STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING 00		COMPLETED		
155771		B. W	B. WING		03/17/2023		
		1	STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	ROVIDER OR SUPPLIEF	R			/ JEFFERSON ST		
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for the	he Investigation of Complaints	F 0	000	The creation and submission of	of	
	IN00403114 and IN	N00403508.			this Plan of Correction do not		
					constitute an admission by this		
	-	3114 - Federal/State deficiencies			provider of any conclusion set forth in the statement of deficiencies or		
	related to the allega	ations are cited at F600.					
					any violation of the regulation.		
	•	3508 - No deficiencies related to			This provider respectfully requ		
	the allegations are	cited.			that this 2567 Plan of Correction	on	
					be considered the Letter of		
	Survey date: March	17, 2023			Credible Allegation of Complia		
					and requests a desk review in	lieu	
	Facility number: 00				of a post-survey review.		
	Provider number: 1						
	AIM number: 2002	247220					
	G D 1 m						
	Census Bed Type:						
	SNF/NF: 36						
	NF: 98						
	Residential: 157 Total: 291						
	10tai: 291						
	Comana Davian Trima						
	Census Payor Type Medicare: 15	: .					
	Medicaid: 93						
	Other: 26						
	Total: 134						
	10tai. 134						
	This deficiency refl	lects State Findings cited in					
	accordance with 41						
	ascordance with Ti						
	Ouality review com	npleted March 20, 2023.					
		1					
F 0600	483.12(a)(1)						
SS=D	Free from Abuse	and Neglect					
Bldg. 00		r from Abuse, Neglect, and					
	Exploitation	, 5 ,					
		the right to be free from					

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

(X6) DATE

TITLE

Shannon Logan Administrator 03/31/2023

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7UYU11 Facility ID: 001127 If continuation sheet Page 1 of 4

A BULINED IDENTIFICATION NUMBER 155771 NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE SINMARY STATEMENT OF DEFICIENCE (XA) ID SINMARY STATEMENT OF DEFICIENCE (RACH DEFICIENCY MUST BE PRECEDED BY PULL RECEIVED A SUBJECT AND STATEMENT OF DEFICIENCE PREERY ADDRESS, CITY, STATE, ZIP COD 1707 W JEFFERSON ST FRANKLIN, IN 46131 PROUDLATORY OR LOS LIDENTIFIYAN INFORMATION TAG ROUGLATORY OR LOS LIDENTIFIYAN INFORMATION abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to fire-edom from corporal punishment, involuntary seclusion Based on interview and record review, the facility flided to protect the residents flight to be five from sexual abuse by a resident to another resident for 2 of 3 resident reviewed for abuse. (Resident B, Resident C, Resident C, and abuse by a resident to another resident for 2 of 3 resident reviewed for abuse. (Resident B, Resident C, Resident C, Besident B, Resident C, Resident M, Breast on 33/423, but she did not work that day. Unificated she was on the unit the day Resident C souched Resident D's breast, on 3/2/23. She heard about Resident D's breast, on 3/2/	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY	
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						intervention to attempt to keep		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7UYU11 Facility ID: 001127

If continuation sheet Page 2 of 4

STATEMENT OF DEFICIENCIES X1) P.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>00</u>		COMPLETED		
		155771	B. WING			03/17/2023	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					JEFFERSON ST		
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CA			\DE		LIN, IN 46131		
OTTERB	DEIN FRANKLIN SE	INIORLIFE COMM RES & COM CA	AINE	FRAIN	LIN, IN 40131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		east. Resident B did not seem			occupied by activities in the		
		lking out loud and smiling,			common area. All three reside		
		t of word salad (confused or			were followed by Social Service	ces	
		re of seemingly random words		for psycho-social distress. All			
		nt B separated from Resident C			three residents were unaffecte		
		om to lay down, rest, and			and remained pleasant without		
	watch TV.				any interruption to their daily		
		6 P 11 . P			routines.	_	
		for Resident D was reviewed			How other residents having t		
		a.m. The diagnoses included,			potential to be affected by th		
		d to, Alzheimer's disease and			same deficient practice will be		
	depression.				identified and what corrective	е	
	A Quarterly MDS assessment, dated 1/11/23,				action(s) will be taken? All other ASCU residents have	tho	
	indicated Resident D was not cognitively intact.			potential to be affected. All ASCU			
	indicated Resident D was not cognitively intact.				residents were interviewed by		
	A progress note, dated 3/2/23 at 4:30 p.m.,				Social Services to see if anyor		
	indicated Resident D was found in Resident C's				had touched them inappropria		
	room. Resident C was present as well. Resident D				since admission to the facility;	-	
	was naked except for a brief. Resident C was				issues were identified. Staff w		
	_	ste down. The CNA witnessed		interviewed by the Unit Manager to			
	Resident C touching Resident D's breast. Resident				see if they had witnessed any		
	D did not look distressed or show any emotion				inappropriate touching of		
	toward the incident. The residents were				residents. No issues were		
	immediately separated.				identified. MDS director		
					completed reassessments on	ALL	
	The clinical record for Resident C was reviewed				ASCU residents for any types		
	on 3/17/23 at 10:36 a.m. The diagnoses included,				sexual behavior and intrusive		
	but were not limited to, cerebral infarct and bipolar			wandering. Identified beha		rs	
	disorder.				were care planned; all		
					interventions are currently		
	A Quarterly MDS assessment, dated 3/3/23,			appropriate.			
	indicated Resident C was not cognitively intact.			What measures will be put i		to	
					place and what systemic		
	A care plan, dated 3/3/23 and current through			changes will be made to			
	5/30/23, indicated Resident C had physical		ensure that the deficient				
	_	directed toward others such as		practice does not recur?			
	touching a female resident's breast, attempting to				Abuse in-service was initiated		
		Interventions included, but			3/2/2023 for staff working on the		
	were not limited to, resident is one to one				ASCU. On 3/6/2023, an Abus	e,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155771	A. BU	2) MULTIPLE CONSTRUCTION A. BUILDING O 3. WING		(X3) DATE SURVEY COMPLETED 03/17/2023	
NAME OF PROVIDER OR SUPPLIER OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CA			STREET ADDRESS, CITY, STATE, ZIP COD 1070 W JEFFERSON ST ARE FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A progress note, da indicated Resident I room. Resident D v incontinence brief at the waist down. CN touching Resident I look distressed or sincident. Residents A progress note, da indicated Resident wheelchair. RN tologive him his medicated wheel past RN. RN opened up a Coke for around the corner in medication, the RN fingers on Resident saw the RN coming Resident B's shirt at immediately separate to his room. A stop doorway. On 3/17/23 at 9:08 provided a copy of titled Abuse, Mistre and Misappropriation indicated this was to facility. A review of have the right to be	ted 3/2/23 at 4:30 p.m., D was found in Resident C's vas nude except for an and Resident C was nude from IA witnessed Resident C D's breasts. Resident D did not show any emotion towards said were immediately separated. ted 3/4/23 at 5:45 p.m., C out in hallway in his d Resident C she was going to ation and he continued to picked up the medicine and for Resident C. Upon going mmediately with the saw Resident C with his B's nipples. When Resident C g, he quickly put his hand up and felt her breast. Both parties ted and Resident C was taken sign was placed across his a.m., the Administrator an undated facility policy, catment, Neglect, Exploitation on of Resident Property, and the current policy used by the f the policy indicated residents free from abuse. ates to Complaint IN00403114.			Dementia, and Behavioral trai (with assistance from a Certific Dementia Specialist) for ALL is was conducted. Intrusive wanderers will be monitored a redirected according to care properties to the deficient practice will not recur, i.e., what quality assurance program will be printo place? Random audits on abuse will given consisting of three questo three partners per day. Random audits of residents would wandering behaviors will be conducted for 15 minutes per to ensure that they are being redirected in accordance with care plan. Audits will be conducted by Administrator, Dunit Managers, and Supervisor Audits will be conducted daily two weeks, and then twice a vertical for two weeks. Audits will be taken to QAPI by Administrator review. By what date the systemic changes for each deficiency will be completed? 3/18/2023	ed staff ind lan. ity ut be tions ith day their DON, ors. for veek or for	

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