STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155171	A. BUILDING 00 B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN MEADOWS	1285 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387901 and IN00388128. Complaint IN00387901 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00388128 - Substantiated. No deficiencies related to the allegations were cited. Survey date: August 24, 2022 Facility number: 000087 Provider number: 155171 AIM number: 100289890 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 2 Medicaid: 56 Other: 17 Total: 75 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 25, 2022.	F 0000	Please find enclosed the Plan of Correction to the complaint survey, IN00387901, that was conducted on August 24, 2022, resulting in an F-689 citation. This letter is to inform you that the plan of correction attached is to serve as Franklin Meadow's credible allegation of compliance. We allege compliance on 9/16/2022. Submission of this plan of correction does not constitute an admission by Franklin Meadows or its management company that the allegations contained in the survey report are a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We cordially ask for a desk review on this alleged deficient practice.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

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

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident residing on the secured memory care unit remained inside the facility for 1 of 3 residents reviewed for elopement. (Resident B) Finding includes: During an interview 8/24/22 at 8:50 a.m., LPN 1 (Licensed Practical Nurse) indicated she was aware of Resident B going outside the facility but was not working that day. The clinical record for Resident B was reviewed on 8/24/22 at 8:46 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and Alzheimer's dementia. An Admission MDS (Minimum Data Set) assessment, dated 8/12/22, indicated Resident B was not cognitively intact. A progress note, dated 8/11/22 at 5:56 p.m., indicated Resident B exited the building and was found outside the facility on the facility property. Resident B was dressed appropriately for weather. Head to toe assessment completed with no injuries noted. Resident B was unable to explain what or where he was going. Resident B was easily redirected into building with no issues and placed on increased supervision. The physician and responsible party notified. During an interview on 8/24/22 at 1:02 p.m., the	F 0689	Please find enclosed the Plan of Correction to the complaint survey, IN00387901, that was conducted on August 24, 2022, resulting in an F-689 citation. This letter is to inform you that the plan of correction attached is to serve as Franklin Meadow's credible allegation of compliance. We allege compliance on 9/16/2022. Submission of this plan of correction does not constitute an admission by Franklin Meadows or its management company that the allegations contained in the survey report are a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **We cordially ask for a desk review on this alleged deficient practice.** **F689** **1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B is placed on 1:1 care for the resident to not exit the facility unassisted for an	09/16/2022

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	DON (Director of Nursing) indicated she was in the facility when Resident B went outside. She was made aware Resident B was in the front of the building by the Business Office Manager. The Business Office Manager brought Resident B inside, and said he was at the front of the building. The DON assessed the resident for any injuries. He was wearing his wander guard (electronic device worn to alert staff that a resident is near a door). Resident B exited through the emergency exit door on the secured unit. The emergency exit door lacked an alarm to notify staff a resident was opening the door. During an interview on 8/24/22 at 1:40 p.m., the Business Office Manager indicated she was leaving work for the day and saw Resident B standing outside by the front of the facility. She approached him and redirected him back into the building. There were no alarms sounding when she saw Resident B outside. On 8/24/22 at 8:57 a.m., the DON provided a copy of a facility policy, titled "Elopement Prevention and Response Program," dated 10/2020, and indicated this was the current policy used by the facility. A review of the policy indicated it is the policy of the facility that staff who have residents under their care are responsible for knowing their location of those residents. This Federal tag relates to Complaint IN00387901. 3.1-45(a)(2)		established time frame as determined by the resident's needs. Resident B has a working wonder guard door alarm bracelet put on to prevent alarmed doors from opening within range of the wonder guard system. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** Residents residing in the facility have the potential to be affected. All residents are reviewed for elopement risk and appropriate interventions implemented. Social Service Director and/or designee reviewed and will continue to maintain elopement risk assessments on admission, quarterly, annually, and upon significant change. All exit doors were assessed for function by a contractor and made needed adjustments. **3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** An audible door alarm is to be	

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			installed on the door that the elopement occurred on to alert staff moving forward if the door is ever breached again. Education was completed for 100% of staff on elopement procedures and residents exiting the building. The door code was changed to prevent unauthorized exit or entry. Education completed for 100% of staff on alarm response procedures. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** ED/DON/designee will complete the elopement QAPI tool and will continue weekly for 4 weeks and monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. The frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5) **By what date the systemic changes for each deficiency will be completed:** 9/16/22	

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