

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>44849</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from misappropriation of residents' controlled medications for 2 of 3 residents reviewed for misappropriation. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record (a document used by the facility to reconcile controlled medications) was found in a binder that it did not belong behind the nurse's station. The medication monitoring record was for Resident B and indicated on 2/14/25, Resident B should have had two oxycodone (prescription narcotic pain medication) 15 milligrams (mg) tablets remaining in the locked medication cart. The medication monitoring record was last used on 2/14/25. When UM 1 looked, there were no oxycodone tablets remaining in the packet. UM 1 reported the discrepancy to the Director of Nursing (DON) that day.</p> <p>The clinical record for Resident B was reviewed on 4/9/25 at 10:13 a.m. The diagnoses included, but were not limited to, cerebral palsy, spondylosis, contractures, and cervical disc disorder with myelopathy.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/1/25, indicated Resident B was cognitively intact.</p> <p>A current physicians order, initiated on 4/12/23, indicated give one oxycodone 15 mg tablet orally three times daily for pain.</p> <p>A Medication Monitoring Record, dated 2/10/25 through 2/14/25, indicated a packet of fifteen oxycodone 15 mg tablets were received from the pharmacy for Resident B. On 2/14/25, Resident B should have had two oxycodone 15 mg tablets left in the medication packet. The monitoring record lacked any documentation of waste, spoilage, nor disposition of the remaining two doses of oxycodone 15 mg.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a facility disciplinary action form, dated 3/19/25, and indicated this was the disciplinary action taken when the Director of Nursing (DON) informed the Administrator that he was made aware of an allegation of misappropriation of Resident B's controlled substances but did not report the information to the Administrator. A review of the disciplinary action form indicated the DON was suspended pending investigation and then terminated for not reporting an allegation of misappropriation on 2/25/25.</p> <p>2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone 15 mg, but instead had been administering allergy pills to Resident C.</p> <p>On 4/18/25 at 10:18 a.m., the Administrator provided the investigation into the misappropriation of resident property. The investigation included, but was not limited to:</p> <ul style="list-style-type: none"> - A typed and signed staff statement, dated 3/6/25, indicated LPN 1 found an unknown small white pill taped into Resident C's packet of oxycodone 15 mg. LPN 1 recognized the unknown pill because the oxycodone were small green tablets, and the unknown medication was a small white tablet. LPN 1 immediately went to UM 1 to report and the DON walked up, so LPN 1 reported to the DON. The statement was signed by LPN 1. - A typed and signed staff statement, dated 3/13/25 at approximately 12:45 p.m., indicated RN 2 reconciled the controlled substances with RN 1. When the reconciliation was completed, RN 2 noticed a medication cup on top of the medication cart that contained a small amount of pink liquid. When RN 2 asked RN 1 what was the pink liquid, RN 1 indicated the pink liquid was Resident C's oxycodone 15 mg that had to be destroyed. RN 2 watched RN 1 destroy the pink liquid, but later recognized Resident C's oxycodone 15 mg was green not pink. RN 2 reported to UM 1 and UM 1 immediately called the DON and reported this. - A typed and signed staff statement, dated 3/17/25, indicated Resident C told LPN 1 when she asked RN 1 for oxycodone 15 mg, RN 1 had been administering a small white tablet of an unknown medication. This was reported to UM 1 immediately. <p>The clinical record for Resident C was reviewed on 4/8/25 at 10:41 a.m. The diagnoses included, but were not limited to, anxiety, chronic obstructive pulmonary disorder, and chronic respiratory failure.</p> <p>A quarterly MDS assessment, dated 2/7/25, indicated Resident C was cognitively intact.</p> <p>A current physicians order, initiated on 1/30/25, indicated give one oxycodone 15 mg orally every six hour as needed for moderate to severe pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/8/25 at 12:58 p.m., Resident C indicated when she would request an oxycodone 15 mg tablet for pain, RN 1 would give her a different unknown medication instead. Resident C had become concerned because she would get very tired and sleepy whenever RN 1 gave her the oxycodone but that was not her normal reaction to the oxycodone. Resident C started paying attention to what RN 1 would give to her when she requested her oxycodone. The oxycodone 15 mg were small green pills but when Resident C would request the oxycodone from RN 1, RN 1 would bring a little white pill shaped like a football.</p> <p>During an interview on 4/8/25 at 1:37 p.m., the Administrator indicated on approximately 3/6/25, LPN 1 made the Director of Nursing (DON) aware that one of Resident C's oxycodone 15 mg tablets had been removed from the pill packet and an unknown pill was placed into the packet then the packet was taped shut.</p> <p>During an interview on 4/8/25 at 2:20 p.m., LPN 1 indicated on 3/6/25, she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone. She recognized the white pill because Resident C's oxycodone was a small green pill. LPN 1 reported the information to the DON immediately.</p> <p>On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a facility disciplinary action form, dated 3/19/25, and indicated this was the disciplinary action taken when the Director of Nursing (DON) informed the Administrator that he was made aware of allegations of misappropriation of Resident B's oxycodone 15 mg, on 2/25/25, and Resident C's oxycodone, on 3/6/25, and on 3/13/25, but did not report the information to the Administrator until 3/17/25. A review of the disciplinary action form indicated the DON was suspended pending investigation and then terminated, on 3/19/25, for not reporting allegations of misappropriation.</p> <p>On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/26/22, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be free from misappropriation of property.</p> <p>This citation relates to Complaint IN00455719.</p> <p>3.1-28(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>44849</p> <p>Based on interview and record review, the facility failed to report allegations of misappropriation of residents' narcotic (prescription controlled substance used to treat pain) pain medications to the Administrator for 2 of 3 residents reviewed for misappropriation. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record was found in a binder behind the nurse's station. The medication monitoring record was for Resident B and indicated Resident B should have had two oxycodone (prescription narcotic pain medication) 15 milligrams (mg) tablets remaining in the locked medication cart. When UM 1 looked, there were no oxycodone tablets remaining in the packet. UM 1 reported this to the Director of Nursing (DON) that day.</p> <p>2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone but instead had been administering allergy pills.</p> <p>During an interview on 4/8/25 at 1:37 p.m., the Administrator indicated on approximately 3/13/25, LPN 1 made the DON aware that a one of Resident C's oxycodone 15 mg tablets had been removed from the pill packet and an unknown pill was placed into the packet and the packet had been taped shut. The DON did not report this information to the Administrator until 3/17/25. The DON was terminated for not reporting this information to the Administrator immediately.</p> <p>During an interview, on 4/8/25 at 2:20 p.m. LPN 1 indicated she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone. She recognized the white pill because Resident C's oxycodone was a small green pill. LPN 1 reported the information to the DON immediately.</p> <p>On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/26/22, and indicated this was the current policy used by the facility. A review of the policy indicated all allegation of misappropriation of a resident's property should be reported to the state health department immediately.</p> <p>This citation relates to Complaint IN00455719.</p> <p>3.1-28(c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>44849</p> <p>Based on observation, interview, and record review, the facility failed to ensure controlled medication records were accurately reconciled to account for all controlled drugs for 2 of 3 residents reviewed for misappropriation of property. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record (a document used by the facility to reconcile the number of controlled substances each resident had) was found in a binder behind the nurse's station. The document did not belong in the binder. The medication monitoring record was for Resident B and indicated Resident B should have had two oxycodone (controlled drug to treat pain) 15 milligrams (mg) tablets remaining in the locked medication cart. The medication monitoring record was last used, on 2/14/25. When UM 1 reviewed the packet of Resident B's oxycodone 15 mg, there were no oxycodone tablets remaining in the packet.</p> <p>The clinical record for Resident B was reviewed, on 4/9/25 at 10:13 a.m. Diagnoses included, but were not limited to, cerebral palsy, spondylosis, contractures, and cervical disc disorder with myelopathy.</p> <p>A current physicians order, initiated 4/12/23, indicated give one oxycodone 15 mg tablet orally three times daily for pain.</p> <p>During a medication reconciliation observation on 4/9/25 at 8:56 a.m., Qualified Medication Aide (QMA) 2 did not remove each controlled medication packets, so that both staff that reconciled the controlled drugs were able to observe the controlled medication in each packet. At that time, QMA 2 indicated when a controlled medication was delivered, the nursing staff should ensure the controlled medications were reconciled. The medication monitoring records were then placed in the controlled drug binder on each medication cart. Each time a nurse or QMA removed a controlled medication from the cart, that person should have signed the medication monitoring record, along with the date and time the medication was given, the amount that was on hand before administering the medication, the amount of medication administered, and the amount of the medication that remained in the cart. If a controlled medication had to be wasted, the staff should document that in the record of waste box and when a resident discharged, the amount of remaining controlled medication in the packet should have been documented in the disposition of remaining doses box. The monitoring records were used by the staff during shift change to reconcile the controlled medications. QMA 2 had not thought about both staff members observing the number of controlled drugs in each packet during a reconciliation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a document, titled Medication Monitoring Record, dated 2/10/25 through 2/14/25. At the top of the monitoring record was a label that indicated a packet of 15 oxycodone 15 mg was delivered for Resident B on 2/10/25. Just below the label was a line that indicated Received by: (print name), licensed nurse and Amount Received. Just below that was a graph with seven tabs that ran across the document. The tabs were labeled from left to right, Name of Person Giving, Initial if in Error, Date MM/DD/YY [month, day, year], Time AM/PM, amount on hand, amount given, and amount remaining. Under the labeled boxes were lines that ran across the document, numbered 1 (first line) through 20 (last line). Just below that was a box labeled record of waste and spoilage and below that another box labeled disposition of remaining doses. A review of the information documented on the medication monitoring document indicated:</p> <p>Received by: (print name), Licensed Nurse like - one signature and one printed name.</p> <p>Date received line - 2/10/25.</p> <p>Amount received line - 15 tablets</p> <p>- Line 1 - signature, 2/10/25 at 12:00 p.m., 15 tablets on hand, 1 tablet administered, 14 tablets remained.</p> <p>- Line 2 - signature, 2/10/25 at 10:00 p.m., 14 tablets on hand, 1 tablet administered, 13 tablets remained.</p> <p>- Line 3 - signature, no date documented at 6:00 a.m., no on hand documented, no amount given documented, 12 tablets remained.</p> <p>- Line 4 - signature, 2/11/25 at 12:00 p.m., 12 tablets on hand, 1 tablet administered, 11 tablets remained.</p> <p>- Line 5 - signature, illegible date, no time documented, no on hand documented, no amount administered documented, 10 tablets remained.</p> <p>- Line 6 - no signature documented, no date documented at 6:00 a.m., no on hand documented, no amount given documented, 9 tablets remained.</p> <p>- Line 7 - signature, 2/12/25 at 12:00 p.m., 9 tablets on hand, 1 tablet administered, 8 tablets remained.</p> <p>- Line 8 - signature, 2/12/25 at 10:00 p.m., 8 tablets on hand, 1 tablet administered, 7 tablets remained.</p> <p>- Line 9 - signature, 2/13/25 at 6:00 a.m., 7 tablets on hand, 1 tablet administered, 6 tablets remained, and a line drawn through the documentation on line 9.</p> <p>- Line 10 - signature, 2/13/25 at 6:00 a.m., 6 tablets on hand, 1 tablet administered, 5 tablets remained.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Line 11 - signature, 2/13/25 at 12:00 p.m., 5 tablets on hand, 1 tablet administered, 4 tablets remained.</p> <p>- Line 12 - signature, 2/13/25 at 10:00 p.m., 4 tablets on hand, 1 tablet administered, 3 tablets remained.</p> <p>- Line 13 - signature, 2/14/25 at 6:00 a.m., 3 tablets on hand, 1 tablet administered, 2 tablets remained.</p> <p>The medication monitoring record, dated 2/10/25 through 2/14/25, lacked sufficient documentation to account for the controlled drug administrations on line 3, line 5, line 6, line 9 when a line was drawn through the documentation on line 9, and no documentation to account for the two remaining oxycodone tablets that remained, on 2/14/25.</p> <p>2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone 15 mg but instead had been administering allergy pills to Resident C.</p> <p>During an interview on 4/8/25 at 2:20 p.m., LPN 1 indicated, on 3/6/25 at approximately 12:00 p.m. (approximately 4 hours after the shift started), she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone 15 mg. She recognized the white pill because Resident C's oxycodone tablets were small green pills. LPN 1 didn't think she saw the oxycodone pill packet when she reconciled the controlled substances that morning.</p> <p>The clinical record for Resident C was reviewed on 4/8/25 at 10:41 a.m. The diagnoses included, but were not limited to, anxiety, chronic obstructive pulmonary disorder, and chronic respiratory failure.</p> <p>A current physicians order, initiated 1/30/25, indicated give one oxycodone 15 mg orally every six hour as needed for moderate to severe pain.</p> <p>On 4/9/25 at 9:20 a.m., the Administrator provided a undated copy of a facility policy, titled Narcotic Discrepancies, and indicated this was the current policy used by the facility. A review of the policy indicated the facility would maintain a signed medication count record.</p> <p>This citation relates to Complaint IN00455719.</p> <p>3.1-25(e)(2)</p>		