

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  08/10/2016
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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 the Investigation of Complaints IN00205846 and IN00206298.</p> <p>Complaint IN00205846 - Unsubstantiated due to lack of evidence. Complaint IN00206298 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: August 9 &amp; 10, 2016</p> <p>Facility number: 000087 Provider number: 155171 AIM number: 100289890</p> <p>Census bed type: SNF/NF: 95 Total: 95</p> <p>Census payor type: Medicare: 10 Medicaid: 68 Other: 17 Total: 95</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings</p>	F 0000		

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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F 0224 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on August 15, 2016.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure residents were free from mistreatment by staff for 2 of 2 residents reviewed for mistreatment in a sample of 5 (Resident #E, Resident #F and CNA #1).</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 8/10/16 at 10:30 a.m. Diagnoses for Resident #E included, but were not limited to, dementia with behavior disturbances and macular degeneration.</p> <p>The Director of Nursing (DON) provided</p>	F 0224	<p><b>F224 Prohibit Mistreatment/Neglect/Misappropriation</b> It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. 1: <b>What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?</b> ·Resident E assessed by charge nurse, social services to follow up, and placed on psychosocial follow up ·Resident F assessed by charge nurse social services to follow up, and placed on psychosocial follow up ·CNA #1 separated from</p>	08/22/2016

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	<p>documentation of a reportable incident on 8/10/16 at 9:35 a.m., that occurred on 8/9/16 at 5:30 a.m., and included Resident #E, Resident #F and CNA #1.</p> <p>An untitled document dated 8/9/16 (no time) and provided by Seniors Helping Seniors #4 (companion to Resident #E) indicated CNA #1 had entered Resident #E's room to provided care (night shift). The companion indicated the resident was moving slowly and the CNA pushed her over too fast and the resident yelled the CNA was hurting her. Additionally, the companion reported the aide was angry the resident had soiled the sheet with a bowel movement and he would have to change the sheets.</p> <p>The companion reported the incident to LPN #2 and Resident #E was assessed for any injuries. LPN #2 indicated the resident was without injury and reported Resident #E indicated she was fine.</p> <p>2. The record for Resident #F was reviewed on 8/10/16 at 10:50 a.m. Diagnoses for Resident #F included, but were not limited to, diabetes and chronic kidney disease.</p> <p>An undated and untitled document written by RN #3 indicated, she overheard CNA #1 speak to Resident #F</p>		<p>employment with company</p> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>· All resident have the potential to be affected by the alleged deficient practice</li> <li>· All other residents that received care by CNA #1 were interviewed with no further findings</li> </ul> <p><b>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>· DNS/designee will in-service all staff on Abuse &amp; Neglect by August 22, 2016</li> </ul> <p><b>4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· The DNS/designee will utilize Abuse Prohibition and Investigation QA tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed.</li> </ul>				

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	<p>in a loud and harsh tone. RN #3 calmed down the resident and then reported the incident to the DON.</p> <p>During an interview with the DON on 8/10/16 at 10:00 a.m., she indicated there have been no other reports from staff or residents regarding care issues with CNA #1.</p> <p>During an interview with the Social Worker on 8/10/16 at 10:10 a.m., she indicated no other residents had reported to her an issue with care from CNA #1.</p> <p>During an interview with Resident #F on 8/10/16 at 11:40 a.m., she indicated he (CNA #1) was just rude sometimes, but did not report him to the facility because she didn't want to get anyone in trouble.</p> <p>During an interview with the DON on 8/10/16 at 12:10 p.m., she indicated the staff called her after attending to the residents. She also indicated the incidents happened near the end of the CNA's shift and after spending approximately 30 minutes on the phone with the nurses and the CNA, he was told he was suspended and to clock out.</p> <p>3.1-28(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2016

FORM APPROVED

OMB NO. 0938-0391

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