CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/05/2023	
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS		1285	T ADDRESS, CITY, STATE, ZIP COD W JEFFERSON ST IKLIN, 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)	(X5) COMPLETION DATE	
E 0000  Bldg	conducted by the Ir accordance with 42  Survey Date: 01/03  Facility Number: 0  Provider Number: 100  At this Emergency Meadows was foun Emergency Prepare Medicare and Mediand Suppliers, 42 0  The facility has 114 the survey, the cens	5/23  000087 155171 289890  Preparedness survey, Franklin d in compliance with edness Requirements for icaid Participating Providers CFR 483.73.  4 certified beds. At the time of	E 0000	This plan of correction is to serve as Franklin Meadows credible allegation of compliance. Submission of this plan of correction does not constitu an admission by Franklin Meadows or its management company that the allegation contained in the survey report are a true and accurate portrayal of the provision of nursing care and other servin this facility. Nor does this submission constitute an agreement or admission of the survey allegations.  We would like to respectful request paper compliance for Franklin Meadows Life Safet Code Recertification and Emergency Preparedness Survey.	t s ort ices ices s che	
Bldg. 01	Licensure Survey v	000087	K 0000	This plan of correction is to serve as Franklin Meadows credible allegation of compliance. Submission of this plan of correction does not constituan admission by Franklin Meadows or its management company that the allegation	t	

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

(X6) DATE

TITLE

Jason Kennedy 01/20/2023

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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 01/05/2023
		1285 W	/ JEFFERSON ST	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
AIM Number: 1002 At this Life Safety O Meadows was found Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one story facilit Type V (000) constr The facility has a fin detection in the corr the corridor. Batter are installed in all re facility has a capaci 80 at the time of this All areas where resi were sprinklered. A services were sprink wooden sheds provi	Code Survey, Franklin d not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. At was determined to be of ruction and is fully sprinklered. The alarm system with smoke ctidors and in all areas open to y operated smoke detectors esident sleeping rooms. The try of 114 and had a census of s visit.  In the system with smoke ctidors are alarm system with smoke ctidors and in all areas open to have greated smoke detectors esident sleeping rooms. The try of 114 and had a census of s visit.  In the system with smoke ctidors are alarm system with smoke ctidors are alarm system with smoke ctidors and in all areas open to have detectors esident sleeping rooms. The try of 114 and had a census of s visit.	TAG	contained in the survey repo are a true and accurate portrayal of the provision of nursing care and other servi in this facility. Nor does this submission constitute an agreement or admission of t survey allegations.  We would like to respectfull request paper compliance for	ces he
Means of Egress - Means of Egress - Aisles, passagewa discharges, exit lo in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility	K 0211	K211 Means of Egress	02/03/2023
	SUMMARY SUMMARY SEACH DEFICIENT REGULATORY OR AIM Number: 1002.  At this Life Safety Company Meadows was found Requirements for Parameter Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code (Life Safety Code) Company This one story facility Protect Life Safety Code (Life Safety Code) Company This one story facility Protect Life Safety Code (Life Safety Code) Company	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  AIM Number: 100289890  At this Life Safety Code Survey, Franklin Meadows was found not in compliance with 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 80 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 01/09/23  NFPA 101  Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility	PROVIDER OR SUPPLIER  IN MEADOWS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  AIM Number: 100289890  At this Life Safety Code Survey, Franklin Meadows was found not in compliance with 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 80 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 01/09/23  NFPA 101  Means of Egress - General Alsles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.1, 7.1.10.1	STREET ADDRESS, CITY, STATE, ZIP COD 1285 W JEFFERSON ST FRANKLIN, IN 46131  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  AIM Number: 100289890  At this Life Safety Code Survey, Franklin Meadows was found not in compliance with Requirements for Participation in Meadows was found not in compliance with 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 80 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 01/09/23  NFPA 101  Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.1.0.1  Based on observation and interview, the facility

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155171	B. W	ING		01/05/2023	
			-	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS			1285 W	/ JEFFERSON ST			
			FRANK	KLIN, IN 46131			
(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' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tained free of all obstructions			I. The conference cha		
	_	full instant use in the case of			was immediately moved to ab	stain	
	_	ency. This deficient practice			from obstructing the path of		
		0 residents, staff and visitors if			egress.		
	needing to exit the	facility.					
					II. Residents and staff		
	Findings include:				have the potential to be affected	ed	
					by the alleged deficient practic	e. A	
		ons with the Executive			walkthrough was done through	nout	
	Director, the Maint	tenance Director and the Field			the building to ensure that all		
	_	rvisor during a tour of the			egresses were unobstructed, a	any	
	facility from 12:20	p.m. to 1:45 p.m. on 01/05/23, the			discrepancies were corrected		
	exit door for the so	uth hall was marked as a facility			immediately.		
	exit with an exit sig	gn. The south hall exit					
	discharges into a ve	estibule which was being used			III. Education will be		
	as a conference roo	om which had an exit door to			provided to all staff regarding	all	
	the outside of the fa	acility which was a delayed			egresses being continuously		
	egress door equippe	ed with the necessary signage.			maintained free of all obstructi	ons	
		chair was placed directly in			or impediments to full instant เ	ıse	
	the path of egress to	o the delayed egress door			in case of emergency.		
		re this means of egress was					
	continually maintai	ined free of all obstructions or			IV. The Maintenance		
	impediments to ful	l instant use in the case of fire			Director/Designee will provide		
	or other emergency	7. Based on interview at the			walking round audits on the		
	time of the observa	tions, the Maintenance			building to ensure all egresses	are	
	_	aforementioned means of			unobstructed, if any objects ar	e	
	egress was not con	tinually maintained free of all			found they will be moved		
	obstructions or imp	pediments to full instant use in			immediately. This audit will		
	the case of fire or o	other emergency and moved the			happen daily for four weeks; the	nen,	
	chair out of the pat	h of egress.			weekly thereafter totaling 12		
					months.		
	This finding was re	eviewed with the Executive					
	Director, the Maint	tenance Director and the Field			Results of these audits will b	е	
	Maintenance Super	rvisor during the exit			reviewed at the monthly facil	ity	
	conference.				Quality Assurance Committe	-	
					meeting and frequency and		
	3.1-19(b)				duration of reviews will be		
	` ′				adjusted as needed		

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V. Plan of Correction

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EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X1) PROVIDER/SUPPLIER/CLIA X1) PROVIDER/SUPPLIER/CLIA X1) PROVIDER/SUPPLIER/CLIA X1) PROVIDER X		A. BUILDING B. WING STREE 1285	CONSTRUCTION 01  T ADDRESS, CITY, STATE, ZIP COD W JEFFERSON ST	(X3) DATE SURVEY COMPLETED 01/05/2023	
FRANKL	IN MEADOWS		FRAN	NKLIN, IN 46131	1
(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)	(X5) COMPLETION DATE
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Aisle, Corridor or 2012 EXISTING The width of aisle unobstructed) ser at least 4 feet and convenient remove on stretchers, exc 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on observatificated to meet the corridors or met an 19.2.3.4(5) states we least 8 feet, project shall be permitted full of the following (a) the fixed furnity floor or to the wall. (b) the fixed furnity unobstructed corriders as permitted (c) the fixed furnity of the corridor.	Ramp Width Ramp Width s or corridors (clear or ving as exit access shall be I maintained to provide the ral of nonambulatory patients rept as modified by rans 1-5.  The nand interview, the facility clear width requirement for 2 of 7 exception per 19.2.3.4(5). LSC refere the corridor width is at the same time into the required width for fixed furniture, provided that conditions are met:  The irre is securely attached to the clear or width to less than six feet,	K 0232	Completion date.  Date of Compliance: 02/03/20 The Administrator will be responsible for ensuring the fis in compliance by date of compliance listed.  K-232 I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation 1- The communit failed to meet the clear width requirement for 2 of 7 corridor The Maintenance Supervisor removed two wooden chairs fithe corridors that were creating obstructions.	02/03/2023  be  n  ty  rs.
	grouping does not of square feet.  (e) the fixed furnitum.	exceed exceed an area of 50  are groupings addressed in eparated from each other by a		II. The facility will identify other residents that may potentially be affected by the deficient practice.	е

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		A. BUILDING <u>01</u> COMPLE		(X3) DATE SURVEY COMPLETED 01/05/2023	
	PROVIDER OR SUPPLIER		1285	r address, city, state, zip cod W JEFFERSON ST KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	obstruct access to b protection equipme (g) corridors throug are protected by an automatic smoke de	hout the smoke compartment electrically supervised stection system in accordance		Resident and Staff in the community could be affected this deficiency.	d by
	arranged and locate by the facility staff space. (h) the smoke comp throughout by an ap	ixed furniture spaces are d to allow direct supervision from a nurse's station or similar partment is protected oproved, supervised automatic		III. The facility will put into place the following system changes to ensure that the deficient practice does not recur.	atic
	This deficient pract	accordance with 19.3.5.8 ice could affect over 20 visitors if needing to exit the		Staff Development Coordina educate all staff on the impo of not obstructing corridors. TELS task was created for Maintenance Supervisor to rhallways weekly for obstruct	rtance New monitor
	Director, the Mainte Maintenance Super facility from 12:20 wooden chair was s Room 113 in the A Room 153 in the D feet into the eight for chairs were not affi. Based on interview observations, the M furniture was stored affixed to the floor This finding was re	aintenance Director agreed I in the corridor at the I locations which was not		IV The facility will monito the corrective action by implementing the following measures.  Maintenance Supervisor, or designee, will monitor and in all corridors during annual Completion date.  V. Plan of Correction completion date is 2/3/2023.	<b>J</b> espect
	· ·	visor during the exit			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155171	B. WI	NG		01/05/2023	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ED ANIZI I	N MEADOWS				/ JEFFERSON ST		
FRANKLI	IN IVIEADOWS			FRAINN	(LIN, IN 46131		
(X4) ID	SUMMARY S	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 APPROPRIAT DEFICIENCY)		(EACH CORRECTIVE ACTION CHOLLED BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				DATE	
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
9 -	_	RKS section any LSC					
	Section 18.3 and 1	-					
		are not addressed by the					
		out are deficient. This					
		with the applicable Life					
		FPA standard citation,					
	•	d on Form CMS-2567.					
	1. Based on observa	ation and interview, the facility	K 0	300	K-300		02/03/2023
	failed to replace bat	tery operated smoke alarms					
	installed in 3 of 4 H	alls housing resident sleeping			I. The corrective actions to b	Эе	
	rooms in accordance	e with NFPA 72. NFPA 72,			accomplished for those		
	2010 Edition, Section	on 14.4.8.1 states unless			residents found to have beer	1	
	otherwise recommen	nded by the manufacturer's			affected by the deficient		
	published instruction	ns, single- and			practice.		
	multiple-station smo	oke alarms shall be replaced					
	•	spond to operability tests but			Observation 1- The facility faile	ed to	
	shall not remain in s	service longer than 10 years			replace battery operated smok	«е	
		nufacture. This deficient			alarms in 3 of 4 halls housing		
	-	t all residents, staff and			resident sleeping rooms in		
	visitors.				accordance with NFPA 72. Th		
					Maintenance Supervisor repla	ced	
	Findings include:				all smoke detectors on affecte	d	
					halls.		
		ons with the Executive					
		enance Director and the Field			II. The facility will identify		
		visor during a tour of the			other residents that may		
		p.m. to 1:45 p.m. on 01/05/23,			potentially be affected by the	<b>;</b>	
		imentation affixed to the First			deficient practice.		
		) battery operated smoke alarm			Desident and Ot #1. II		
		ing in resident sleeping Room			Resident and Staff in the		
		dicated the smoke alarm was //11. An installation date of			community could be affected by	уy	
		n on the back of the smoke			this deficiency.		
		pe of smoke detector was					
		ent sleeping rooms in the A, B			III. The facility will put into		
		on interview at the time of the			place the following systemat	ic	
		aintenance Director and the				10	
	oosei valions, the M	annenance Director and the	1		changes to ensure that the		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPLETED	
		155171	B. WI	NG		01/05/	2023
		<u> </u>	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			JEFFERSON ST		
FRANKI	IN MEADOWS				LIN, IN 46131		
110000	III WE RECOVE			110 000		1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Supervisor stated each			deficient practice does not		
		oom in the A, B and C Halls has			recur.		
		ttery operated smoke alarm			l		
		n and agreed resident sleeping			TELS task was created for		
		ted smoke alarms installed in 3			Maintenance Supervisor to ins	spect	
		resident sleeping rooms in			smoke alarms monthly.		
	facility were more	than ten years old.			N/ The facility will manufact		
	This finding was ro	viewed with the Evecutive			IV The facility will monitor		
	1	viewed with the Executive enance Director and the Field			the corrective action by		
	· ·	visor during the exit			implementing the following measures.		
	conference.	visor during the exit			measures.		
	conference.				Maintenance Supervisor, or		
	3.1-19(b)				designee, will monitor and ins	nect	
	3.1 17(0)				all battery-operated smoke ala		
	2. Based on record	review, observation and			during annual CQR.	211110	
	interview; the facili				adining dimiddi e qi ti		
		the preventative maintenance			V. Plan of Correction		
		ted smoke alarms in resident		completion date.			
		e. NFPA 101 in 4.6.12.3 states					
	_	features obvious to the public,			Plan of Completion date is		
	if not required by the	ne Code, shall be maintained.			2/3/2023		
	NFPA 72, National	Fire Alarm and Signaling Code,					
	2010 Edition, 29.10	) Maintenance and Tests states					
		ment shall be maintained and					
	tested in accordance	e with the manufacturer's					
	*	ons and per the requirements					
	_	PA 72, 14.2.1.1.1 Inspection,					
	_	nance programs shall satisfy					
	•	this Code and conform to the					
		cturer's published instructions.					
		ice could affect all residents,					
	staff, and visitors.						
	Findings include:						
	Based on review of	Direct Supply TELS Logbook					
		h the Executive Director, the					
	Maintenance Direct	tor and the Field Maintenance					
	Supervisor during r	record review from 9:00 a.m. to					

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

PRINTED: 01/25/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155171		A. BUILDING B. WING	01	COMPLI 01/05/2	ETED	
	ROVIDER OR SUPPLIER		1285 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST ILIN, IN 46131		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	NATE	DATE
	12:20 p.m. on 01/05	5/23, battery operated smoke				
	detector cleaning do	ocumentation for the most				
		n period was not available for				
		nterview at the time of record				
		ance Director stated the				
	_	attery operated smoke				
	_	h monthly test but agreed an				
		battery operated smoke				
		thin the most recent twelve				
	_	ot available for review. Based				
		h the Executive Director, the or and the Field Maintenance				
		tour of the facility from 12:20 n 01/05/23, manufacturer's				
		ted to the First Alert Model SA				
		d smoke alarm installed on the				
		leeping Room 102 in the A Hall				
		nit monthly. Based on				
		e of the observations, the				
		or and the Field Maintenance				
		ch resident sleeping room in				
	-	s has the same type of battery				
		rm installed in the room.				
	-	imentation affixed to the				
	Kidde Model i9010	battery operated smoke alarm				
	installed on the ceili	ing in resident sleeping Room				
	150 in the D Hall sta	ated to clean the unit annually.				
	This finding was rev	viewed with the Executive				
	_	enance Director and the Field				
	Maintenance Superv					
	conference.	8				
	3.1-19(b)					
K 0321	NFPA 101					
SS=E	Hazardous Areas					
Bldg. 01	Hazardous Areas					
		are protected by a fire				
	barrier having 1-ho	our fire resistance rating				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155171	B. WI	NG		01/05/	/2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			JEFFERSON ST		
EDVVIKI	IN MEADOWS				LIN, IN 46131		
FIVAININL	IN MEADOWS			FIVAINI	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(with 3/4 hour fire	rated doors) or an					
	automatic fire exti	nguishing system in					
	accordance with 8	3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
		e areas shall be separated					
	•	s by smoke resisting					
	•	ors in accordance with 8.4.					
	Doors shall be sel						
	_	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.						
		and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	A == =	Automotic Comindes					
	Area Separation	Automatic Sprinkler					
	·	-Fired Heater Rooms					
		er than 100 square feet)					
		nance, and Paint Shops					
	•	nance, and raint Shops coms (exceeding 64					
	gallons)	Joins (exceeding 04					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal						
	, -	orage Rooms/Spaces					
	(over 50 square fe						
		classified as Severe					
	Hazard - see K32						
		on and interview, the facility	K 03	321	K-321		02/03/2023
		f over 9 hazardous areas such	11 0.	,21			02/03/2023
	as combustible stor	age areas (over 50 square feet			I. The corrective actions to b	е	
		ated from other spaces by			accomplished for those		
	· •	titions and doors. Doors shall			residents found to have beer	1	
		atomatic closing in accordance			affected by the deficient		
		deficient practice could affect			practice.		
	over 20 residents, s	taff and visitors in the vicinity					
	of the Nursing Supp	ply Room by the corridor door			Observation 1- The facility faile	ed to	
	set to the A Hall.				ensure 1 of over 9 hazardous		

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/05/2023 155171 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST FRANKLIN MEADOWS FRANKLIN, IN 46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE areas such as combustible Findings include: storage areas were separated from other spaces by smoke resistant Based on observations with the Executive partitions and doors. Doors shall Director, the Maintenance Director and the Field be self-closing or automatic Maintenance Supervisor during a tour of the closing in accordance with facility from 12:20 p.m. to 1:45 p.m. on 01/05/23, the 7.2.1.8. Maintenance Supervisor latching plate on the door frame for the corridor replaced latching plate on door to the Nursing Supply Room by the corridor hazardous area that would not door set to the A Hall was missing which caused a close properly. one inch gap in between the face of the door and the door stop on the handle side of the door when II. The facility will identify the door was in the fully closed and latched other residents that may position. The gap would not resist the passage of potentially be affected by the smoke. The Nursing Supply Room was greater deficient practice. than 50 square feet in size and was used as a storage room for combustible boxes and supplies. Resident and Staff in the Based on interview at the time of the community could be affected by observations, the Maintenance Director agreed this deficiency. the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. III. The facility will put into place the following systematic This finding was reviewed with the Executive changes to ensure that the Director, the Maintenance Director and the Field deficient practice does not Maintenance Supervisor during the exit recur. conference. SDC to educate staff on the 3.1-19(b) importance of notifying maintenance if doors are not latching. Monthly TELS task was created for Maintenance Supervisor to ensure doors to hazardous areas close properly. IV The facility will monitor the corrective action by implementing the following

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measures.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  01/05/2023	
	PROVIDER OR SUPPLIE	R	<u> </u>	1285 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON ST (LIN, IN 46131	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
					Maintenance Supervisor, or designee, will monitor and ins all doors to hazardous areas during annual CQR. Door Inspection QI tool will be completed weekly for 6 weeks then monthly for a total of 12 months.  V. Plan of Correction completion date.  Plan of Completion date is 2/3/2023.		
K 0331 SS=F Bldg. 01	exposed interior s as fixed or moval columns, and hav Class A or Class	Ceiling Finish ceiling finishes, including surfaces of buildings such ole walls, partitions, we a flame spread rating of B. The reduction in class of a sprinkler system as 2.8.1 is permitted.					
	interview; the facil corridors and 2 of 2 with a complete in rating of Class A of facility. LSC 10.2 be tested in accord Standard Test Meth Characteristics of I 723, Standard for 7	view, observation and ity failed to ensure 1 of 6 2 dining rooms were provided terior finish with a flame spread r Class B for a sprinklered 3.4 states products required to ance with ASTM E 84, hod for Surface Burning Building Materials or ANSI/UL Test for Surface Burning Building Materials shall be	K 0	331	K331 Interior Wall and Ceilin Finish  I. The facility has failed to ensure 1 of 6 corridors and 2 dining rooms were provided a complete interior finish with flame spread rating a minimum Class B. The maintenance supervisor contacted Underwood Construction to get the laminal	ed 2 of with a m of	02/03/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		A. BUILDING <u>01</u> COMPLETED		(X3) DATE SURVEY COMPLETED 01/05/2023	
	PROVIDER 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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	grouped in the followith their flame spr (a) Class A Interior spread 0-25; smoke any material classif spread test scale and scale. Any element not continue to property (b) Class B Interior spread 26-75; smoke any material classif more than 75 on the 450 or less on the second for the spread 76-200; smowed any material classif more than 2 scale and 450 or less This deficient pract staff and visitors.  Findings include:  Based on record reversity by the Maintenance Superplant on 01/05/23, flocumentation for infacility was not available.	wing classes in accordance ead and smoke development.  Wall and Ceiling Finish. Flame development 0-450. Includes ited at 25 or less on the flame d 450 or less on the smoke test thereof, when so tested, shall pagate fire.  Wall and Ceiling Finish. Flame e development 0-450. Includes ited at more than 25 but not e flame spread test scale and moke test scale.  Wall and Ceiling Finish. Flame ke development 0-450. al classified at more than 75 00 on the flame spread test so on the smoke test scale. itee could affect all residents,	TAG	finishes removed. Underwood Construction will be back 1/2 to complete.  II. Residents and staff have the potential to be affect by the alleged deficient practical All corridors and dining rooms were inspected to ensure confire rating was provided and documented.  III. Educated was provided and documented.  III. Educated was provided and documented.  IV. The maintenance department regarding proper flame spread rating.  IV. The maintenance director/designee will ensure corridor and dining room is an during the annual review.  Results of these audits will reviewed at the monthly fact Quality Assurance Committed meeting and frequency and duration of reviews will be adjusted as needed  V. Plan of Correction completion date.	d DATE d 7/23 eted ce. s rect ided nt d d each udited be
	Supervisor during a p.m. to 1:45 p.m. or	tour of the facility from 12:20 n 01/05/23, a laminate finish was fall corridor walls below the		Date of Compliance: 02/03/20	023
	handrails. Wood w C Hall dining room the dining room. To open to the corridor was installed below	as also affixed to a wall of the to create a large sign board in the C Hall dining room was.  In addition, a laminate finish the wall trim on all walls of the The main dining room was also		The Administrator will be responsible for ensuring the f is in compliance by date of compliance listed.	acility

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

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155171  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  155171		(X2) MULTII A. BUILDII B. WING		nstruction 01	(X3) DATE SURVEY COMPLETED 01/05/2023				
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 1285 W JEFFERSON ST FRANKLIN, IN 46131						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	time of the observat Supervisor stated fladocumentation for t wood sign board in not available for rev was not treated with stated the laminate is removed from the w These findings were Director, the Mainte	he laminate interior finish and the C Hall dining room was view, the laminate wall finish in flame retardant material and interior finish was due to be							
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system  Provide in REMAR	supply source  RKS information on non-required or partial er system.							
	Based on record rev	riew, observation and ty failed to maintain automatic	K 0353		K-353		02/03/2023		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/05/2023 155171 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST FRANKLIN MEADOWS FRANKLIN, IN 46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE sprinkler systems in accordance with NFPA 25. I. The corrective actions to be LSC 9.7.5 requires all sprinkler systems shall be accomplished for those inspected, tested, and maintained in accordance residents found to have been with NFPA 25, Standard for the Inspection, affected by the deficient Testing, and Maintenance of Water-Based Fire practice. Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or Observation 1- The facility failed to designated representative shall correct or repair maintain automatic sprinkler deficiencies or impairments that are found during systems in accordance with the inspection, test and maintenance required by NFPA 25. A contractor has made this standard. Corrections and repairs shall be all required repairs from the performed by qualified maintenance personnel or previous "Form for Inspection. a qualified contractor. NFPA 25, 4.3.1 requires Testing and Maintenance of Wet records shall be made for all inspections, tests, Pipe Fire Sprinkler Systems " and maintenance of the system components and documentation dated 03/21/22 of shall be made available to the authority having multiple deficiencies. jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the II. The facility will identify facility. other residents that may potentially be affected by the Findings include: deficient practice. Based on review of the sprinkler system Resident and Staff in the inspection contractor's "Form for Inspection, community could be affected by Testing and Maintenance of Wet Pipe Fire this deficiency. Sprinkler Systems" documentation dated 03/21/22 with the Executive Director, the Maintenance Director and the Field Maintenance Supervisor III. The facility will put into during record review from 9:00 a.m. to 12:20 p.m. place the following systematic on 01/05/23, numerous deficiencies were noted changes to ensure that the during the contractor's annual sprinkler system deficient practice does not inspection. The "Deficiency Summary" section of recur. the 03/21/22 report included many different deficiencies which included "missing (2) chrome Monthly TELS task was created 200 FR uprights" spare sprinklers, corroded and for Maintenance Supervisor to painted sprinkler head locations including the inspect automatic sprinkler closets in Room 108 and Room 140, corroded and systems. missing escutcheon locations, locations where there are gaps in between sprinkler escutcheons IV The facility will monitor and ceiling tiles, sprinkler head locations are too the corrective action by

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED			
		155171	B. WING			01/05/2023			
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 1285 W JEFFERSON ST FRANKLIN, IN 46131					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWDERS BLANCE CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG CROSS-REFERENCED TO THE APPROF		IE.	DATE		
	long or too short, two sprinkler head locations in				implementing the following				
	the laundry are insta	alled less than six feet apart			measures.				
	and the sprinkler head in the storage room by the								
	oxygen room is hanging three inches below the				Maintenance Supervisor, or				
	ceiling tile. Based on interview at the time of			designee, will monitor and					
	-	Maintenance Director stated he			automatic sprinkler systems				
	was not aware if any	y specific deficiency from the			during annual CQR.				
	03/21/22 inspection	has been corrected, the							
	facility had been working with the contractor to				V. Plan of Correction				
	get the deficiencies	corrected but agreed repair or			completion date.				
	replace documentati	ion to correct the 03/21/22							
		nual inspection deficiencies			Plan of Completion date is				
	was not available fo	or review at the time of record			2/3/2023.				
	review. The Mainte	enance Director supplied an							
	e-mail document dated 1:17 p.m. on 01/05/23 from								
	the sprinkler system inspection contractor stating								
	"We have a tech coming today to get a better look								
	at the situation and get a material list. This is on								
	the schedule for Monday, January 09. Not sure if								
	it will be completed	in (1) day but we should have							
	it all done by the en	d of next week." Based on							
	observations with th	ne Executive Director, the							
		or and the Field Maintenance							
		tour of the facility from 12:20							
		n 01/05/23, the sprinkler							
		et for Room 108 and Room 140							
	were painted.								
	TE1 (* 1;	t talan e							
	These findings were reviewed with the Executive Director, the Maintenance Director and the Field								
	Maintenance Supervisor during the exit								
	conference.								
	3.1-19(b)								

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