

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  07/31/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>35099</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received continuous oxygen treatment therapy for 1 of 3 residents reviewed for oxygen. (Resident 81)</p> <p>Finding includes:</p> <p>During an observation on 7/24/24 at 10:12 a.m., Resident 81 was observed lying in bed with her eyes closed and the head of the bed elevated. At the head of Resident 81's bed, next to the wall was an oxygen concentrator with oxygen tubing lying from the back side of concentrator over the top with the nasal cannula on the front side of concentrator. The tubing was observed to be out of Resident 81's reach.</p> <p>During an observation on 7/24/24 at 1:08 p.m., Resident 81 was observed in bed with a food tray on the over bed table. The head of the bed was elevated. Resident 81's speech was slurred and she had difficulty keeping her eyes open. Resident 81's nasal cannula was observed to still be over the concentrator at the head of bed, out of reach of Resident 81.</p> <p>During an observation on 7/24/24 at 1:14 p.m., RN 2 placed pulse oximeter, (a device which detects and displays a person's oxygen saturation level) observed the pulse oximeter result display indicated a reading of 75 percent. RN 2 then placed oxygen nasal cannula on Resident 81. Resident 81 was observed to become more alert with clear, audible speech.</p> <p>During an observation 7/26/24 at 9:32 a.m., Resident 81 was observed up in a wheelchair propelling herself in the hallway with no oxygen. During an interview at that time, RN 10 indicated she was not familiar with Resident 81. RN 10 noted per order that Resident 81 had an order for continuous oxygen per nasal cannula.</p> <p>On 7/24/24 at 12:50 p.m., Resident 81's clinical record was reviewed. Resident 81's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease and acute and chronic Respiratory failure with hypoxia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/10/24, indicated Resident 81 was severely cognitively impaired and utilized oxygen treatment therapy.</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
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician Orders included, but were not limited to, oxygen per nasal cannula continuous inhalation to maintain oxygen saturation greater than 90 percent, every shift for respiratory failure, initiated 12/9/22.</p> <p>The Care Plans included, but were not limited to: At risk for respiratory complications, initiated 2/25/22 The interventions included, but were not limited to, administer oxygen as ordered.</p> <p>On 7/29/24 at 10:02 a.m., the Administrator provided a copy of the Oxygen Therapy Policy, reviewed 11/2014, and indicated it was the current policy in use by the facility. A review of the policy indicated, .It is the policy of the Nursing Department to administer oxygen in accordance with physician's order and on an emergency basis .</p> <p>3.1-47(a)(6)</p>		

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<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>38466</p> <p>Based on record review and interview, the facility failed to document the drug dispositions for 2 of 3 closed records reviewed for drug dispositions. (Resident 139, Resident 44)</p> <p>Findings include:</p> <p>1. Resident 139's closed clinical record was reviewed on 7/29/24 at 9:17 a.m. Resident 139 was discharged home on 6/12/24. The diagnoses included, but were not limited to, multiple sclerosis; dementia; mood disturbance and anxiety; epilepsy; GERD (gastro-esophageal reflux disease); congestive heart failure (CHF); hyperlipidemia (HDL); depression; constipation, pain, and hypertension (HTN).</p> <p>Physician's Orders, dated June 2024 and current at the time of Resident 139's discharge from the facility, included but were not limited to the following:</p> <ul style="list-style-type: none"> <li>- Acetaminophen (over the counter pain medication) 1000 milligrams (mg) by mouth at bedtime for pain</li> <li>- Albuterol Sulfate (a bronchodilator) inhalation nebulization solution 2.5 mg/3 ml (milliliters) .083% every 8 hours as needed for wheezing.</li> <li>- Atorvastatin (a medication used to treat high cholesterol) 20 mg at bedtime.</li> <li>- Cholecalciferol (Vitamin D) 50 micrograms (mcg) daily.</li> <li>- Docusate sodium (stool softner) 100 mg twice a day.</li> <li>- Escitalopram oxalate (antidepressant) 5 mg daily.</li> <li>- Furosemide (a diuretic medication) 20 mg daily.</li> <li>- Levetiracetam (anticonvulsant medication) 500 mg twice a day.</li> <li>- Metoprolol tartrate (a blood pressure medication) 12.5 mg twice a day.</li> <li>- Pantoprazole sodium (a medication used to treat GERD) 20 mg daily.</li> </ul> <p>The closed clinical record lacked a drug disposition document for Resident 139's non-narcotic medications.</p> <p>2. Resident 44's closed clinical record was reviewed on 7/30/24 at 8:30 a.m. The diagnoses included, but were not limited to, HTN, type 2 diabetes, atrial fibrillation (a-fib), chronic kidney disease, HDL, restless leg syndrome (RLS), anemia, GERD, CHF, pain, and major depression.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician's Orders, dated July 2024 and current at the time of Resident 44's death, included but were not limited to the following:</p> <ul style="list-style-type: none"> <li>- Acetaminophen extended release 650 mg every 6 hours as needed for pain.</li> <li>- Aspirin (anti-inflammatory medication) 81 mg daily.</li> <li>- Atorvastatin calcium 20 mg at bedtime.</li> <li>- Empagliflozin (medication used to treat diabetes) 25 mg daily.</li> <li>- Ferrous sulfate (iron supplement) 325 mg every other day.</li> <li>- Gabapentin (nerve pain medication) 100 mg, 2 capsules daily at bedtime.</li> <li>- Humalog kwik-pen insulin sliding scale for diabetes</li> <li>- Isosorbide mononitrate (a medication for heart related chest pain) 20 mg daily.</li> <li>- Pantoprazole sodium 40 mg daily.</li> <li>- Rivaroxaban (blood thinner) 15 mg daily.</li> <li>- Torsemide (diuretic medication) 60 mg twice a day.</li> </ul> <p>The closed clinical record lacked a drug disposition document for Resident 44's non-narcotic medications.</p> <p>During an interview on 7/29/24 at 11:45 a.m., the Administrator indicated the closed clinical records for Resident 139 and Resident 44 lacked drug dispositions records for their non-narcotic medications. The facility disposed of the medications upon the resident's discharge from the facility; however, a non-narcotic drug disposition record was not completed for either resident.</p> <p>During an interview on 7/31/24 at 8:45 a.m., Unit Manager 11 indicated resident medications were to be destroyed at the time of the resident's discharge from the facility. Non-narcotic drug disposition records were not completed when residents were discharged .</p> <p>On 7/29/24 at 11:40 a.m., the Administrator provided a copy of the Medication Disposal and Returns policy, dated 6/21/17, and indicated it was the current policy in use by the facility. A review of the document indicated, .facilities will dispose of .medications .in accordance with local, State, and Federal regulations .</p> <p>3.1-25(s)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38466</p> <p>Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 6 of 6 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Assistant Dietary Manager, Chef 5, Dietary Aide 6, Dietary Aide 7, Kitchen Contractor 8, and Dietary Aide 9)</p> <p>Findings include:</p> <p>1. During the initial kitchen tour with the Dietary Manager (DM), on 7/23/24 from 10:10 a.m. to 10:20 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- Assistant DM was observed walking throughout the kitchen area where the noon meal was being prepared. Assistant DM's hair located in front of her ears was approximately 2 inches in length and the hair at the neckline was approximately 4 inches in length. The hair was observed to not be covered.</li> <li>- Chef 5 was observed walking throughout the kitchen area where the noon meal was being prepared. Chef 5's hair, approximately 2 inches in length, was observed to not be covered.</li> </ul> <p>2. During a follow-up kitchen observation, on 7/23/24 from 11:30 a.m. to 12:05 p.m., the following as observed:</p> <ul style="list-style-type: none"> <li>- Dietary Aide 6 was observed at the steamtable taking the noon starting food temperatures and plating the noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.</li> <li>- Dietary Aide 7 was observed plating the noon meal at the steamtable. Dietary Aide 7 had multiple loose hairs in front of her ears and across the top of her head. The loose hairs were approximately 1 inch in length and were observed to not be covered.</li> <li>- Chef 5 was observed walking throughout the kitchen area where the noon meal was being plated. Chef 5 was observed preparing food for the evening meal. Chef 5 had multiple loose hairs in front of his ears and at the neckline. The loose hairs were approximately 2 inches in length and were observed to not be covered.</li> <li>- Kitchen Contractor 8 was observed walking throughout the kitchen area and near the steamtable where the noon meal foods were being plated. Kitchen Contractor 8's hair on his head was approximately 1 inch in length. He also had facial hair, approximately 2 inches in length, that covered his entire facial area. Kitchen Contractor 8's hair was observed to not be covered.</li> </ul> <p>During an interview at that time, Kitchen Contractor 8 indicated all hair was to be kept covered when in the kitchen area.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a dining observation on 7/23/24 at 12:10 p.m., Dietary Aide 9 was observed in the Rehabilitation Unit. Dietary Aide 9 was observed working at the steamtable unit and was plating the resident's noon meal. Dietary Aide 9 had multiple hair braids in front of the left ear. The braids were approximately 7 inches in length and were observed to not be covered.</p> <p>4. During a follow-up kitchen observation, on 7/23/24 from 12:30 p.m. to 12:45 p.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- Chef 5 was observed walking throughout the kitchen area; near the steamtable where the noon meal was being plated; and working at the food preparation table preparing desserts for the evening meal. Chef 5 had multiple loose hairs in front of his ears and at the neckline. The loose hairs were approximately 2 inches in length and were observed to not be covered.</li> <li>- Dietary Aide 6 was observed plating the noon meals at the steamtable and was taking the ending temperatures for the noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.</li> </ul> <p>5. During a follow-up kitchen observation, on 7/30/24 from 11:10 a.m. to 11:20 a.m., the following was observed:</p> <ul style="list-style-type: none"> <li>- Dietary Aide 6 was observed frying an egg on the grill and taking the noon meal food starting temperatures at the steamtable. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.</li> <li>- Assistant DM was observed near the grill area where noon foods were being prepared and was near the steamtable where the noon meal foods were being held. Assistant DM's hair located in front of her ears was approximately 2 inches in length and the hair at the neckline was approximately 4 inches in length. The hair was observed to not be covered.</li> </ul> <p>6. During a follow-up kitchen observation, on 7/30/24 from 1:15 p.m. to 1:20 p.m., Dietary Aide 6 was observed at the steamtable plating the noon meal and began taking the ending temperatures for noon meal. Dietary Aide 6 had multiple loose hairs in front of her ears and at the neckline. The loose hairs were approximately 3 inches in length and were observed to not be covered.</p> <p>During an interview on 7/23/24 at 12:50 p.m.c, the DM indicated all staff's hair was to be covered while in the kitchen.</p> <p>During an interview on 7/30/24 at 1:25 p.m., the Corporate Traveling Chef indicated staff were to keep their hair completely covered while in the kitchen.</p> <p>On 7/25/24 at 9:00 a.m., the DM provided a copy of the Employee Sanitary Practices policy, dated 2013, and indicated it was the current policy in use by the facility. A review of the policy indicate, .all kitchen employees will practice standard sanitary procedures .wear hair restraints when preparing food (hairnet, hat, and/or beard restraint) to prevent from contacting exposed food .follow all federal, state, and local requirements .</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/25/24 at 4:05 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, .food employees shall wear hair restraints, such as .beard restraints .</p> <p>3.1-21(i)(2)</p> <p>3.1-21(i)(3)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35099</p> <p>Based on observation, record review, and interview, the facility failed to ensure the staff were wearing PPE (personal protection equipment) for 1 of 3 residents who were observed for enhanced barrier precautions. (Resident 9)</p> <p>Findings Include:</p> <p>On 7/24/24 at 10:30 a.m., RN 2, CNA 4, LPN 3, entered Resident 9's room to provide wound care. RN 2 carried in supplies retrieved from treatment cart, LPN 3 assisted with turning and positioning Resident 9 while CNA 4 held clean linen. RN 2, LPN 3, and CNA 4 donned gloves. RN 2 and LPN 3 turned Resident 9 on his left side and RN 2 removed the old bandage and changed her gloves, no hand hygiene was observed. RN 2 cleaned the wound and a topical medication was applied to the wound. CNA 4 then provided incontinence care with only gloves. Only gloves were utilized during the observed treatment by all three staff providing care.</p> <p>Resident 9's clinical record was reviewed on 7/24/24 at 11:00 a.m., The diagnosis included, but was not limited to, pressure ulcer of right buttock, stage 3.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 6/14/24, indicated Resident 9 had moderate cognitive impairment and an open area to the right buttock.</p> <p>The Physician Orders included, but were not limited to, Enhanced Barrier Precautions- Gloves and Gown with treatment and or care every shift for wound ordered 3/16/20</p> <p>During an interview on 7/26/9:28 a.m., Resident 9 indicated that Nurses never wear a gown when providing wound care.</p> <p>During an interview on 7/26/24 at 11:00 a.m., Administrator indicated that staff should wear gloves and gown with Enhanced Barrier Precautions.</p> <p>On 7/29/24 at 10:02 a.m., the Administrator provided a copy of policy titled, [NAME] Senior Life Procedure, Isolation Precautions, revised 8/1/22. The policy indicated Elements of Enhanced Barrier Precautions, gloves and gowns should be work during high-contact resident care, dressing, bathing/showering, changing linens, transferring (when in resident room), providing hygiene, toileting, device care (use in central line, urinary catheter, feeding tube, tracheostomy) and wound care (skin opening requiring a dressing).</p> <p>3.1-18(b)(1)</p>