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	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Meadows	1285 W Jefferson St Franklin, IN 46131

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45292 Based on interview and record review, the facility failed to ensure that the written Notice of Transfer and Discharge was provided to the resident, the resident's representative, and to the Office of the State Long-Term Care Ombudsman for 2 of 4 residents reviewed for transfers. (Resident 34, Resident 90) Findings include: 1. On 9/26/24 at 10:19 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and chronic cholecystitis with chronic cholecystitis-Pulled chole drain (condition that causes cholesterol to build up in the gallbladder forming polyps). A progress note, dated 4/22/24 at 8:12 p.m., indicated Resident 34 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written Notice of Transfer or Discharge document was provided to Resident 34, the representative, or the Office of the State Long-Term Care Ombudsman for the hospital transfer on 4/22/24. 2. On 9/26/24 at 1:00 p.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, COPD, kidney disease, and diabetes. A progress note, 7/31/24 at 4:07 p.m., indicated Resident 90 was transferred to the hospital emergency department on 7/31/24. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written Notice of Transfer or Discharge documents were provided to Resident 90, the representative, or the Office of the State Long-Term Care Ombudsman for the hospital transfer on 7/31/24. During an interview on 9/27/24 at 11:20 a.m., the Corporate Nurse Consultant indicated the facility lacked verification that the written notification of the transfer and discharge notice was given to the residents, the representatives, and to the Office of the State Long-Term Care Ombudsman. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 8:00 a.m., the Director of Nursing Services provided a copy of the American Senior Communities Hospital Discharge/Transfer policy, dated February 2019, and indicated it was the current policy in use by the facility. A review of the policy indicated, .Nursing will contact the responsible party/family member to inform them of the pending discharge/transfer to the acute care hospital .transfer notification will be reviewed with the responsible part at the time of notification and documented in the medical record . 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45292 Based on interview and record review, the facility failed to ensure written bed hold notifications were provided to the resident and the resident's representative for 2 of 4 residents reviewed for transfers. (Resident 34, Resident 90) Findings include: 1. On 9/26/24 at 10:19 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), congestive heart failure (a condition that occurs when the heart can't pump enough blood to meet the body's needs), and atrial fibrillation (an irregular heartbeat). A progress note, dated 4/22/24 at 8:12 p.m., indicated Resident 34 was transferred to the hospital emergency department. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written bed hold notification was provided to Resident 34 or the representative for the hospital transfer on 4/22/24. 2. On 9/26/24 at 1:00 p.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, COPD, type 1 diabetes mellitus, and congestive heart failure. A progress note, dated 7/31/24 at 4:07 p.m., indicated Resident 90 was transferred to the hospital emergency department on 7/31/24. The transfer was a facility-initiated transfer. The clinical record lacked documentation that the written bed hold notification was provided to Resident 90 or the representative for the hospital transfer on 7/31/24. During an interview on 9/27/24 at 11:20 a.m., the Corporate Nurse Consultant indicated the facility lacked verification that the written bed hold notification was given to the resident and their representative. On 9/27/24 at 8:00 a.m., the DON (Director of Nursing) provided a copy of the American Senior Communities Bed Hold policy, dated November 2017, and indicated it was the current policy in use by the facility. A review of the policy indicated that the resident and the resident's representative will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave and that the facility will document the notification to the resident and resident representative of the bed hold policy. 3.1-12(a)(25) 3.1-12(a)(26)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36746 Based on observation, interview, and record review, the facility failed to ensure the accuracy of an Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for dental. The resident had ill fitting dentures that were not coded. (Resident 21) Finding includes: On 9/24/24 at 11:18 a.m., observed Resident 21 sitting on her bed watching television. Resident 21 had no bottom front teeth. On 9/26/24 at 9:45 a.m., observed Resident 21 sitting on her bed visiting with her spouse. Resident 21 was observed to have no bottom front teeth. During an interview at that time, the resident indicated she had a partial set of dentures. She indicated they did not fit her anymore, the dentures were in the top drawer of her dresser. On 9/26/24 at 10:00 a.m., Resident 21's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus. An Admission (MDS) assessment, dated 8/30/24, indicated Resident 21 had no dentures or partials. During an interview on 9/26/24 at 9:47 a.m., the MDS Coordinator indicated the assessment should have indicated Resident 21 had missing bottom front teeth. During an interview on 9/26/24 at 10:20 a.m., the Director of Nursing indicated an oral exam should have been completed during Resident 21's admission assessment. During an interview on 9/26/24 at 11:33 a.m., the Director of Nursing indicated the facility did not have a specific policy for the Minimum Data Set assessment. The facility utilized RAI manual. On 9/26/24 at 12:00 p.m., the RAI Manual, dated 10/2024, was reviewed. A review of the manual indicated Required Tracking Records: A comprehensive assessment is required upon admission and annual.3. If the resident has dentures or partials, examine for loose fit . 3.1-31(d)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35099 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 policy of the facility to ensure that any Pre-Admission Screening and Resident Review (PASRR) recommendations which impact those with intellectual and mental disability or related conditions were completed as prescribed and PASRR assessments were updated with significant changes in mental or physical status. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 38466 Based on observation, interview, and record review, the facility failed to ensure a resident's hospice communication binder contained the on-going communication and collaboration between the facility and the hospice staff for 1 of 3 residents reviewed for hospice services. The hospice communication binder lacked any hospice documentation of services provided to the resident. (Resident 8) Finding includes: During an interview on 9/24/24 at 12:05 p.m., Resident 8 indicated he was receiving hospice services. On 9/25/24 at 1:23 p.m., Resident 8's clinical record was reviewed. The diagnosis included, but was not limited to, bladder cancer. Physician orders, dated 8/30/24 with no end date noted, indicated Resident 8 had elected to receive hospice services due to bladder cancer. The Significant Change Minimum Data Set (MDS) assessment, dated 9/6/24, indicated Resident 8 was moderately cognitively impaired and had a diagnosis of bladder cancer. Resident 8 had elected to receive hospice services. During an observation on 9/25/24 at 2:30 p.m., Resident 8's hospice communication binder, located at the nurse's station, was observed and reviewed. On the outside of the binder the following information was observed: Resident 8's name and room number and the hospice provider's name and contact information. Observed inside the binder was a type-written Table of Contents document which listed the various documents that were to be in the binder. A review of the document included but was not limited to: consents; physician orders; nursing notes; hospice aide assignment and notes; social worker notes; medication profile; and chaplain notes. No resident information or provider documentation was found inside the communication binder. During an interview at that time, RN 3 indicated Resident 8's hospice provider employees were to place their documentation into the hospice communication binder. The binder was a tool to ensure the facility was kept up to date on the resident's hospice status. RN 3 indicated she was unaware that the binder lacked the hospice provider's documentation. On 9/27/24 at 9:10 a.m., the Director of Nursing Services (DNS) provided a copy of Medicaid Hospice Election document. A review of the document indicated Resident 8's appointed Power of Attorney opted for Resident 8 to receive hospice services as of 8/30/24. The document was signed by the Power of Attorney on 8/30/24. Resident 8's hospice communication binder and electronic clinical record lacked an on-going communication and collaboration records were shared between the facility and the hospice staff. During an interview on 9/25/24 at 2:40 p.m., the DNS indicated she was unaware that the hospice communication binder and the facility's electronic clinical record lacked Resident 8's hospice provider documentation. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 1:45 p.m., the 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 provider and the facility. On 9/26/24 at 9:10 a.m. the DNS provided a copy of the One Time Nursing Facility and Hospice Services Agreement 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 provision of all necessary care and services .in accordance with each party's policies and procedures .liaisons to facilitate cooperation and communication between the parties . The document was executed on 8/29/24 as indicated by the signature of both parties. 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 establish .a pattern of communication between the hospice company, healthcare professionals, facility staff and resident/representative . 3.1-37(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45292 Based on interview and record review, the facility failed to follow vaccination administration guidelines for the pneumococcal vaccine. The appropriate pneumococcal vaccine was not given for residents who had consented to receive their pneumococcal vaccinations per CDC (Centers for Disease Control and Prevention) guidelines for 2 of 8 residents reviewed for immunizations. (Resident 41, Resident 78) Findings include: 1. On 9/24/24 at 1:00 p.m., Resident 41's clinical record was reviewed. Resident 41's diagnoses included, but were not limited to, unspecified dementia, chronic atrial fibrillation (a type of irregular heartbeat), type 2 diabetes, and chronic kidney disease. -Resident 41's immunization records indicated Resident 41 received a PCV (pneumococcal conjugate vaccine) 13 on 9/12/16 but lacked any documentation for a PPSV (pneumococcal polysaccharide) vaccine. -Resident 41 was of [AGE] years of age or older. On 9/25/24, the DON (Director of Nursing), provided a copy of Resident 41's pneumococcal vaccination consent form which was marked as resident wished to receive pneumococcal vaccinations per the recommendations of the CDC's pneumococcal vaccine timing for adults. The form was unsigned but was dated for 8/21/24 at 1:00 p.m. 2. On 9/24/24 at 1:30 p.m., Resident 78's clinical record was reviewed. Resident 78's diagnoses included, but were not limited to, unspecified dementia, COPD (a lung disease that makes it difficult to breathe), and old myocardial infarction (a heart attack). -Resident 78's immunization records lacked any documentation for either a PCV type or a PPSV type pneumococcal vaccine. -Resident 78 was of [AGE] years of age or older. On 9/25/24, the DON, provided a copy of Resident 78's pneumococcal vaccination consent form, which was marked as resident wished to receive pneumococcal vaccinations per the recommendations of the CDC's pneumococcal vaccine timing for adults. The form was signed by resident or by resident's responsible party and was dated for 2/8/24 at 1:57 p.m. During an interview on 9/25/24 at 1:25 p.m., the DON indicated that the appropriate pneumococcal vaccinations should have been given for both residents. On 9/24/24 at 10:05 a.m., the DON provided an undated policy titled, Pneumococcal Vaccination, and indicated it was the policy currently in use. The policy stated that the facility utilized CDC guidance for pneumococcal vaccine recommendations per the CDC's pneumococcal vaccine timing for adults. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 10:30 a.m., a review of the CDC guidelines at the following website regarding 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 are all chronic health conditions where pneumococcal vaccinations are recommended for adults 19 through [AGE] years old in addition to being recommended for adults [AGE] years old and older. 3.1-13(a)