PRINTED: 10/25/2024
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155171	B. WING		09/30/2024	
	PROVIDER OR SUPPLIER	2	1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131		
(X4) ID		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		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00	Licensure Survey. Investigation of Co. IN00441099, IN004 Complaint IN00439 the allegations were Complaint IN00441 the allegations were Complaint IN00442 the allegations were Complaint IN00442 the allegations were Survey dates: Septe 2024 Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type Medicare: 3 Medicaid: 67 Other: 15 Total: 85	1099 - No deficiencies related to e cited. 2457 - No deficiencies related to e cited. 2312 - No deficiencies related to e cited. 2mber 24, 25, 26, 27, and 30, 289890	F 0000	Please find enclosed the Plan Correction to the annual surve Survey Event ID RSH311, that conducted on September 30, 2024, resulting in an F-623 Citation, an F-625 citation, an F-641 citation, an F-644 citation and a F-849 citation, and a F-883 citation. This letter is to inform that the plan of correction attached is to serve as Frankli Meadow's credible allegation compliance. We allege compliance on 11/1/2024. Submission of this plan of correction does not constitute admission by Franklin Meadow or its management company the allegations contained in the survey report are a true and accurate portrayal of nursing of and other services in this facil Nor does this provision constitute and agreement or admission of survey allegations. We cordially ask for a desk reformed the services in the services alleged deficient practices.	ey, t was on, you in of an ws hat e care ity. tute t the	
	These deficiencies i	reflect State Findings cited in				

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

(X6) DATE

TITLE

Jason Kennedy Executive Director 10/18/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RSH311 Facility ID: 000087 If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155171 B. WING 09/30/2024 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 PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Quality review completed October 1, 2024. F 0623 483.15(c)(3)-(6)(8) SS=D Notice Requirements Before Bldg. 00 Transfer/Discharge F 0623 F623 Notice Requirements Before 11/01/2024 Based on interview and record review, the facility Transfer/Discharge failed to ensure that the written Notice of Transfer What corrective action(s) will and Discharge was provided to the resident, the be accomplished for those resident's representative, and to the Office of the residents found to have been State Long-Term Care Ombudsman for 2 of 4 affected by the deficient residents reviewed for transfers. (Resident 34, practice? Resident 90) Findings include: Ombudsman/Resident/Family Representative notified of Resident 1. On 9/26/24 at 10:19 a.m., Resident 34's clinical 34 & 90, of discharge record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic How will you identify other Obstructive Pulmonary Disease) and chronic residents having the potential cholecystitis with chronic cholecystitis-Pulled to be affected by the same chole drain (condition that causes cholesterol to deficient practice and what build up in the gallbladder forming polyps). corrective action will be taken? A progress note, dated 4/22/24 at 8:12 p.m., indicated Resident 34 was transferred to the Other residents who have hospital emergency department. The transfer was hospital transfer have the potential a facility-initiated transfer. to be affected by the alleged deficient practice. A facility audit The clinical record lacked documentation that the was completed to ensure the written Notice of Transfer or Discharge document ombudsman had been notified of was provided to Resident 34, the representative, all residents discharges. or the Office of the State Long-Term Care Ombudsman for the hospital transfer on 4/22/24. What measures will be put into place or what systemic 2. On 9/26/24 at 1:00 p.m., Resident 90's clinical changes you will make to record was reviewed. The diagnoses included, ensure that the deficient but were not limited to, COPD, kidney disease, practice does not recur? and diabetes.

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

Event ID:

RSH311

Facility ID: 000087

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/30/2024	
FRANKL	PROVIDER OR SUPPLIE	R	1285 W FRANK	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST KLIN, IN 46131	
	SUMMARY (EACH DEFICIENT REGULATORY OF A progress note, 7/2 Resident 90 was treemergency departrewas a facility-initial. The clinical record written Notice of Todocuments were prepresentative, or the Long-Term Care Control transfer on 7/31/24. During an interview Corporate Nurse Collacked verification the transfer and discresidents, the representative, the State Long-Term Con 9/27/24 at 8:00 Services provided Communities Hospidated February 200 current policy in ust the policy indicate responsible party/fr	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION (31/24 at 4:07 p.m., indicated ansferred to the hospital ment on 7/31/24. The transfer atted transfer. Lacked documentation that the transfer or Discharge rovided to Resident 90, the he Office of the State Ombudsman for the hospital			pate Pers Pers
	hospitaltransfer with the responsible	notification will be reviewed le part at the time of notification the medical record"		Quality Assurance and Performance Improvement Committee overseen by the Executive Director; If a threshold of 95% is a achieved, an action plan will b developed to ensure complian	not pe

DEPARTMENT	OF HEALTH AND HUMAN SERVIC	ES
CENTERS FOR	MEDICARE & MEDICAID SERVICE	ES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155171	l í	JILDING	onstruction 00	(X3) DATE COMPL 09/30 /	ETED
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	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)	TE	(X5) COMPLETION DATE
					Plan of Correction Date: Date of compliance 11/1/2024	1	
					The administrator will be responsible for ensuring the fais in compliance by date of compliance listed.	icility	
F 0625 SS=D Bldg. 00	Based on interview failed to ensure writh were provided to the representative for 2 transfers. (Resident Findings include: 1. On 9/26/24 at 10 record was reviewed were not limited to, makes it difficult to failure (a condition can't pump enough needs), and atrial fill heartbeat). A progress note, dai indicated Resident 3 hospital emergency a facility-initiated to	19 a.m., Resident 34's clinical d. The diagnoses included, but COPD (a lung disease that breathe), congestive heart that occurs when the heart blood to meet the body's brillation (an irregular sed 4/22/24 at 8:12 p.m., 34 was transferred to the department. The transfer was	F 00	525	F-625 Notice of Bed Hold Police Before/Upon Transfer What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to ensure written bed hold notifications will given to Resident 34 & Resident 90, or their appointed family representatives, at time of transesidents 34 & Resident 90, appointed family members, we provided with a copy of the behold policy. Additionally, the facility documented in Resident and Resident 90 EMR confirmation that they were received. How will you identify other	vere ent and ere d	11/01/2024

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

Event ID:

RSH311 Facility ID: 000087

If continuation sheet

Page 4 of 16

PRINTED: 10/25/2024

DEPARTMEN	T OF HEALTH AND HU	JMAN SERVICES				FO	RM APPROVED
CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155171	B. W	ING		09/30	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	I.R			V JEFFERSON ST		
FRANKL	IN MEADOWS				KLIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	written bed hold no	otification was provided to			residents having the potential	al	
		representative for the hospital			to be affected by the same		
	transfer on 4/22/24	l .			deficient practice and what		
					corrective action will be		
		:00 p.m., Resident 90's clinical			taken?		
		ed. The diagnoses included, but					
		o, COPD, type 1 diabetes			Other residents that tran	sfer	
	mellitus, and conge	estive heart failure.			out of the facility have the pote	ential	
					to be affected by the alleged		
		ated 7/31/24 at 4:07 p.m.,			deficient practice. Facility aud		
		90 was transferred to the			will be completed to determine	e if a	
		y department on 7/31/24. The			copy of the Bed Hold Policy w		
	transfer was a facil	lity-initiated transfer.			given and the facility documer	nted	
					confirmation of the residents,		
		l lacked documentation that the			and/or POA, receiving the pol	су.	
		otification was provided to					
		representative for the hospital			What measures will be put		
	transfer on 7/31/24	1.			into place or what systemic		
					changes you will make to		
	_	w on 9/27/24 at 11:20 a.m., the			ensure that the deficient		
		Consultant indicated the facility			practice does not recur?		
		that the written bed hold					
	_	ven to the resident and their			ED/Designee to provide		
	representative.				education to licensed nurses a		
	0.0/27/24 .0.00	1 DOM (D)			social services regarding issui	-	
		a.m., the DON (Director of			copy of the Bed Hold Policy to	the	
		a copy of the American Senior			resident and the family		
		Hold policy, dated November			representative immediately up		
		d it was the current policy in use			transfer. Education to be given	ı by	
		eview of the policy indicated			11/01/2024.		
		nd the resident's representative			All diopharma to ba		
	_	ne bed hold policy at the time of			All discharges to be		
	_	er or therapeutic leave and that cument the notification to the			reviewed the following busines		
	· ·	ent representative of the bed			day by DNS/Designee to ensu		
	hold policy.	in representative of the bed			Notice of discharge/transfer a		
	i noiu poncy.		1		bed hold policy were provided	. (U)	I

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

3.1-12(a)(25)

3.1-12(a)(26)

Event ID:

RSH311

Facility ID: 000087

If continuation sheet

BOM/Designee to mail

notice of discharge transfer and bed hold policy if not provided at

Page 5 of 16

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	WIEDICARE & MEDIC	AID SERVICES			ONIB NO. 0936-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
ANDILAN	OI COMMECTION			55	
		155171	B. WING		09/30/2024
NAME OF D	PROVIDER OR SUPPLIER	,	STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF P	NO VIDER OR SUPPLIER		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	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	ILLEGERITORI OF	DEATH THIS IN ORDER	1710	the time of discharge	DATE
				How the corrective action (s	s)
			1	will be monitored to ensure	the
				deficient practice will not	
				recur, i.e., what quality	
					4
				assurance program will be p	uı
				into place?	
				The POC QAPI Tool (B)	will
				be utilized by ED/designee we	
					-
				x 4 weeks, monthly x 6 month	
			1	and quarterly thereafter for on	
				year with results reported to the	ne
			1	Quality Assurance and	
			1	Performance Improvement	
			1	Committee overseen by the	
			1	_	
				Executive Director;	
				If a threshold of 95% is a	not
				achieved, an action plan will b	
				developed to ensure compliar	
				developed to ensure compilar	100%
				Plan of Correction Date:	
				Date of compliance 11/1/2024	4
				Date of compliance 11/1/2024	Ť
				The administrator will be	
				responsible for ensuring the fa	acility
				is in compliance by date of	<u> </u>
				compliance listed.	
			1		

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

Event ID:

RSH311

Facility ID: 000087

If continuation sheet

Page 6 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/30/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0641 483.20(g) SS=D Accuracy of Assessments Bldg. 00 Based on observation, interview, and record F 0641 11/01/2024 F641 Accuracy of Assessments review, the facility failed to ensure the accuracy of What corrective action(s) will an Minimum Data Set (MDS) assessment for 1 of 1 be accomplished for those residents reviewed for dental. The resident had ill residents found to have been fitting dentures that were not coded. (Resident 21) affected by the deficient practice? Finding includes: Resident 21's MDS was On 9/24/24 at 11:18 a.m., observed Resident 21 modified to reflect the dental/ sitting on her bed watching television. Resident ill-fitting dentures 21 had no bottom front teeth. How will you identify other On 9/26/24 at 9:45 a.m., observed Resident 21 residents having the potential sitting on her bed visiting with her spouse. to be affected by the same Resident 21 was observed to have no bottom deficient practice and what front teeth. During an interview at that time, the corrective action will be resident indicated she had a partial set of taken? dentures. She indicated they did not fit her anymore, the dentures were in the top drawer of Other residents having her dresser. dentures have the potential to be affected by the alleged deficient On 9/26/24 at 10:00 a.m., Resident 21's clinical practice. Facility audit was record was reviewed. The diagnosis included, but completed on all residents having was not limited to, type 2 diabetes mellitus. dentures to ensure reflection on residents MDS assessment. An Admission (MDS) assessment, dated 8/30/24, indicated Resident 21 had no dentures or partials. What measures will be put into place or what systemic During an interview on 9/26/24 at 9:47 a.m., the changes you will make to MDS Coordinator indicated the assessment ensure that the deficient should have indicated Resident 21 had missing practice does not recur? bottom front teeth. ED/designee to provide During an interview on 9/26/24 at 10:20 a.m., the education to MDS coordinator Director of Nursing indicated an oral exam should regarding coding: dental, section have been completed during Resident 21's L, per RAI manual. Education to

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

admission assessment.

Event ID:

RSH311

Facility ID: 000087

If continuation sheet

be given by 11/01/2024.

Page 7 of 16

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

i ´		r í		ONSTRUCTION	(X3) DATE SURVEY	
		A. BUILDING 00 COMPLETED B. WING 09/30/2024			COMPLETED	
155171			B. W			09/30/2024
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD	
FRANKI	IN MEADOWS				/ JEFFERSON ST ILIN, IN 46131	
	T				LIIN, IIN TOTOT	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL S I SC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	During an interview Director of Nursing have a specific policassessment. The factor of 9/26/24 at 12:00 10/2024, was review indicated "Required comprehensive asses admission and annursisment of the second of the	a con 9/26/24 at 11:33 a.m., the indicated the facility did not cry for the Minimum Data Set cility utilized RAI manual. D. p.m., the RAI Manual, dated wed. A review of the manual at Tracking Records: A resident is required upon that. "3. If the resident has a examine for loose fit"		TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE DATE
					Date of compliance 11/1/2024	4

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

Event ID:

RSH311

Facility ID: 000087

If continuation sheet

Page 8 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155171 B. WING 09/30/2024

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST

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		
			The administrator will be responsible for ensuring the facility is in compliance by date of compliance listed			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments					
Biag. UU	Based on record review and interview, the facility failed to ensure a resident was referred to the State-designated authority contractor for a Level II (PASRR) for new mental health diagnosis for 1 of 1 residents reviewed for PASRR. (Resident 80) Finding includes: On 9/26/24 at 1:00 p.m., Resident 80's clinical record was reviewed. Resident 80 had a new diagnosis of psychoactive disorder on 6/18/24 without a referral for a Level II PASRR evaluation. During an interview on 9/25/24 at 1:35 p.m., the Director of Nursing indicated that a PASRR Level II referral was not completed and it should have been updated for Resident 80 after the new diagnosis of psychoactive disorder. On 9/26/24 at 9:10 a.m., the Director of Nursing Services (DON) provided a copy of an American Senior Communities PASRR Policy, dated 11/2017, and indicted that it was the current policy in use by the facility. The policy indicated it was the	F 0644	F-644 Coordination of PASARR and Assessments What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility failed to ensure a resident was referred to the State-designated authority contractor for a Level II for new mental health diagnosis. Facility has corrected Resident 80's PASARR Level II. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other residents that have a new mental health diagnosis have	11/01/2024		

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

Event ID:

RSH311 Facility ID: 000087

If continuation sheet

Page 9 of 16

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155171	A. BUILDING B. WING	00	COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS		1285 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON ST (LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	(PASRR) recomme with intellectual an conditions were con PASRR assessmen	endations which impact those d mental disability or related impleted as prescribed and its were updated with in mental or physical status.	TAG	of residents will be completed identify if any other residents is a new PASARR Level II for ne mental health diagnoses. Any concerns identified will be corrected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ED/Designee will provide education to Social Services regarding the policy on initiatin new PASARR Level II's for an new mental health diagnosis. Education to be given by 11/01/2024. Daily meeting discussion review all psych diagnosis changes will be implemented ensure all needed PASARR's completed from previous businday. (G) How the corrective action (swill be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The POC QAPI Tool (D) be utilized by ED/designee were at the process of the policy of the	e ng yy n to to are ness the ut will eekly s,
	1			year with results reported to the	ne

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

Event ID:

RSH311 Facility ID: 000087

If continuation sheet

Page 10 of 16

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

CTATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
f '		A. BUILDING		` '	
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER		00	COMPLETED
		155171	B. WING		09/30/2024
	PROVIDER OR SUPPLIER		1285 W	ADDRESS, CITY, STATE, ZIP COD / 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	CY 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
				Quality Assurance and Performance Improvement Committee overseen by the	
				Executive Director¿	
				If a threshold of 95% is r	
				achieved, an action plan will b	
				developed to ensure compliar	ice;
				Plan of Correction Date:	
				Date of compliance 11/1/2024	4
				The administrator will be responsible for ensuring the fais in compliance by date of compliance listed.	acility
F 0849 SS=D	483.70(o)(1)-(4) Hospice Services				
Bldg. 00	review, the facility hospice communication-going communication-going communication between the facility 3 residents reviewed	on, interview, and record failed to ensure a resident's ation binder contained the cation and collaboration and the hospice staff for 1 of d for hospice services. The	F 0849	F849 -Hospice What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	n
	_	ntion binder lacked any hospice ervices provided to the 8)		Documentation relating the hospice services of Reside was placed in the designated hospice binder.	

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

Event ID:

RSH311

Facility ID: 000087

How will you identify other

If continuation sheet

Page 11 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVI	CES
CENTERS FOR MEDICARE & MEDICAID SERVI	CES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155171		l í	JILDING	ONSTRUCTION 00	(X3) DATE : COMPL 09/30/	ETED		
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	During an interview Resident 8 indicated services. On 9/25/24 at 1:23 was reviewed. The not limited to, bladd Physician orders, da noted, indicated Reshospice services during an observation of bladde elected to receive her During an observation Resident 8's hospice located at the nurse reviewed. On the of following information name and contact in the binder was a type document which list that were to be in the document included consents; physician hospice aide assignmotes; medication president information was found inside the During an interview Resident 8's hospice place their document included their document which list that were to be in the document included consents; physician hospice aide assignmotes; medication president information was found inside the During an interview Resident 8's hospice place their document	p.m., Resident 8's clinical record ediagnosis included, but was der cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et to bladder cancer. Intel 8/30/24 with no end date sident 8 had elected to receive et ele		TAG	residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other residents on hosp services have the potential to affected by this deficient practice. Audit on all current hospice patients will be compl by Social Services/Designee to ensure required documentation in resident hospice binder. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ED/Designee to provide education to social services to of ensuring all current hospice residents have proper hospice binders containing required documentation. Education to be given by 11/01/2024. Social Services/Designee complete a daily rounding tool reviewing required documentation is in all current hospice reside binders will be implemented for previous business day. How the corrective action (see the same and the same a	ice be eted to an is earn et et to ation ants om	DATE	
	ensure the facility v	der. The binder was a tool to vas kept up to date on the atus. RN 3 indicated she was			will be monitored to ensure to deficient practice will not recur, i.e., what quality	the		

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPLETED	
155171		155171	B. W	B. WING		09/30/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					JEFFERSON ST		
FRANKL	IN MEADOWS				ILIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		nder lacked the hospice			assurance program will be p	ut	
	provider's documentation.				into place?		
	On 9/27/24 at 9:10	a.m., the Director of Nursing			The POC QAPI Tool (E)	will	
		vided a copy of Medicaid			be utilized by ED/designee we		
		ocument. A review of the			x 4 weeks, monthly x 6 month	-	
	_	Resident 8's appointed Power			and quarterly thereafter for on		
	of Attorney opted f	or Resident 8 to receive			year with results reported to the		
	hospice services as	of 8/30/24. The document			Quality Assurance and		
	was signed by the F	ower of Attorney on 8/30/24.			Performance Improvement		
					Committee overseen by the		
		e communication binder and			Executive Director		
		ecord lacked an on-going					
	communication and collaboration records were				If a threshold of 95% is ı	not	
	shared between the facility and the hospice staff.				achieved, an action plan will b	e	
					developed to ensure compliar	nce	
	During an interview on 9/25/24 at 2:40 p.m., the						
	DNS indicated she was unaware that the hospice						
		der and the facility's electronic					
		ed Resident 8's hospice					
	provider documentation.				Plan of Correction Date:		
	During an interview on 9/26/24 at 1:45 p.m., the				Date of compliance 11/1/2024	4	
	DNS indicated the facility's hospice				·		
	communication binder was to contain Resident 8's						
	hospice provider's documentation to ensure						
	communication and collaboration between the				The administrator will be		
	provider and the facility.				responsible for ensuring the facility		
	·				is in compliance by date of		
	On 9/26/24 at 9:10 a.m. the DNS provided a copy				compliance listed		
	of the "One Time Nursing Facility and Hospice						
	_	t" dated 8/29/24 and indicated					
	it was the current facility and hospice agreement						
	in use by the facility. A review of the document						
	indicated, "Coordination of Responsibilities: the						
	parties agree to accept responsibility for the						
	•	essary care and servicesin					
		ch party's policies and					
	proceduresliaisons to facilitate cooperation and						
	communication between the parties" The						

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

Event ID:

RSH311 Facility ID: 000087

If continuation sheet Page 13 of 16

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM			COMPL	COMPLETED	
		155171	B. WING		09/30/	09/30/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				JEFFERSON ST			
FRANKLIN MEADOWS				FRANKLIN, IN 46131				
(VA) ID			I	ID		Т		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
mo		uted on 8/29/24 as indicated		1710			BITTE	
	by the signature of b							
	- ,	F						
	On 9/26/24 at 2:44 p.m., the DNS provided a copy							
	of the Hospice Policy, dated September 2024, and							
	indicated it was the	current policy in use by the						
	facility. A review of the policy indicated, "it is the							
	policy of this facility that when a resident elects							
	hospice benefit, the contracted hospice company							
	and facility will coordinate to establisha pattern							
	of communication between the hospice company,							
	healthcare professionals, facility staff and resident/representative"							
	resident/representati	ive						
	3.1-37(a)							
	3.1 3 / (a)							
F 0883	483.80(d)(1)(2)							
SS=D	Influenza and Pneumococcal Immunizations							
Bldg. 00								
			F 0	383	F-883 Influenza and		11/01/2024	
	Based on interview and record review, the facility failed to follow vaccination administration				Pneumococcal Immunizations What corrective action(s) will			
	guidelines for the pneumococcal vaccine. The				be accomplished for those			
	appropriate pneumococcal vaccine was not given				residents found to have been	•		
	for residents who had consented to receive their pneumococcal vaccinations per CDC (Centers for				affected by the deficient			
	Disease Control and Prevention) guidelines for 2				practice?			
	of 8 residents reviewed for immunizations.				Facility failed to follow			
	(Resident 41, Resident 78)				vaccination administration			
	(resident 11, resident 70)				guidelines for the pneumococo	cal		
	Findings include:				vaccine for Resident 41 and			
					Resident 78. Resident 41 and			
	1. On 9/24/24 at 1:00 p.m., Resident 41's clinical				Resident 78 have both receive	; d		
	record was reviewed. Resident 41's diagnoses				the pneumococcal vaccine.			
	included, but were not limited to, unspecified							
	dementia, chronic atrial fibrillation (a type of				How will you identify other			
	irregular heartbeat), type 2 diabetes, and chronic				residents having the potentia	ıl		
	kidney disease.				to be affected by the same			
	-Resident 41's immunization records indicated				deficient practice and what			
	-Kesident 41's immi	unization records indicated			corrective action will be			

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

Event ID:

 $RSH311 \qquad {\tt Facility \, ID:} \quad 000087$

If continuation sheet Page 14 of 16

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155171	B. WING			09/30/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2			/ JEFFERSON ST		
FRANKLIN MEADOWS					(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	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Resident 41 receive	d a PCV (pneumococcal			taken?		
	conjugate vaccine)	13 on 9/12/16 but lacked any					
	documentation for a PPSV (pneumococcal			An audit of all resident			
	polysaccharide) vac	ecine.			vaccine consents have been		
				reviewed to identify if any other			
	-Resident 41 was of	f 65 years of age or older.			residents were affected by th	ed by the	
					alleged deficient practice. Ar	tice. Any	
	On 9/25/24, the DO	N (Director of Nursing),			issues identified were correc	ted.	
	provided a copy of	Resident 41's pneumococcal					
	vaccination consent	form which was marked as			What measures will be put		
	resident wished to r	receive pneumococcal			into place or what systemic		
	vaccinations per the	e recommendations of the		changes you will make to			
	CDC's pneumococo	al vaccine timing for adults.		ensure that the deficient			
	The form was unsigned but was dated for 8/21/24				practice does not recur?		
	at 1:00 p.m.				1.		
					DNS/Designee will pro-	vide	
	2. On 9/24/24 at 1:30 p.m., Resident 78's clinical				education to infection preventionist		
	record was reviewed. Resident 78's diagnoses				and backup to the infection		
	included, but were not limited to, unspecified				preventionist. regarding the		
	dementia, COPD (a lung disease that makes it				facilities policy on providing		
	difficult to breathe), and old myocardial infarction				vaccination requests by any		
	(a heart attack).				resident. Education to be given by		
					11/01/2024.		
	-Resident 78's immunization records lacked any						
	documentation for either a PCV type or a PPSV				Daily clinical meetings	with	
	type pneumococcal vaccine.			Infection Prevention nurse to			
	97- 1			discuss all pending vaccinations			
	-Resident 78 was of 65 years of age or older.				to be given and status of each		
	resident 70 was 61 65 years of age of older.			vaccine to ensure vaccines are			
	On 9/25/24, the DON, provided a copy of Resident			given per administration guidelines			
	78's pneumococcal vaccination consent form,			as per resident consents from			
which was marked as resident wished to receive			previous business day. (G)				
	pneumococcal vaccinations per the						
	recommendations of the CDC's pneumococcal				How the corrective action ((s)	
	vaccine timing for adults. The form was signed by			will be monitored to ensure the			
	resident or by resident's responsible party and				deficient practice will not		
	was dated for 2/8/24 at 1:57 p.m.			recur, i.e., what quality			
	was dated for 2/6/24 at 1.3/ p.m.				assurance program will be	nut	
	During an interview on 9/25/24 at 1:25 p.m., the				into place?	put	
	_	the appropriate pneumococcal			into piaco:		

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED		
155171		155171	B. W	ING		09/30/	/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIEF	8			JEFFERSON ST			
FRANKLIN MEADOWS			FRANKLIN, 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	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	vaccinations should have been given for both				The POC QAPI Tool (F)			
	residents.				be utilized by ED/designee weekly			
					x 4 weeks, monthly x 6 months,			
		5 a.m., the DON provided an			and quarterly thereafter for on			
	undated policy title				*	year with results reported to the		
	· ·	ndicated it was the policy			Quality Assurance and			
	-	e policy stated that the facility			Performance Improvement			
	_	nce for pneumococcal vaccine			Committee overseen by the			
	recommendations per the CDC's pneumococcal				Executive Director¿			
	vaccine timing for adults.							
					If a threshold of 95% is not			
	On 9/27/24 at 10:30 a.m., a review of the CDC				achieved, an action plan will b			
	guidelines at the following website regarding				developed to ensure compliance¿			
	pneumococcal vaccine times for adults							
	(https://www.cdc.gov/pneumococcal/downloads/							
	Vaccine-Timing-Adults-JobAid.pdf), last updated							
	on 9/12/24, indicated that diabetes mellitus, chronic lung diseases, and chronic heart diseases				Plan of Correction Date:			
	_				D			
	are all chronic heal				Date of compliance 11/1/2024	4		
	*	inations are recommended for						
	_	4 years old in addition to being						
	recommended for a	dults 65 years old and older.						
	2.1.12()				The administrator will be			
	3.1-13(a)				responsible for ensuring the fa	acility		
					is in compliance by date of			
					compliance listed.			
			- 1		I		I	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RSH311 Facility ID: 000087 If continuation sheet Page 16 of 16