STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 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 Complaint IN00398091. Complaint IN00398091 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F689, and F9999. Survey date: January 9, 2023 Facility number: 001127 Provider number: 155771 AIM number: 200247220 Census Bed Type: SNF/NF: 40 NF: 86 Residential: 154 Total: 280 Census Payor Type: Medicare: 19 Medicaid: 80 Other: 27 Total: 126 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 17, 2023.	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.**	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Logan	Administrator	01/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents right to be free from physical and verbal abuse by another resident for 1 of 3 residents reviewed for abuse. (Resident B, Resident C) Finding includes: Resident B's clinical record was reviewed on 1/9/23 at 1:35 p.m.. The diagnoses included, but were not limited to, dementia unspecified severity with agitation, psychotic disturbances, and Alzheimer disease. The progress notes indicated that on 11/21/22, Resident B had a resident to resident altercation with his roommate, Resident C. Resident B pushed Resident C down by the bathroom door and blocked the staff from entering the room. Resident B continued to yell at Resident C. The police and security were called to assist to get into the room. Upon opening the door, Resident C was observed to be on the floor with Resident B standing over the top of him. Resident C's clinical record wad reviewed on 1/9/23 at 12:00 p.m. The diagnosis included, but was not limited to, dementia without behaviors. The clinical indicated Resident B had no cognitive	F 0600	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B and Resident C were immediately separated. Resident C was sent to the ER via 911. Resident B was removed from MSCU to the HC2 and placed on 1:1 supervision until resident could be transferred to Witham Behavior Hospital. Upon Resident B's return to the facility, resident was placed on HC2 with a wander guard. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who reside on MSCU have the potential to be affected. The Nursing Staff determined there were no other residents on MSCU exhibiting any type of similar behaviors. **3. What measures will be put**	02/03/2023

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	impairment. The progress note indicated that on 11/21/22, Resident C was trying to come out of his room to see staff when there was a resident to resident altercation. Resident B pushed Resident C to the floor and would not let Resident C out of the room. Resident C blocked the door. After the door was able to be opened, the staff removed Resident C from the floor was assessed to have a skin tear on the left upper arm. During an interview with House Supervisor on 1/9/23 at 3:55 p.m., she indicated she was called by the CNA (Certified Nursing Assistant) to come to the Special Care Unit immediately. Upon her arrival, she observed the CNA and nurse attempting to get into Resident B and Resident C's room, however, Resident B was blocking the door. Security and police were called and were able to remove Resident C out of the room. During an interview with CNA 1 on 1/9/23 at 4:10 p.m., she indicated she was coming out of another room and heard a door open slowly then slammed shut. At that time, she was able to get the door open slightly and she observed Resident B standing over Resident C with his foot on Resident C's abdomen. Then Resident B slammed the door shut again and she was unable to get into the room. This Federal tag relates to Complaint IN00398091. 3.1-27(a)(1) 3.1-27(b)		**into place and what systematic changes will be made to ensure that the deficient practice does not recur?** Any noted similar behaviors will be managed according to policy. The DON and/or designee will educate all staff on the facility abuse policy and Corporate directed, in-depth dementia training to be completed by 2/3/2023. All behaviors are currently being monitored daily and discussed in the clinical meeting Monday through Friday. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Social Services will bring all behavior monitor tracking to the Quality Assurance Meeting monthly for six months. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits; however, the review by the IDT on a Monday through Friday basis will continue. The Administrator and IDT are responsible for implementing and monitoring this plan. **5. By what date the systemic changes for each deficiency**	

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			will be completed? 2/3/2023	
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 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 interview and record review, the facility failed to provide supervision to prevent elopements for 1 of 1 residents reviewed for elopement. (Resident B) Finding includes: On 1/9/23 at 1:50 p.m., SS (Social Services) indicated when Resident B returned from a hospitalization he was placed on the unsecured side of the facility until a bed on the secured unit was available. Resident B's clinical record wad reviewed on 1/9/23 at 2:15 p.m. The diagnoses included but were not limited to, dementia with behaviors. An Annual MDS (Minimum Data Set) assessment, dated 12/28/22, indicated Resident B was not cognitively intact. A late entry progress note dated, 11/30/22 at 3:31 a.m., indicated Resident B was observed sitting in a recliner in the common area at 1:15 a.m. The nurse started passing medications down the east	F 0689	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B has declined, is on hospice care, and is no longer ambulating independently. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents who do not reside on a locked unit have been assessed for wandering and elopement risk. Any resident identified as a risk was assessed for memory care placement and if deemed inappropriate, a wander guard was ordered, placed, care planned, and placed in the treatment book for monitoring. **3. What measures will be put**	02/03/2023

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	hall and heard the elevator open. The nurse had run up front to find Resident B had gotten on the elevator. A head count was initiated and the nurse and staff started looking for Resident B. At 2:00 a.m., the resident was seen walking up to the employee entrance door and came inside. A progress note, dated 11/29/22 at 1:16 p.m., the SS indicated during an interview with Resident B, Resident B remembered taking a walk and stated he just wanted to take a walk. Resident B was placed on 15 minutes checks. This Federal tag relates to Complaint IN00398091. 3.1-45(a)(2)		**into place and what systematic changes will be made to ensure that the deficient practice does not recur?** Any resident identified as a wander or elopement risk will be assessed for memory care placement and if deemed inappropriate, a wander guard will be ordered, placed, care planned, and placed in the treatment book for monitoring. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Unit Managers will audit wander guard monitoring and will bring audits to the Quality Assurance Meeting monthly for six months. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once the six months are completed and 100% compliance has been achieved, the Committee may decide to stop the written audits; however, the monitoring of the wander guards will continue. The Administrator and IDT are responsible for implementing and monitoring this plan. **5. By what date the systemic changes for each deficiency will be completed?** 2/3/2023	

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F 9999 Bldg. 00	3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: This State rule is not met as evidenced by: Based on interview and record review, the facility failed to report to the Indiana Department of Health (IDOH) a resident's elopement from the facility for 1 of 1 residents reviewed for elopement. Findings include: On 1/9/23 at 1:50 p.m., SS (Social Services) indicated when Resident B returned from a hospitalization he was placed on the unsecured side of the facility until a bed on the secured unit was available. Resident B's clinical record wad reviewed on 1/9/23 at 2:15 p.m. The diagnoses included but were not limited to, dementia with behaviors. An Annual MDS (Minimum Data Set) assessment, dated 12/28/22, indicated Resident B was not	F 9999	**1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** It is the policy of the facility to immediately inform the Indiana Department of Health by telephone and/or written notice within 24 hours of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who reside in the facility have the potential to be affected by this finding. A 30 Day "look back" at all incidents was completed to ensure proper reporting of any unusual occurrences that met Indiana Department of Health comprehensive care facility reportable guidelines. The facility found no unreported incidents that met criteria. **3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** Admin/DON/Designee will monitor	02/03/2023

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	cognitively intact. A late entry progress note dated, 11/30/22 at 3:31 a.m., indicated Resident B was observed sitting in a recliner in the common area at 1:15 a.m. The nurse started passing medications down the east hall and heard the elevator open. The nurse had run up front to find Resident B had gotten on the elevator. A head count was initiated and the nurse and staff started looking for Resident B. At 2:00 a.m., the resident was seen walking up to the employee entrance door and came inside. On 1/9/23 at 2:00 p.m., the Administrator indicated the incident was not reported because the resident returned on his own. On 1/9/23 at 2:30 p.m., the Indiana State Department of Health Division of Long Term Care Incident Reporting Policy, effective 7/15/15 through 12/7/22, indicated, types of incidents reportable under State rules only, occurrences that directly threatens the welfare, safety, or health of a resident, examples included, elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts were unknown or whose return involved law enforcement. This State tag relates to Complaint IN00398091.		nursing progress notes and physician notifications daily at the CQI meeting to ensure any event that meets reportable guidelines was reported appropriately and timely as per policy and regulation. This monitoring will continue weekly for 4 weeks and monthly for a period of no less than 6 months to ensure ongoing compliance. The nurse manager will monitor for changes in condition and/or status on weekends or holidays to ensure required notifications are made per policy and regulation. At that time the monitoring will be PRN ongoing. Any concerns will be addressed as found. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** At the Monthly QAPI any reportable incidents will be reviewed by Administrator/Designee. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **5. By what date the systemic changes for each deficiency will be completed?**	

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			2/3/2023	