STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155651	B. WING 02/07/2023				
			CTREET	ADDRESS CITY STATE ZIR COD			
NAME OF P	ROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD			
	EW CENTED OF E	DANKI IN	651 SOUTH STATE STREET FRANKLIN, IN 46131				
HOMEVII	EW CENTER OF F	RANKLIN	FRAIN	ALIIN, IIN 46131			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 0000	K 000			
		ndiana Department of Health in		The completion of this plan of			
	accordance with 42			correction does not constitute	· · · · · · · · · · · · · · · · · · ·		
				admission that the alleged			
	Survey Date: 02/07	7/23		deficiency exists. The plan of			
	J : :::::			correction is provided as evide	ence		
	Facility Number: 0	000353		of the facilities' desire to comp			
	Provider Number:			with the regulations and contin	-		
	AIM Number: 100			to provide quality care in a saf			
				environment. The facility is			
	At this Emergency	Preparedness survey,		requesting a desk review for			
		of Franklin was found in		compliance.			
		nergency Preparedness		compliance.			
	-	Medicare and Medicaid					
	_	ders and Suppliers, 42 CFR					
	483.73.	acis and suppliers, 12 circ					
	103.73.						
	The facility has 119	o certified beds. At the time of					
	the survey, the cens						
	une sur vey, the com	was ron					
	Quality Review cor	mpleted on 02/09/23					
		inpresent off 02/05/25					
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 0000	K 000			
		vas conducted by the Indiana	10000	The completion of this plan of			
		lth in accordance with 42 CFR		correction does not constitute			
	483.90(a).			admission that the alleged			
	()			deficiency exists. The plan of			
	Survey Date: 02/07	7/23		correction is provided as evide	ence		
		·· 		of the facilities' desire to comp	· · · · · · · · · · · · · · · · · · ·		
	Facility Number: 0	000353		with the regulations and contin	-		
	Provider Number:			to provide quality care in a saf			
	AIM Number: 100			environment. The facility is	Ĭ		
	100			requesting a desk review for			
	At this Life Safety	Code survey, Homeview Center		compliance.			
	120 mis Dire Surety	and survey, from eview contain		Compilation.			

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

(X6) DATE

Mark Gavorski Administrator 02/21/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: IEKH21 Facility ID: 000353 If continuation sheet

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155651		(X2) MUL A. BUIL B. WIN	DING	NSTRUCTION 01	(X3) DATE : COMPL 02/07/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 651 SOUTH STATE STREET FRANKLIN, IN 46131					
	SUMMARY (EACH DEFICIEN REGULATORY OR OF Franklin was fou Requirements for P. CFR Subpart 483.90 the 2012 edition of Association (NFPA and 410 IAC 16.2. This one story facil: Building 01, the ori determined to be of was fully sprinklere Wing addition adde building in 2005 is and was fully sprinklere Wing addition adde building 02 were re Existing Health Car Building 03 is the e 2020 and includes, Physical Therapy R 24 new resident slee 122-136, 325-332 a Room 333. Building 200 Wing Memory Building 03 and Bu to be of Type V(11)	RANKLIN STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION and not in compliance with articipation in Medicare, 42 0(a), Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC) ity consists of four buildings. ginal building built in 1985 was Type V (111) construction and and and Building 02, the New d to the south of the original of Type V (111) construction clered. Building 01 and eviewed with Chapter 19,	PI	651 SOL	JTH STATE STREET	NTE.	(X5) COMPLETION DATE	
	The facility has a findetection in the correction in resident has a capacity of 11 the time of this survey. All areas where residence is surveyer sprinklered.	re alarm system with smoke ridor and hard wired smoke t sleeping rooms. The facility 9 and had a census of 104 at rey. Idents have customary access the facility has one detached facility services which was not						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155651		(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 02/07/2023	
	PROVIDER OR SUPPLIER		651 S	TADDRESS, CITY, STATE, ZIP COD OUTH STATE STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION INPUT ON 102/09/23	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=C Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to maintain that it had accurate accordance with the 2012 edition, Section 2010 edition, Section 2011 edition, Section 2011 edition, Section 2012 edition, Section 2013 edition, Section 2013 edition, Section 2012 edition, Section 2013 edition, Section 2012 edition, Section 2012 edition, Section 2013 edition, Section 2012 edition, Section 201	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	K 345 The facility will ensure that the requirement is met through the following corrective measures 1. No residents have been harmed. 2. All residents have the potential to be affected by the and time not being reset on the fire alarm panel. 3. The maintenance staff manually reset the date and to on the fire alarm panel to the current time. The fire alarm panel to the current time. The fire alarm panel date and time can be out of some based upon being placed in the service mode. The maintenar staff has been in-serviced on requirements of the panels' condition to the current time. 4. The fire alarm panel date and time will be audited week and until 100% compliance is achieved for the next six week.	ne si: n e date ne ime anel ync est or nce the orrect ate kly

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155651	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/07/2023
	PROVIDER OR SUPPLIER		651 SC	ADDRESS, CITY, STATE, ZIP COD DUTH STATE STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0500	display the correct of day. This finding was re-	e remote fire panel did not date and the correct time of viewed with the Administrator tions Director during the exit		and documented in TELS then be audited monthly for six mor and until 100% compliance is maintained. 5. The findings of these au will be presented during the facility's monthly QAPI meeting and the plan of action will be adjusted accordingly.	nths
SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 5 of 5 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Plant Operations Director during a tour of the facility from 11:40 a.m. to 2:00 p.m. on 02/07/23, the following five water heaters had expired Certificate of Inspection documentation from the State of Indiana: a. the service water heater identified as IN310129		K 0500	K 500 The facility will ensure that this requirement is met through the following corrective measures: No residents have been harmed. All residents have the potential to be affected by the expired boiler permit. Each bo has been inspected by our insurance company and those inspections have been sent to Homeland Security along with payment.	iler
				 The maintenance staff h been set up with a user name, password, and have been educated on Homeland Securi online system for payment and 	ity's

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155651		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/07/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 651 SOUTH STATE STREET FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
	stating the expiration but the service water had a Certificate of stating the expiration cut the service water had a Certificate of stating the expiration dut the service water had a Certificate of stating the expiration eutre the service water had a Certificate of stating the expiration duties and a Certificate of stating the expiration duties and a Certificate of stating the expiration deservations, the Plum current Certificate of was not available for aforementioned service expired Certificate of the State of In This finding was resistant and control of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificate of the State of In This finding was resistant and certificat	ant Operations Director stated of Inspection documentation or review and agreed the vice water heaters each had of Inspection documentation		printing of boiler permit certification the Homeland Security website. All permits have been paid for and received as of 02/8/2023. 4. A monthly audit of the boiler permits will be completed TELS for six months and untiful 100% compliance is achieved then every quarter for six monand untiful 100% compliance is maintained. 5. The findings of these a will be presented during the facility's monthly QAPI meeting and the plan of action will be adjusted accordingly.	ed in I d, nths			
K 0522 SS=D Bldg. 01	heating plant, is d combustible mate device, and has a and shut down eq excessive temper- fuel fired, the devi * is chimney or ve	ing Device e, other than a central esigned and installed so rials cannot be ignited by safety feature to stop fuel uipment if there is ature or ignition failure. If ce also:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO JILDING	INSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
155651		B. WING 02/07/2023					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 651 SOUTH STATE STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
TAG	* provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 2 of 2 natural gas fired dryers in the Laundry were continually provided with combustion air taken directly from the outside. This deficient practice could affect over two staff and visitors. Findings include: Based on observations with the Administrator and the Plant Operations Director during a tour of the facility from 11:40 a.m. to 2:00 p.m. on 02/07/23, two openings providing makeup air in the outside wall behind the two natural gas fired dryers in the Laundry were covered over with wood to prevent the cold air from the outside from entering the area behind the dryers in the Laundry room. Each of the two natural gas fired dryers were in operation at the time of the observations and no other openings for makeup air from the outside were noted behind the dryers. Based on interview at the time of the observations, the Plant Operations Director stated the wood is only used to cover the makeup air openings when there is cold air from		K 0	PREFIX TAG REACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROPRIES PLAN OF CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROPRIES PLAN OF CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROPRIES PLAN OF CORRECTIVE ACTION SHOULD IT CROSS-REFERENCED TO THE APPROPRIES PLAN OF CORRECTIVE ACTION THE APPROPRIES CROSS-REFERENCED TO THE APPROPR		see cee chas ted cea me cee and	02/13/2023
	dryers in the Laund provided with comb	ed the two natural gas fired ry were not continuously pustion air taken directly from			facility's monthly QAPI meeting and the plan of action will be	gs	
	This finding was re	e dryers are in operation. viewed with the Administrator tions Director during the exit			adjusted accordingly.		
K 0000							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	LETED
		155651	B. WI	NG		02/07	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			OUTH STATE STREET		
HOMEVII	EW CENTER OF F	RANKLIN		l	(LIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 03							
	-	Recertification and State	K 0	000	K 000		
	-	as conducted by the Indiana			The completion of this plan of		
	-	Ith in accordance with 42 CFR			correction does not constitute	an	
	483.90(a).				admission that the alleged		
	a 5 00/05	- /0.0			deficiency exists. The plan of		
	Survey Date: 02/07	//23			correction is provided as evide		
	E 32 M 1 0	00252			of the facilities' desire to comp	•	
	Facility Number: 0				with the regulations and contin		
	Provider Number:				to provide quality care in a saf	e	
	AIM Number: 100	291330			environment. The facility is		
	At this Life Sefety	Code survey, Homeview Center			requesting a desk review for		
	-	and not in compliance with			compliance.		
		articipation in Medicare, 42					
	-	0(a), Life Safety from Fire and					
	-	the National Fire Protection					
) 101, Life Safety Code (LSC)					
	and 410 IAC 16.2.) 101, Elle Salety Code (ESC)					
	una 110 1110 10.2.						
	This one story facil	ity consists of four buildings.					
		ginal building built in 1985 was					
	-	Type V (111) construction and					
		ed and Building 02, the New					
		ed to the south of the original					
	-	of Type V (111) construction					
	-	klered. Building 01 and					
	Building 02 were re	eviewed with Chapter 19,					
	Existing Health Car	re Occupancies.					
		ast end addition constructed in					
		but is not limited to, the					
	Physical Therapy Room, Therapy Court Yard and						
	24 new resident sleeping rooms to be numbered						
	•	and Room 334. There will be no					
		ng 04 is the newly constructed					
		Care constructed in 2021.					
	_	ilding 04 were both determined					
		1) and were fully sprinklered.					
	L Dilliging H4 and Ph	THE THE THE PROPERTY OF THE PR					·

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155651		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 02/07/2023	
	PROVIDER OR SUPPLIER		651 SC	ADDRESS, CITY, STATE, ZIP COD OUTH STATE STREET (LIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 04	The facility has a findetection in the correction in resident has a capacity of 11 the time of this survey. All areas where resist were sprinklered. The building providing a sprinklered. Quality Review corrections are survey with the time of this survey. Quality Review corrections are survey with the survey with the survey of Eacility Number: 02/07. Facility Number: 02/07. At this Life Safety of Franklin was four Requirements for Packet of Franklin was four Requirements for Packet of Franklin of Association (NFPA and 410 IAC 16.2.	dents have customary access The facility has one detached facility services which was not Impleted on 02/09/23 Recertification and State ras conducted by the Indiana Ith in accordance with 42 CFR 7/23 00353 155651 291330 Code survey, Homeview Center Ind not in compliance with articipation in Medicare, 42 0(a), Life Safety from Fire and Ithe National Fire Protection 1) 101, Life Safety Code (LSC) ity consists of four buildings.	K 0000	K 000 The completion of this plan of correction does not constitute admission that the alleged deficiency exists. The plan of correction is provided as evit of the facilities' desire to conswith the regulations and constone to provide quality care in a senvironment. The facility is requesting a desk review for compliance.	e an f dence nply tinue afe
		ginal building built in 1985 was Type V (111) construction and			

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

PRINTED: 03/01/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04			(X3) DATE SURVEY COMPLETED		
155651			B. WI			02/07		
NAME OF I	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 651 SOUTH STATE STREET					
HOMEVIEW CENTER OF FRANKLIN				FRANK	LIN, IN 46131			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION ed and Building 02, the New	+	TAG	DEFICIENCY)		DATE	
		ed to the south of the original						
	_	of Type V (111) construction						
	_	klered. Building 01 and						
	Building 02 were re	eviewed with Chapter 19,						
	Existing Health Ca	re Occupancies.						
	Building 03 is the 6	east end addition constructed in						
	2020 and includes,	but is not limited to, the						
	Physical Therapy F	Room, Therapy Court Yard and						
		eping rooms to be numbered						
		and Room 334. There will be no						
		ng 04 is the newly constructed						
		Care constructed in 2021.						
		ailding 04 were both determined 1) and were fully sprinklered.						
		ailding 04 were reviewed with						
		lealth Care Occupancies.						
	The facility has a fi	ire alarm system with smoke						
	detection in the cor	ridor and hard wired smoke						
	detectors in residen	at sleeping rooms. The facility						
		19 and had a census of 104 at						
	the time of this survey.							
	All areas where residents have customary access							
		The facility has one detached						
	building providing sprinklered.	facility services which was not						
	Quality Review con	mpleted on 02/09/23						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: IEKH21 Facility ID: 000353 If continuation sheet Page 9 of 9