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	09/16/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to ensure a resident with a nicotine dependence had the right to continue her preference for 1 of 1 residents reviewed for resident rights. (Resident 41)Finding includes: During an interview on 9/10/25 at 11:31 a.m., Resident 41 indicated the facility took her chew away. She indicated she always liked to chew, but the facility took it away. On 9/12/25 at 10:33 a.m., the clinical record for Resident 41 was reviewed. The diagnosis included, but was not limited to, nicotine dependence. A care plan, dated 1/5/24, indicated Resident 41 will be allowed to use chewing tobacco (a type of smokeless tobacco product that is placed between the cheek in order to draw out the nicotine) per preference. A Physician's order, dated 3/24/25 with no end date, indicated May have chewing [to] tobacco per facility policy. A Physician's Progress Note, dated 8/27/25, indicated She [Resident 41] continues to use chewing tobacco. She [Resident 41] declines stopping the chewing tobacco. continues to utilize chewing tobacco with no plans for cessation- continue current plan of care. During an interview, on 9/15/25 at 9:00 a.m., the Director of Nursing Services (DNS) indicated upon return from a recent hospitalization, Resident 41 did not have a doctor's order for continued tobacco use. At that time the chewing tobacco was removed from the resident's room. The facility offered the resident a nicotine patch to replace the tobacco. The resident refused the nicotine patch. On 9/15/25 at 2:07 p.m., the Corporate Nurse Consultant provided a document titled Your Rights and Protections as a Nursing Home Resident, undated, and indicated the document was currently being used by the facility. The document indicated What are my rights in a nursing home? .you have the right make your own decisions . 3.1-3(u)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure a resident's advanced directive (code status) preference was documented accurately in the clinical record for 1 of 8 residents reviewed for advanced directives. (Resident 2) Finding includes: On 9/11/25 at 11:06 a.m., Resident 2's clinical record was reviewed. The Quarterly Minimum Data Set (MDS) assessment, dated 8/13/25, indicated Resident 2 was cognitively intact. The home screen tab portion of the electronic clinical record included an overview of Resident 2's vital information. A review of the tab indicated Resident 2's code status (decision regarding health care intervention) was listed as a full code (meaning a desire for all life sustaining measures to be implemented). Physician orders, dated 1/3/25 and with no end date noted, indicated Resident 2 was a full code. Resident 2's care plan, initiated 1/10/25, indicated . Resident/legal guardian prefers a full code status.preference in regard to code status will be honored. On 9/12/25 at 9:14 a.m., the Corporate Nurse Consultant provided a copy of Resident 2's completed Indiana Physician Orders for Scope of Treatment (POST) form. A review of the document indicated it was completed, signed, and dated by Resident 2 and the attending physician on 8/12/25. The document indicated the designated code status preference was Do Not Attempt Resuscitation/DNR. The current POST form, dated 8/12/25, was uploaded into Resident 2's electronic clinical record on 8/22/25. No subsequent POST form was provided. The clinical record was not updated to accurately reflect Resident 2's preferred DNR code status, a change from full code to DNR status, as indicated by the most recent POST form dated 8/12/25. During an interview on 9/11/25 at 3:00 p.m., the Social Services Director indicated she was unaware Resident 2's code status had changed from full code to DNR. She was not sure why the clinical record did not reflect the new code status. During an interview 9/11/25 at 3:16 p.m., the Director of Nursing Services indicated she was unaware Resident 2's code status had changed from full code to DNR. The clinical record should have been updated to reflect Resident 2's change in code status. During an interview on 9/12/25 at 9:50 a.m., Resident 2 indicated that some time ago she changed her preferred code status and at that time the new DNR code status paperwork was completed and had been provided to the facility. During an interview on 9/15/25 at 9:40 a.m., Licensed Practice Nurse (LPN) 2 indicated the resident's designated code status preference was listed on the home screen tab portion of the electronic clinical record. Staff retrieved the code status information for each resident from that portion of the resident's clinical record. On 9/12/25 at 9:14 a.m., the Corporate Nurse Consultant provided a copy of the Advanced Directives policy, dated July 2023, and indicated it was the current policy in use by the facility. A review of the document indicated, .ensure that physician's orders indicating the decisions made on the POST form are added to the resident's orders.resident wishes are accurately reflected in the plan of care. 3.1-4(f)(4)(A)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to read the results of a two-step Mantoux skin test series (a tool used in screening for tuberculosis) after administering the skin tests for 1 of 5 residents reviewed for TB (tuberculosis) skin tests. (Resident 80)Finding includes:On 9/11/25 at 8:45 a.m., Resident 80's clinical record was reviewed. Resident 80's diagnosis included, but was not limited to, Alzheimer's disease (a progressive, irreversible neurodegenerative disease affecting thinking and memory).Resident 80 had an admission date of 2/13/25. Resident 80's TB test administration history indicated that the resident had received a first step TB test upon admission and had an order to read the result of the TB test on 2/16/25. The electronic health record did not indicate if the test was read with a negative or a positive result. Resident 80's second step TB test was given on 2/28/25 and had an order to read the result of the TB test on 3/2/25. The electronic health record did not indicate if the test was read with a negative or a positive result. During an interview on 9/15/25 at 9:20 a.m., the DNS (Director of Nursing Services) and the RNC (Regional Nurse Consultant) indicated that Resident 80's first and second step TB skin tests lacked a result read for both skin tests and the electronic health record should have included a negative or a positive result after each administration. On 9/15/25 at 9:00 a.m., the DNS provided a copy of a policy titled Tuberculosis Control Program, dated January 2022, and indicated it was the policy in use by the facility. A review of the policy indicated that upon admission, residents are to be screened for the prevention and control of TB infections, including the appropriate documentation of resident TB screening. 3.1-18(b)(1)

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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** Based on interview and record review, the facility failed to follow the current vaccine administration guidelines for pneumococcal vaccinations for a resident who had consented to receive vaccinations for 1 of 5 residents reviewed for immunization records. (Resident 8)Finding includes:On 9/11/25 at 9:25 a.m., Resident 8's clinical record was reviewed and indicated the following:Resident 8's preventative health section in the electronic health record lacked records for any pneumococcal vaccinations.Resident 8's diagnosis included, but was not limited to, Alzheimer's disease (a progressive, irreversible neurodegenerative disease affecting thinking and memory).Resident 8 had an admission date of 7/5/25 and was of age [AGE] or older. On 9/12/25 at 9:30 a.m., the DNS (Director of Nursing Services) provided pneumococcal vaccination consent forms indicating the resident had signed the consent forms on 7/10/25 and had indicated consent . to receive pneumococcal vaccine(s) per the recommendation of the CDC's Pneumococcal Vaccine Timing for Adults.During an interview on 9/15/25 at 9:20 a.m., the DNS and the RNC (Regional Nurse Consultant) indicated that Resident 8's record lacked pneumococcal vaccinations and that the resident should have received an appropriate vaccine close to the time of admission. On 9/12/25 at 10:15 a.m., the DNS provided a policy titled Pneumococcal Vaccination, reviewed December 2024, and indicated it was the policy currently in use by the facility. The policy indicated that residents are to be screened on admission for pneumococcal vaccinations and should be offered pneumococcal vaccinations if a vaccine consent is signed and appropriate criteria are met. On 9/16/25 at 4:00 p.m., a review of the CDC guidelines at the following website for pneumococcal guidelines (https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html#note-pneumo), updated 7/2/25, indicated that adults [AGE] years of age or older should have the recommended pneumococcal vaccinations, and for an individual over [AGE] years of age whose vaccination record is unknown or has not had any previous pneumococcal vaccinations, a dose of PCV 20 or PCV 21 is recommended.3.1-13(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer Covid-19 vaccinations upon admission for residents who consented to receive the vaccines for 2 of 5 residents reviewed for immunization records. (Resident 8 and Resident 80)Findings include: 1. On 9/11/25 at 9:25 a.m., Resident 8's clinical record was reviewed and indicated the following:Resident 8's preventative health section in the electronic health record lacked records for any Covid-19 vaccinations.Resident 8's diagnosis included, but was not limited to, Alzheimer's disease (a progressive, irreversible neurodegenerative disease affecting thinking and memory).Resident 8 had an admission date of 7/5/25 and was of age [AGE] or older.Resident 8 had signed a Covid-19 vaccine consent form on 7/10/25, checking the consent portion of the form which indicated the resident wished to be offered Covid-19 vaccinations per the recommendations of the CDC. 2. On 9/11/25 at 8:45 a.m., Resident 80's clinical record was reviewed and indicated the following:Resident 80's preventative health section in the electronic health record indicated two historical Covid-19 vaccinations given in an outside care setting prior to admission on [DATE] and 3/18/21.Resident 80's diagnosis included, but was not limited to, Alzheimer's disease (a progressive, irreversible neurodegenerative disease affecting thinking and memory).Resident 80 had an admission date of 2/13/25 and was of age [AGE] or older. Resident 80's responsible party had signed a Covid-19 vaccine consent form on 2/18/25, checking the consent portion of the form which indicated the resident wished to be offered Covid-19 vaccinations per the recommendations of the CDC.During an interview on 9/15/25 at 9:20 a.m., the DNS (Director of Nursing Services) and the RNC (Regional Nurse Consultant) indicated each of the residents should have received the appropriate vaccination or booster close to the time of admission. On 9/12/25 at 9:30 a.m., the DNS provided a policy titled Resident Covid-19 Vaccination, revised 9/27/22, and indicated it was the policy in use by the facility. A review of the policy indicated that on admission, residents are to be offered Covid-19 vaccinations based on their vaccination history, and should be offered the Covid-19 vaccine, additional doses, and boosters per CDC recommendations. On 9/16/25 at 4:00 p.m., a review of the CDC guidelines at the following website for Covid-19 guidelines (https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html), updated 7/2/25, indicated that adults [AGE] years of age or older were to receive two of more doses of the 2024-2025 vaccination boosters. 3.1-13(a)