STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155171	B. W	NG		11/16/	/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			/ JEFFERSON ST			
FRANKL	IN MEADOWS				KLIN, IN 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	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
	An Emergency Prep	paredness Survey was	E 0	000				
	conducted by the In	ndiana Department of Health in						
	accordance with 42	CFR 483.73.						
	Survey Date: 11/16	5/23						
	Facility Number: 0	000087						
	Provider Number:							
	AIM Number: 100							
	At this Emergency	Preparedness survey, Franklin						
		d in compliance with						
		edness Requirements for						
		icaid Participating Providers						
	and Suppliers, 42 C							
	11							
	The facility has 114	certified beds. At the time of						
	the survey, the cens							
	•							
	Quality Review cor	mpleted on 11/20/23						
		•						
K 0000								
Bldg. 01								
	A Life Safety Code	Recertification and State	K 0	000	Please find enclosed the Plan	of		
	Licensure Survey w	vas conducted by the Indiana			Correction to the annual surve	 •y,		
	Department of Heal	lth in accordance with 42 CFR			Survey Event ID J71R21, that	was		
	483.90(a).				conducted on November 16th	,		
					2023, resulting in three citation	ns		
	Survey Date: 11/16	5/23			K-300, K-324, and K-353. This	S		
					letter is to inform you that the	plan		
	Facility Number: 0	000087			of correction attached is to se	rve		
	Provider Number:	155171			as Franklin Meadow's credible	.		
	AIM Number: 100	289890			allegation of compliance. We			
					allege compliance on			
	At this Life Safety	Code Survey, Franklin			12/15/2023.			
	Meadows was foun	d not in compliance with			Submission of this plan of			

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

(X6) DATE

TITLE

Jason Kennedy Executive Director 12/07/2023

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 disclodays 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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12/11/2023 PRINTED:

	I OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPL 11/16	SURVEY LETED
NAME OF	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST		
FRANKL	IN MEADOWS			KLIN, 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 APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I Health Care Occup This one story facil Type V (000) const The facility has a fi detection in the cor the corridor. Batter are installed in all r facility has a capac 81 at the time of the All areas where res were sprinklered. A services were sprin wooden sheds prov	articipation in 1, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of rruction and is fully sprinklered. re alarm system with smoke ridors and in all areas open to ry operated smoke detectors esident sleeping rooms. The ity of 114 and had a census of	TAU	correction does not constitute admission by Franklin Meado or its management company the allegations contained in the survey report are a true and accurate portrayal of nursing and other services in this facil Nor does this provision constan agreement or admission of survey allegations. We cordially ask for a desk resofthese alleged deficient practices.	that the care lity. itute of the	DATE
K 0300 SS=E Bldg. 01	Section 18.3 and requirements that provided K-tags, I information, along Safety Code or N should be include Based on observations.	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.	K 0300	Please find enclosed the Plar		12/15/2023
	installed in 1 of 58	ttery operated smoke alarms resident sleeping rooms in		Correction to the annual survey Survey Event ID J71R21, that	t was	

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Edition, Section 14.4.8.1 states unless otherwise

recommended by the manufacturer's published

instructions, single- and multiple-station smoke

Event ID:

J71R21

Facility ID: 000087

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2023, resulting in three citations

letter is to inform you that the plan

K-300, K-324, and K-353. This

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155171	B. W	ING		11/16/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			JEFFERSON ST		
FRANKI	IN MEADOWS				LIN, IN 46131		
I I VAININE				I IVAINA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	_	aced when they fail to respond			of correction attached is to ser		
		but shall not remain in service			as Franklin Meadow's credible)	
		s from the date of manufacture.			allegation of compliance. We		
		ice could affect over 30			allege compliance on		
		visitors in the vicinity of			12/15/2023.		
	resident sleeping Ro	00m 124.	1		Submission of this plan of		
	Finding in 1 1				correction does not constitute		
	Findings include:				admission by Franklin Meadov		
	Rosed on observation	ons with the Executive			or its management company t		
		enance Director and the Field			the allegations contained in th	e	
		visor during a tour of the			survey report are a true and accurate portrayal of nursing of	ooro	
	_	a.m. to 12:50 p.m. on 11/16/23,			and other services in this facili		
	1	a.m. to 12.30 p.m. on 11/10/23, amentation affixed to the First			Nor does this provision constit	•	
		0 battery operated smoke alarm			an agreement or admission of		
		ing in resident sleeping Room			survey allegations.	uic	
		noke alarm was manufactured			We cordially ask for a desk re	view	
		interview at the time of the			of these alleged deficient	VICVV	
		laintenance Director stated			practices.		
		ng room has a battery			pradado.		
		rm installed in the room, all			K-300 Protection- Other¿		
	_	oke alarms in the facility were			What corrective action(s) wil	ı	
		most recent twelve month			be accomplished for those		
	1 -	ry operated smoke alarm			residents found to have beer	า	
	_	om 124 must have been missed			affected by the deficient		
	_	lent sleeping room battery	1		practice?		
		rm installed in Room 124 was			Facility failed to replace		
	more than ten years	old.			battery-operated smoke alarm	ıs in	
					1 of 58 resident sleeping room	ıs.	
	These findings were	e reviewed with the Executive			How will you identify other		
	•	enance Director and the Field			residents having the potentia	al	
	Maintenance Super	visor during the exit	1		to be affected by the same		
	conference.				deficient practice and what		
					corrective action will be		
	3.1-19(b)				taken?		
					All residents have the		
					potential to be affected by the		
					alleged deficiency.		
					Entire building audit		
			1		(attachment A) will be complet	ted	

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Facility ID: 000087

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(x3) date survey completed 11/16/2023	
	ROVIDER OR SUPPLIE N MEADOWS	R	1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				to ensure that no other expire battery-powered smoke deterare still in service by the Maintenance Director, or designee. In-service (attachment will be completed by ED/desito the environmental departmegarding the importance of pronexpired smoke detectors being used moving forward. The X1 smoke detector was not within compliance was replaced immediately on 11/2 with a brand-new battery smodetector within manufacturer guidelines. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? POC QAPI Audit tool (attachment C) to be completed by the Maintenance Director, designee, to be utilized to enall battery-powered smoke detectors are of the correct ty and within the manufacturer's recommendation for the detectified expectancy of the unit motorward. Any deficiencies identified during the audit will be addresimmediately by ED/designee How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality	ed ctors B) gnee nent proper in that as 16/23 poke in the company of the company

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Event ID:

J71R21

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2023
	ROVIDER OR SUPPLIER		1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST 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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DATE
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cook * residential cooking appliances such a toasters) are used cooking in accordate 19.3.2.5.2 * cooking facilities smoke compartments comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer patents complements of the cooking facilities with 30 or fewer patents complements complements cooking facilities with 30 or fewer patents	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under		assurance program will be into place? POC QAPI Tool (atta C) completed by the Maint Director, or designee, will be utilized weekly x 4 weeks, monthly x 6 months, and of thereafter for one year to e all battery-operated smoked detectors are within the manufacturer guidelines, we results reported to the Quarance and Performan Improvement Committee oby the Executive Director If a threshold of 100% achieved, an action plan we developed to ensure compact Total compliance date; 12/	achment tenance be quarterly ensure e with ality ce overseen % is not vill be oliance

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Event ID:

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Facility ID: 000087

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CENTEMENT OF DEFICIENCIES VIA PROVIDER (CLIDALIER (CLIDALIER)			770)) (777 mm) = -	ON COMPLICATION I	OVIB NO. 0936-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155171	B. WING		11/16/2023	
NAME OF F	PROVIDER OR SUPPLIER)	STREET	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	NOVIDER OR SUPPLIER	X.	1285 V	V JEFFERSON ST		
FRANKL	IN MEADOWS		FRANK	KLIN, 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 DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Cooking facilities	protected according to				
	NFPA 96 per 9.2.3	3 are not required to be				
	enclosed as haza	rdous areas, but shall not				
	be open to the cor	rridor.				
	18.3.2.5.1 through	n 18.3.2.5.4, 19.3.2.5.1				
	through 19.3.2.5.5	5, 9.2.3, TIA 12-2				
	Based on observation	on and interview, the facility	K 0324	Please find enclosed the Plan	of 12/15/2023	
		f 1 kitchen range hood		Correction to the annual surve	∍y,	
		ms was maintained in proper		Survey Event ID J71R21, that	was	
		PA 96, 2011 edition, Section		conducted on November 16th	,	
	10.1.2 requires cool	king equipment that produces		2023, resulting in three citatio	ns	
	grease-laden vapors	s and that might be a source of		K-300, K-324, and K-353. This	s	
	ignition of grease ir	the hood, grease removal		letter is to inform you that the	plan	
	device, or duct shal	l be protected by		of correction attached is to se	rve	
	fire-extinguishing e	equipment. Section 11.1.6 states		as Franklin Meadow's credible	e	
	cooking equipment	shall not be operated while its		allegation of compliance. We		
	fire-extinguishing s	ystem or exhaust system is		allege compliance on		
	nonoperational or in	mpaired. This deficient		12/15/2023.		
	practice over two k	itchen staff.		Submission of this plan of		
				correction does not constitute	an	
	Findings include:			admission by Franklin Meado	ws	
				or its management company t	hat	
		ons with the Executive		the allegations contained in th	e	
	Director, the Mainte	enance Director and the Field		survey report are a true and		
	_	visor during a tour of the		accurate portrayal of nursing		
		a.m. to 12:50 p.m. on 11/16/23,		and other services in this facil	ity.	
		range hood extinguishing		Nor does this provision consti	tute	
		e not properly positioned over		an agreement or admission of	the	
		nent under the hood. All four		survey allegations.		
		ishing system nozzles were		We cordially ask for a desk re	view	
	1 -	he range hood baffles under		of these alleged deficient		
	_	pinted downward over the		practices.		
	_	nge and griddle below the		K-324 Cooking Facilities¿		
		interview at the time of the		What corrective action(s) will	II	
		faintenance Director stated the		be accomplished for those		
		on contractor must have		residents found to have been	n	
	1 -	zzles during their most recent		affected by the deficient		
	_	ion and agreed the nozzles		practice?		
	_	ownward over the cooking		Facility failed to ensure	1 of	
	equipment below as	nd had facility staff reposition		1 kitchen range hood		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		F CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIE	R	1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF DEPUTE VING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	the nozzles during These findings we Director, the Main	the survey. The reviewed with the Executive tenance Director and the Field tryisor during the exit	TAG	extinguishing systems were maintained in proper working order. How will you identify other residents having the potentito be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficiency. In-service (attachment E will be completed by ED/design to the environmental department regarding the kitchen hood nozzles being in the proper orientation for fire protection services. The 1 of 1 kitchen Ansul Nozzles were immediately adjusted and set back into the proper position of orientation of 11/16/23. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? POC QAPI tool (attachment E) will be utilized to ensure prorientation of the Ansul kitchen nozzles. TELS task for Ansul Hoosystems "Owners inspection" in place monthly to ensure Nozzles are in proper orientation of the Ansule will during the audit/TELS task will during the audit/TELS task will work will be utilized to ensure that the deficient protein of the Ansule kitchen to proper orientation or the Ansule kitchen to proper orientati	on onent oper n od put ion.	

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	T OF HEALTH AND HUR MEDICARE & MEDICARE					RM APPROVED
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIE	R	1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PREFIX (EACH CORRECTION OF CORRECTION OF CORRECTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION OF		(X5) COMPLETION DATE	
				addressed immediately by ED/designee How the corrective action (s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? POC QAPI Tool (attach E) completed by the Maintena Director, or designee, will be utilized weekly x 4 weeks, monthly x 6 months, and qual thereafter for one year to ensull Ansul chemical nozzles are proper orientation, with result reported to the Quality Assura and Performance Improveme Committee overseen by the Executive Director If a threshold of 100% is achieved, an action plan will be developed to ensure compliant Total compliance date; 12/15/2005.	ment ance rterly ure e in s ance nt	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkl are inspected, te	- Maintenance and Testing - Maintenance and Testing ler and standpipe systems sted, and maintained in NFPA 25, Standard for the				

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Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked

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Facility ID: 000087

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155171	B. WING 11/16/2023			/2023	
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
EDANIZI					/ JEFFERSON ST		
FRANKL	IN MEADOWS			FRANK	LIN, IN 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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	b) Who provided	system test					
	, .	•					
	c) Water system	supply source					
	Dravida in DEMAI	DIC information on					
		RKS information on					
		non-required or partial					
	automatic sprinkle	-					
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25 on and interview, the facility	17.0	252	Please find enclosed the Plan	of	12/15/2022
			K 0	333			12/15/2023
		he ceiling construction in 11 of g rooms. NFPA 13, 2010			Correction to the annual surve	-	
					Survey Event ID J71R21, that		
		.5.4 defines a smooth ceiling as			conducted on November 16th		
	1	g free from significant			2023, resulting in three citation		
		s, or indentations. The ceiling			K-300, K-324, and K-353. This		
		ses around the sprinkler and			letter is to inform you that the		
	_	to operate at a specified			of correction attached is to ser		
	_	on 8.5.4.1.1 states the distance			as Franklin Meadow's credible	;	
		er deflector and the ceiling			allegation of compliance. We		
		eted based on the type of			allege compliance on		
		pe of construction. This			12/15/2023.		
	_	ould affect all residents, staff,			Submission of this plan of		
	and visitors.				correction does not constitute		
					admission by Franklin Meadov		
	Findings include:				or its management company t		
					the allegations contained in th	е	
		ons with the Executive			survey report are a true and		
		enance Director and the Field			accurate portrayal of nursing of		
	_	visor during a tour of the			and other services in this facili	-	
	1	a.m. to 12:50 p.m. on 11/16/23, a			Nor does this provision constit		
		ne ceiling of resident sleeping			an agreement or admission of	the	
		1, 142, 143, 149, 152, 153, 156, 157			survey allegations.		
		covered over with an open			We cordially ask for a desk re	view	
	_	nole exposed the interstitial			of these alleged deficient		
		wall ceiling for the room or			practices.		
		vith cardboard. Based on					
	interview at the tim	e of the observations, the			K-353 Sprinkler System-		
		tor and the Field Maintenance			Maintenance and Testing¿		
	Supervisor agreed t	he holes in the ceiling of each			What corrective action(s) wil	I	
		ent sleeping rooms did not			be accomplished for those		
	maintain the ceiling	g construction in the room and			residents found to have beer	า	

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155171	B. WING		11/16/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIEF	₹	1285 V	V JEFFERSON ST	
FRANKLIN MEADOWS		FRAN	KLIN, IN 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 APPROPRIATION OF THE APPROPRIATION	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	could delay activati	ion of the sprinklers in the		affected by the deficient	
	rooms.			practice?	
				Facility failed to maintain	
	1	e reviewed with the Executive		the ceiling construction in 11 o	of 58
	•	enance Director and the Field		resident sleeping rooms.	
	_	visor during the exit		How will you identify other	
	conference.			residents having the potentia	al
	2.1.10(1)			to be affected by the same	
	3.1-19(b)			deficient practice and what	
				corrective action will be	
				taken?	
				All residents have the	
				potential to be affected by the	
				alleged deficiency.	
				Total facility audit	
				(attachment F) of all resident	
				sleeping rooms completed by	nno.
				Maintenance Director, or design to ensure no other cardboard	Juee
				coverings are being used.	
				Completed on 11/17/23.	
				In-service (attachment G	:)
				will be completed by ED/desig	*
				to the environmental department	
				regarding the ceiling grates no	
				being blocked by cardboard	•
				sections.	
				The 11 of 58 resident	
				sleeping rooms that were affect	cted
				by these cardboard coverings	
				been removed as of 11/16/23.	
				What measures will be put in	ato.
				place or what systemic	
				changes you will make to	
				ensure that the deficient	
				practice does not recur?	
	I		I	P. 301100 4000 HOL 1004H	1

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Event ID:

J71R21

Facility ID: 000087

If continuation sheet

POC QAPI tool (attachment

Maintenance Director, or designee

H) will be utilized by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155171	B. WING			11/16/2023	
			<u> </u>		_		
NAME OF F	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP COD		
				JEFFERSON ST			
FRANKLIN MEADOWS			FRANK	LIN, IN 46131			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					to ensure no other cardboard		
					coverings are being used		
					throughout the facility moving		
					forward in resident sleeping		
					rooms.		
					Any deficiencies identifie	ed	
					during the audit/TELS task will	l be	
					addressed immediately by the	ED	
					How the corrective action (s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					POC QAPI Tool (attachn	nent	
					H) completed by the Maintena	nce	
					Director, or designee, will be		
					utilized weekly x 4 weeks,		
					monthly x 6 months, and quart	-	
					thereafter for one year to ensu	ıre	
					all resident sleeping rooms ha	ve	
					no cardboard coverings put in		
					place into the ceiling spaces, v	with	
					results reported to the Quality		
					Assurance and Performance		
					Improvement Committee overs	seen	
					by the Executive Director		
					If a threshold of 100% is		
					achieved, an action plan will b		
					developed to ensure complian	ce	
					Total compliance date; 12/15/2	2023	

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