STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155171	A. BUILDING -- B. WING	11/16/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/16/23 Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890 At this Emergency Preparedness survey, Franklin Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 81. Quality Review completed on 11/20/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/23 Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890 At this Life Safety Code Survey, Franklin Meadows was found not in compliance with	K 0000	Please find enclosed the Plan of Correction to the annual survey, Survey Event ID J71R21, that was conducted on November 16th, 2023, resulting in three citations K-300, K-324, and K-353. 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 12/15/2023. Submission of this plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Kennedy	Executive Director	12/07/2023

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	155171	A. BUILDING 01 B. WING	11/16/2023

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke detectors are installed in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 81 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached wooden sheds providing facility storage. Quality Review completed on 11/20/23		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 of these alleged deficient practices.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 replace battery operated smoke alarms installed in 1 of 58 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke	K 0300	Please find enclosed the Plan of Correction to the annual survey, Survey Event ID J71R21, that was conducted on November 16th, 2023, resulting in three citations K-300, K-324, and K-353. This letter is to inform you that the plan	12/15/2023

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	alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 30 residents, staff and visitors in the vicinity of resident sleeping Room 124. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:50 p.m. on 11/16/23, manufacturer's documentation affixed to the First Alert Model SA 340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 124 indicated the smoke alarm was manufactured 08/17/11. Based on interview at the time of the observations, the Maintenance Director stated each resident sleeping room has a battery operated smoke alarm installed in the room, all battery operated smoke alarms in the facility were replaced within the most recent twelve month period but the battery operated smoke alarm replacement for Room 124 must have been missed and agreed the resident sleeping room battery operated smoke alarm installed in Room 124 was more than ten years old. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		of correction attached is to serve as Franklin Meadow's credible allegation of compliance. We allege compliance on 12/15/2023. 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 of these alleged deficient practices. K-300 Protection- Other¿ **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility failed to replace battery-operated smoke alarms in 1 of 58 resident sleeping rooms. **How will you identify other residents having the potential to 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. Entire building audit (attachment A) will be completed	

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			to ensure that no other expired battery-powered smoke detectors are still in service by the Maintenance Director, or designee. In-service (attachment B) will be completed by ED/designee to the environmental department regarding the importance of proper non-expired smoke detectors being used moving forward. The X1 smoke detector that was not within compliance was replaced immediately on 11/16/23 with a brand-new battery smoke detector within manufacturer guidelines. **What measures will be put into 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, or designee, to be utilized to ensure all battery-powered smoke detectors are of the correct type and within the manufacturer's recommendation for the detector's life expectancy of the unit moving forward. Any deficiencies identified during the audit will be addressed immediately by ED/designee **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place? POC QAPI Tool (attachment C) completed by the Maintenance Director, or designee, will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year to ensure all battery-operated smoke detectors are within the manufacturer guidelines, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance Total compliance date; 12/15/2023	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.			

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	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice over two kitchen staff. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:50 p.m. on 11/16/23, four of four kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood. All four range hood extinguishing system nozzles were pointed directly at the range hood baffles under the hood and not pointed downward over the natural gas fired range and griddle below the nozzles. Based on interview at the time of the observations, the Maintenance Director stated the range hood inspection contractor must have repositioned the nozzles during their most recent semiannual inspection and agreed the nozzles were not pointed downward over the cooking equipment below and had facility staff reposition	K 0324	Please find enclosed the Plan of Correction to the annual survey, Survey Event ID J71R21, that was conducted on November 16th, 2023, resulting in three citations K-300, K-324, and K-353. 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 12/15/2023. 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 of these alleged deficient practices. K-324 Cooking Facilities¿ **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility failed to ensure 1 of 1 kitchen range hood	12/15/2023

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	the nozzles during the survey. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		extinguishing systems were maintained in proper working order. **How will you identify other residents having the potential to 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 D) will be completed by ED/designee 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 on 11/16/23. **What measures will be put into 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 proper orientation of the Ansul kitchen nozzles. TELS task for Ansul Hood systems “Owners inspection” put in place monthly to ensure Nozzles are in proper orientation. Any deficiencies identified during the audit/TELS task will be	

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			addressed immediately by ED/designee **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?** POC QAPI Tool (attachment E) completed by the Maintenance Director, or designee, will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year to ensure all Ansul chemical nozzles are in proper orientation, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance Total compliance date; 12/15/2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the 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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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 11 of 58 resident sleeping rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 11:30 a.m. to 12:50 p.m. on 11/16/23, a hole was noted in the ceiling of resident sleeping Room 106, 110, 121, 142, 143, 149, 152, 153, 156, 157 and 160 which was covered over with an open metal grate. Each hole exposed the interstitial space above the drywall ceiling for the room or was covered over with cardboard. Based on interview at the time of the observations, the Maintenance Director and the Field Maintenance Supervisor agreed the holes in the ceiling of each of the eleven resident sleeping rooms did not maintain the ceiling construction in the room and	K 0353	Please find enclosed the Plan of Correction to the annual survey, Survey Event ID J71R21, that was conducted on November 16th, 2023, resulting in three citations K-300, K-324, and K-353. 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 12/15/2023. 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 of these alleged deficient practices. K-353 Sprinkler System-Maintenance and Testing¿ **What corrective action(s) will be accomplished for those residents found to have been**	12/15/2023

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	could delay activation of the sprinklers in the rooms. These findings were reviewed with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**affected by the deficient practice?** Facility failed to maintain the ceiling construction in 11 of 58 resident sleeping rooms. **How will you identify other residents having the potential to 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. Total facility audit (attachment F) of all resident sleeping rooms completed by Maintenance Director, or designee to ensure no other cardboard coverings are being used. Completed on 11/17/23. In-service (attachment G) will be completed by ED/designee to the environmental department regarding the ceiling grates not being blocked by cardboard sections. The 11 of 58 resident sleeping rooms that were affected by these cardboard coverings have been removed as of 11/16/23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** POC QAPI tool (attachment H) will be utilized by the Maintenance Director, or designee	

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			to ensure no other cardboard coverings are being used throughout the facility moving forward in resident sleeping rooms. Any deficiencies identified during the audit/TELS task will be addressed immediately by the ED **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?** POC QAPI Tool (attachment H) completed by the Maintenance Director, or designee, will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year to ensure all resident sleeping rooms have no cardboard coverings put in place into the ceiling spaces, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance Total compliance date; 12/15/2023	