

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2015
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NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 24, 25, 26, 27, 28, 31, and September 1, 2015.</p> <p>Facility number: 000087 Provider number: 155171 AIM number: 100289890</p> <p>Census bed type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 8 Medicaid: 61 Other: 17 Total: 86</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 30576 on September 4, 2015.</p>	F 0000	The creation and submission of this Plan of Correction on behalf of Franklin Meadows does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of any regulation. This provider respectfully requests that the Plan of correction be considered the Letter of Credible Allegation by September 18, 2015 and requests a Desk Certification Review.	
F 0278	483.20(g) - (j)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SS=D Bldg. 00	<p>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure a Minimum Data Set assessment of a resident's urinary continence status was accurate. (Resident #82)</p> <p>Findings include:</p> <p>The clinical record of Resident #82 was</p>	F 0278	F 278 Assessment/Accuracy/Coordination/Certified It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident	09/22/2015

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F 0282 SS=D Bldg. 00	<p>reviewed on 8/31/15 at 12:45 p.m. Diagnoses for the resident included, but were not limited to, senile dementia and urinary tract infection.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 5/11/15, indicated the resident was always continent of urine. This assessment was signed by the Director of Nursing Service #4.</p> <p>A significant change MDS assessment dated 7/31/15 indicated the resident was always incontinent.</p> <p>On 8/31/15 at 12:59 p.m., MDS Coordinator #5 indicated the charting for the assessment period of 5/12/15 - 5/18/15 indicated Resident #82 was always incontinent and she had made an error. The MDS dated 5/11/15 should have indicated the resident was always incontinent.</p> <p>MDS Coordinator #5 indicated she would do a modification of the 5/11/15 significant change MDS assessment.</p> <p>3.1-31(g)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>		<p>#82 Minimum Data Set assessment was modified and resubmitted. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the same alleged deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The RAI specialist conducted an audit of all other resident's Minimum Data Sets. Any other identified areas were corrected and resubmitted. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? The DNS/designee will monitor MDS input weekly using a CQI tool times four (4) weeks, bi-monthly times two (2) months, monthly times four (4) and then quarterly to encompass all shifts until continued compliance is maintained for two (2) consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed and implemented.</p>		

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure plans of care were followed for a resident requiring a positioning device (cradle mattress) (Resident #22), and 2 residents dependent on staff for showers (Residents #19 and #38).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #22 was reviewed on 8/27/15 at 3:01 a.m. Diagnoses included, but were not limited to, dementia and Parkinson's.</p> <p>A careplan, initiated 7/7/15, updated 8/19/15, indicated, "Resident is at risk..." Interventions included, "...cradle mattress to bed...."</p> <p>A Fall Event Report, dated 8/19/15, indicated a cradle mattress was the intervention put into place to prevent another fall.</p> <p>An IDT (Interdisciplinary Team) note dated 8/19/15 at 8:04 a.m., indicated, "...Immediate intervention was to provide resident with cradle mattress. IDT recommends to continue with this</p>	F 0282	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 22 had cradle mattress placed to bed. Resident #19 and #38 care plans and profiles updated for bathing preferences. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents with fall interventions have been reviewed with all interventions in place. All residents interviewed for bathing preferences with care plans and profiles updated accordingly. 3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? DNS/designee will in-service nursing staff on fall interventions/Fall Program and ADL assistance for residents by September 18, 2015. Customer Care Representatives to do resident care rounds daily to ensure fall interventions are in place daily with results reviewed by ED/designee. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality</p>	09/22/2015

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	<p>intervention to assist resident from rolling out of bed...."</p> <p>During an observation on 8/31/15 at 11:20 a.m., Resident #22 was resting in bed on a regular mattress.</p> <p>On 8/31/15 at 11:38 a.m., the DON (Director of Nursing) observed Resident #22's bed and indicated a regular mattress was in place. The DON indicated Resident #22 was supposed to have a cradle mattress on her bed at that time.</p> <p>On 8/28/15 at 9:00 a.m., the DON provided the Fall Management Program Policy dated 02/2015, and indicated the policy was the one currently used by the facility. The policy indicated, "...The report must be completed in full in order to identify possible root cause of the fall and provide immediate interventions."</p> <p>2. The clinical record of Resident #19 was reviewed on 8/31/15 at 10:49 a.m. Diagnoses for the resident included, but were not limited to, multiple sclerosis, lower leg contracture, and depression.</p> <p>An annual Minimum Data Set assessment, dated 8/6/15, indicated Resident #19 was independent in her ability to make decisions, needed extensive assist of 2 or more staff for bed</p>		<p>assurance program will be put into place? DNS/designee will be responsible for the completion of Fall Program CQI and Resident Care Rounds Tool weekly times four (4) weeks, bi-monthly times two (2) months, monthly times four (4) months and then quarterly to encompass all shifts until continued compliance is maintained for two (2) consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed and implemented.</p>	

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	<p>mobility, transfer, dressing, toileting and personal hygiene, bathing.</p> <p>A current care plan, dated 11/7/11, indicated the resident needed assistance with activities of daily living (ADLs) The goal was her ADL needs would be met. Approaches included providing a shower 2 times per week.</p> <p>A review of shower reports for July and August, 2015, provided by the Director of Nursing on 8/31/15 at 3:00 p.m., indicated Resident #19 received a shower on 7/1, 7/11, 7/22, and bed baths on 7/4, 7/8, 7/15, 7/18, 7/25 and 7/29, 2015. In August, she received a shower on 8/5, and 8/12, and bed baths on 8/1, 8/8, 8/15, 8/19, 8/22, and 8/26, 2015.</p> <p>No documentation was found in the resident's record which indicated she refused her showers.</p> <p>During an interview on 8/26/15 at 12:17 p.m., Resident #19 indicated, "We are supposed to get 2 showers a week but don't always get them because there's not enough help. They say they are sorry. Sometimes people don't get showers."</p> <p>3. The clinical record of Resident #38 was reviewed on 8/26/15 at 10:46 a.m. Diagnoses for the resident included, but</p>			

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	<p>were not limited to, heart failure and diabetes.</p> <p>A quarterly Minimum Data Set assessment, dated 8/13/15, indicated the resident was independent in his ability to make decisions and needed extensive assistance of 2+ staff for bed mobility, transfer, toileting and part of bathing.</p> <p>A current care plan, dated 3/21/15, indicated Resident #38 required, "assistance and/or monitoring for ADL care..." The goal was the resident's ADL needs would be met. Approaches included tasks for AM and PM care included bathing.</p> <p>During an interview on 8/26/15 at 10:46 a.m., Resident #38 indicated he would like to have more showers but, "they just don't have enough help."</p> <p>A review of shower reports for the resident for July and August, 2015, indicated the resident received bed baths on July 3, 7, 10, 14, 17, 21 24, 28, and 31, 2015, but no showers. The reports indicated in August he received a shower on 8/14, and bed baths on August 4, 7, 11, 21 and 25. A report indicated he refused a shower on 8/18/15. No other documentation was found in the resident's record which indicated he</p>			

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F 0323 SS=D Bldg. 00	<p>refused his showers.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a positioning device (cradle mattress), was placed on a resident's bed, to prevent falls for 1 of 2 residents reviewed for accidents. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record for Resident #22 was reviewed on 8/27/15 at 3:01 p.m. Diagnoses included, but were not limited to, dementia and Parkinson's.</p> <p>A careplan, initiated 7/7/15, updated 8/19/15, indicated, "Resident is at risk..." Interventions included, "...cradle mattress to bed...."</p> <p>A Fall Event Report, dated 8/19/15, indicated a cradle mattress was the intervention put into place to prevent another fall.</p>	F 0323	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#22 had cradle mattress placed to bed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents with fall interventions have been reviewed and all interventions are in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS/designee will in-service nursing staff on fall interventions/fall program by September 18, 2015. Customer Care Representatives to complete resident care rounds to ensure fall interventions are in place daily with results reviewed</p>	09/22/2015			

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	<p>An IDT (Interdisciplinary Team) note dated 8/19/15 at 8:04 a.m., indicated, "...Immediate intervention was to provide resident with cradle mattress. IDT recommends to continue with this intervention to assist resident from rolling out of bed...."</p> <p>During an observation on 8/31/15 at 11:20 a.m., Resident #22 was resting in bed on a regular mattress.</p> <p>On 8/31/15 at 11:38 a.m., the DON (Director of Nursing) observed Resident #22's bed and indicated a regular mattress was in place. The DON indicated Resident #22 was supposed to have a cradle mattress on her bed at that time.</p> <p>On 8/28/15 at 9:00 a.m., the DON provided the Fall Management Program Policy dated 02/2015, and indicated the policy was the one currently used by the facility. The policy indicated, "...The report must be completed in full in order to identify possible root cause of the fall and provide immediate interventions."</p> <p>3.1-45(a)(2)</p>		<p>by the ED/designee. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? DNS/designee will be responsible for the completion of Fall Program CQI tool weekly times four (4) weeks, bi-monthly times two (2) months, monthly times four (4) and then quarterly to encompass all shifts until continued compliance is maintained for two (2) consecutive quarters. The results of these audits will be reviewed by the CQI Committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed and implemented.</p>		