.m., trained medication aide (TMA)-A stated she did not know anything about glucometer calibration. During an interview on 4/23/26 at 12:10 a.m., licensed practical nurse (LPN)-B who had earlier stated she did not think glucometers were calibrated, obtained R5's glucometer from the medication cart and the brand was Arkray Assure Platinum. Together with LPN-B, looked in medication room for evidence glucometers had been calibrated. LPN-B found unopened boxes of control solutions with expiration dates of 2027, but no binder or other documentation that indicated calibration was being done. During a telephone interview on 4/23/26 at 3:13 p.m., licensed practical nurse (LPN)-A recalled R5's blood sugar greater than 500 mg/dl at the end of March. LPN-A admitted she did not call the provider to notify him, but may have sent the provider an electronic message, however, could not say for certain. LPN-A acknowledged the importance of following provider orders and notifying a provider with a significantly elevated blood sugar to allow the provider to make medication adjustments if necessary. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F did not recall being informed of R5's elevated blood sugars greater than 400 mg/dl in March and April. APRN-F stated the reason it was good to be notified for anything over 400 mg/dl was so action could be taken, such as a one-time dose of insulin. Informed there had been an order to inform the provider of blood sugars great than 400 mg/dl – he was not aware of that and stated he would expect nursing staff to follow provider orders and/or facility policy. Facility Blood Glucose Monitoring policy dated 2023, indicated the facility would perform blood glucose monitoring as per physician's orders and report critical test results to the physician timely. Calibration checks on glucometers must be performed _____ (this space was left blank) as per manufacturer's instructions. Manufacturer Instructions: The Quality Assurance/Quality Control Reference Manual with revised date of 10/24, found on website (Assure Platinum Blood Glucose Meter - ARKRAY USA, Inc.) for the Arkray Assure Platinum glucometer, indicated, the user should check meter and test strips using Assure Dose Control Solutions (Normal-Level 1 and High-Level 2) to confirm the meter and test strips are working properly, or to check if testing correctly. Assure Dose Control Solutions contain known amounts of glucose and are used to check that the meter and the test strips are working properly. The test strip bottles have Assure Dose Control Solution ranges printed on the labels. Compare the result displayed on the meter to the Assure Dose Control Solution range printed on the test strip bottle. Before using a new meter or a new bottle of test strips, conduct a control solution test following the procedure with two different levels of control solutions (Normal-Level 1 and High-Level 2). USE CONTROL SOLUTION To test technique. Before testing with the meter for the first time. When opening a new bottle of test strips. When suspecting the meter or test strips may not be functioning properly. If the test results appear to be abnormally high or low or are not consistent with clinical symptoms. When the meter has been dropped or stored below 32ºF (0ºC) or above 122ºF (50ºC). The test strip bottle has been left open or has been exposed to light, temperatures below 39 degrees F (4 degrees C) or above 86 degrees F (30 degrees C), or humidity levels above 80%. Each time the batteries are changed. NON-PRESSURE SKIN CONDITION (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness, mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated [DATE], indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds. R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date. Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During observation and interview on 4/20/26 at 3:11 p.m., R22 was awake in her bed. R22 had four small scabs (0.1cm to 0.4cm) and 3 scabs (0.3cm to 0.6cm) on her left arm. R22 had one larger scab (0.7cm) on her right arm that she was actively picking open. R22 stated nurses did not check on her scabs, put medication on them, or ask her what they were from. R22 stated she always had scabs. R22's weekly bath audits dated 4/5/26 and 4/12/26, indicated no skin alterations or open areas, other than wound to coccyx. During interview on 4/22/26 at 11:59 a.m., TMA-B stated she was aware of R22's skin-picking and her multiple scabs. TMA-B stated she thought they used to monitor the scabs and document it on the treatment record, but they no longer did that. TMA-B stated they used to use a cream on her scabs but she didn't see that ordered anymore either. TMA-B stated those areas would normally be documented and monitored on weekly bath audits but she did not see them documented for R22. During interview on 4/22/26 at 12:07 p.m., LPN-C stated R22 had a bath on 4/19/26, and she didn't see that R22's scabs were documented or assessed at that time. LPN-C stated she did not see any monitoring or treatment for R22's scabs on her physician's orders. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he was aware of R22's skin-picking diagnosis but was not sure if they were monitoring or treating her scabs. DON stated he didn't think they were doing anything for the scabs. DON stated if R22 had wounds from skin-picking he would expect them to be monitored for signs of infection and worsening to prevent future injury or illness for R22. Facility Skin Assessment policy printed 4/22/26, indicated a full body skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three, and weekly thereafter. Documentation of skin assessment: document observation, types of wounds, other information as indicated.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow provider orders for wound care dressing changes for 1 of 1 resident (R4) reviewed for pressure injury.Findings include:R4's face sheet provided on 4/22/26, included diagnoses of paraplegia (paralysis causing impairment of motor sensory function of lower extremities) and pressure ulcers to right and left buttock.R4's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. No behaviors. Pressure ulcer to sacral region. Independent with most activities of daily living. Mobility per motorized wheelchair.R4's provider orders dated 4/22/26, indicated: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day, start 4/22/26.R4's care plan dated 11/23/21, indicated R4 had a pressure injury stage 4 to coccyx, and that R4's pressure injuries would show signs of healing and remain free from infection by/through review date of 6/17/26. R4 requested his bed as flat as possible to reduce shear and preferred to be repositioned independently. Care plan with revised date of 4/21/23, indicated staff to administer treatments as ordered and monitor for effectiveness. Provide treatment at times requested by resident. R4 preferred to sleep in every day.R4 was seen by wound care provider on 4/21/26, with subsequent note documented at 3:38 p.m.:Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4, full thickness skin and tissue loss. Wound was present on admission. No signs and symptoms of infection.Measurements: Length 10.18 cm (centimeters). Width 9.6 cm. Depth 0 cm. Area (cm2): 72.33 cm.Exudate amount: Moderate. Seropurulent: mixture of purulent and serous. Nursing progress note dated 4/22/26 at 12:52 p.m., indicated new wound care orders received on 4/21/26: Discontinue previous wound care orders, cleanse coccyx wound BID (twice a day) with wound cleanser, place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed, place barrier cream around peri wound, cover with ABD and tape down.During an interview on 4/23/26 at 9:10 a.m., LPN-C was shown R4's treatment administration record (TAR) for the day prior, 4/22/26, which indicated R4's dressing which had been ordered to be changed twice a day had not been changed at all. One space on the TAR was blank and the other indicated the number seven, which LPN-C stated meant R4 had been sleeping. In addition, the TAR indicated a daily dressing change to the coccyx had not been done on 4/15/26. LPN-C verified the dates where a dressing change had not been documented as being done and could not speculate as to why they had not been done. During an interview and observation on 4/23/26 at 9:44 a.m., in R4's room, LPN-C stated generally R4 prioritized his wound care and she was not aware of him refusing dressing changes. LPN-C stated she generally talked to R4 at the start of her shift and the two agreed upon a time to do the dressing change. While LPN-C was preparing supplies for the dressing change, R4 stated his dressing had not been changed since the provider changed it on 4/21/26. R4 stated he didn't know why the nurse on duty had not changed it the evening prior. R4 stated he rarely refused care and did not mind if staff woke him to change his dressing. R4's sacral wound was significant and covered nearly the entirety of both buttocks and was approximately the size of a woman's hand. Minimal exudate observed, flesh and pink in color. No odor. LPN-C changed the dressing according to the orders. During an interview on 4/23/26 at 1:02 p.m., regional clinical consultant (RCC)-D was informed a twice a day dressing changes had not been done at all on 4/22/26. RCC-D stated she would have expected staff to have completed dressing changes on 4/22/26, as ordered by the provider, and especially since the provider changed the wound care orders on 4/21/26, potentially indicating previous orders were not effective. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F was informed after his visit to R4 on 4/21/26, and changing the R4's dressing change orders, R4's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing had not been changed until today, 4/23/26. APRN-F stated he expected staff to perform R4's dressing changes as ordered. APRN-F stated he changed the order because R4 had been having problems with his skin from the Mepilex (a dressing with absorbent foam and an adhesive border) so he changed the order to cloth tape. In addition, APRN-F stated he added calcium alginate to the dressing change orders to absorb more of the drainage, adding R4's wound had seemed to plateau in healing, and therefore, Important to stay on top of it.Facility Wound Treatment Management policy dated 2023, indicated to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence -based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatments would be documented on the treatment administration record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 consulting pharmacist recommendations were addressed or acted upon for 2 of 5 residents (R8, R28) reviewed for unnecessary medications.Findings include:R28's face sheet received on 4/23/26, included diagnoses of wedge compression fracture of lumbar vertebrae, hypertension, dependence on renal dialysis, hyperlipidemia (high levels of fat in the blood), depression, diabetes, congestive heart failure (heart not able to pump enough blood) and anemia. R28's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated her brief interview for mental status (BIMS) was 99, indicating the cognitive interview was not able to be completed. R28 had clear speech, could understand and be understood. Behaviors included rejection of care and verbal behaviors directed towards others. R28 was dependent upon staff for activities of daily living (ADLs) and didn't walk. R28's orders included 28 medications. R28's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following nine months: 6/13/25, 8/11/25, 10/13/25, 11/10/25, 12/5/25, plus waiting for response to previous recommendation, 1/10/26, 2/6/26, 3/9/26, plus waiting for response to previous recommendation, and 4/21/26. Requested copies of pharmacy recommendation with provider responses for each of the months. Of the nine months, only one recommendation with a provider response was provided for 10/13/25. R8's face sheet provided on 4/23/26, included diagnoses of Alzheimer's disease and dementia.R8's annual MDS assessment dated [DATE], indicated serve cognitive impairment, unclear speech, rarely/never understood and rarely/never understands. R8 was dependent upon staff for ADLs and did not walk. R8 was receiving hospice care.R8's orders included eight medications. R8's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following four months: 6/13/25, 9/11/25, 12/5/25, and 3/9/26. Requested copies of pharmacy recommendation with provider responses for each of the months and none were received. During an interview on 4/22/26 at 12:20 p.m., the regional clinical consultant (RCC)-D stated she did not believe they would find any more recommendations with provider responses than what had already been provided. The process was the responsibility of the interim director of nursing (DON). During a telephone interview on 4/22/26 at 12:30 p.m., the consultant pharmacist (CP)-E stated getting pharmacy recommendations with a provider response back from the facility was an ongoing issue. CP-E stated she had brought it up at QAPI (quality assurance and performance improvement) meetings and the medical director was aware. CP-E stated there had been a significant number of staff changes which likely contributed to the lack of sustained improvement. CP-E stated the interim DON informed her he would develop a process and create a binder, but CP-E had not seen that happen. During an interview on 4/23/26 at 11:36 p.m., the interim DON stated pharmacy sent the recommendations to him and he put them in the provider folder at the desk for providers to review and sign. He believed the providers gave the recommendations to the nurses when complete and, The nurses took care of them. After that, the interim DON stated the forms were scanned into the electronic medical record (EMR). The interim DON admitted he did not follow through to ensure the recommendations were address by providers, implemented, and the completed forms scanned into the EMR. Regarding R28's recommendations with provider responses, the interim DON stated he had looked for those and couldn't find them. During a telephone interview on 4/23/26 at 11:38 a.m., the medical director (MD)-C stated pharmacy recommendation reports had been talked about at QAPI and in May 2025, the facility had created a new process to ensure compliance but it had not been sustained as a result of transitions in nursing leadership. Facility Medication Regime Policy dated (continued on next page)

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	04/23/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2024, indicated the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. The pharmacist communicated any irregularities to the facility in the following ways: 1) Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. 2) Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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	04/23/2026

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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 0727 Level of Harm - Potential for minimal 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. Based on interview and document review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day for 5 of 7 days reviewed. This had the potential to affect all 34 residents living in the facility.Findings include:Review of nursing schedule in the last 30 days identified no registered nurse (RN) had been scheduled on 3/15/26, 3/16/26, and 4/5/26.On 4/22/26 at 11:54 a.m., the administrator stated the facility had obtained a waiver for RN coverage and the facility was currently working on filling the RN positions and actively recruiting RN staff and offering incentives. During the interview the administrator stated the facility was using agency nursing staff to fill the RN coverage, was actively hiring RN's, was aware not all days had a scheduled RN, and confirmed the facility had a waiver. The administrator stated finding RN's in a rural area was difficult and the facility was competing with other facilities such as homecare, hospice, and hospitals.