DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN SENIOR LIVING LLC	1375 NICOLE DRIVE 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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440763. Complaint IN00440763 - State deficiencies related to allegation cited at R0052. Survey date: August 23, 2024 Facility number: 015132 Residential Census: 26 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed August 30, 2024.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to protect the resident's right to be from neglect for 1 of 3 residents reviewed for elopement. This deficient practice resulted in a cognitively impaired resident residing on a secured memory care unit exiting the facility through vacant apartment windows three times. (Resident B) Finding includes: During an interview on 8/23/24 at 8:36 a.m., the Administrator indicated Resident B climbed out a window of a vacant apartment on 8/19/24. There was a small alarm that had been placed on the windows, but since Resident B closed the door the staff did not hear the alarm. Resident B had	R 0052	**1 How the facility will correct the deficiency as it relates to the individual:** For Resident B, following interventions have been implemented: a Alarms added to memory support windows 7/26/24 and community provided 1:1 supervision daily until resident's exit seeking behaviors greatly reduced. b One on one supervision from private caregiver from 4p-10pm 8/20/24, which is resident's high elopement risk time.	09/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Traci Scott	Regional Director of Operations	09/12/2024

Any defiencystatement 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.

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	eloped 2 previous times through a window. On 7/20/24 at an unknown time, Resident B eloped through a window in another vacant apartment. Resident B went to the neighborhood behind the facility a man that was standing outside saw him and called the police. At approximately 9:00 a.m., the police brought Resident B back to the facility, but never came in to talk to the staff so we were not aware of where the police picked him up. On 7/23/24 during the night shift, Resident B went out through a window in another vacant apartment. A staff member climbed out the window, so Resident B was never out of sight. At that time, Resident B was on one-on-one observation, but was not able to be redirected. During an interview on 8/23/24 at 8:52 a.m., QMA 1 (Qualified Medication Aide) indicated Resident B had been exit seeking for several weeks. Resident B often pushed on doors and tried to follow visitors out the door in the past. The clinical record for Resident B was reviewed on 8/23/24 at 9:07 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, and anxiety. A BIMS (Brief Interview for Mental Status) assessment, dated 7/19/24, indicated Resident B was severely cognitively impaired. A Wander Risk Assessment, dated 7/19/24, indicated Resident B was at high risk to wander. A Service Plan, dated 7/23/24, included, but was not limited to: - Resident B had exit seeking behaviors. Interventions included, but were not limited to,		c Medication review by pharmacist requested 8/20/24. d Physician saw resident 8/21/2024. e Director of Plant Operations spoke with ISDH Life Safety regarding further securing windows on Memory Support and further security measures of *occupied* apartments not recommended. The windows in the *unoccupied* apartments have been further secured to deter resident. **2 How the facility will act to protect residents in similar situations:** a Community assesses each resident at move-in and completes a wander risk assessment. This assessment is completed every six months and with change in condition. b Resident Services Director (RSD) reviews resident chart (PointClickCare) documentation to identify any residents with potential to exit seek or wandering risk on daily basis and upon notification from staff of new exit seeking behaviors. c Staff interventions to distract from exit seeking. d Physician notification of exit seeking behaviors. e Residents identified with exit seeking behavior will be observed for location on memory support neighborhood frequently throughout shift.	

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	physician review of Resident B's behaviors and recommend medication changes related to anxiety and agitation if needed, initiated 7/23/24. Resident B had exit seeking behavior and tended to get out of the facility through doors and windows, initiated 7/24/24. - Resident B was at risk for elopement. Interventions included, but were not limited to, observe Resident B's location in the community in the secured unit, initiated 7/23/24. Resident B was to be on one-on-one supervision to ensure resident remains safe, initiated 7/20/24. Resident B tried to exit secured unit via windows and doors, initiated 7/23/24. - Resident B required safety. The intervention was Resident B was on one-on-one supervision, initiated 7/23/24. A Progress Note, dated 7/20/24 at 9:00 a.m., indicated Resident B was brought on to the secured unit, at approximately 9:00 a.m., by staff. Receptionist stated Resident B was found in the neighborhood behind the facility and brought back to the facility by the police. A Progress Note, dated 7/23/24 at 9:30 a.m., indicated Resident B was still looking to exit unit to find his wife. Resident B exited the facility during the night through a window with staff following behind him. A Progress Note, dated 8/19/24 at 10:36 p.m., indicated Resident B walked into a vacant apartment. When staff entered the apartment Resident B was seen in front of building. Staff was able to assist Resident B back to the secured unit. The window in the apartment was shut but the screen was popped out and on the ground. During an interview on 8/23/24 at 10:05 a.m., the		f Recommendations for 1:1 supervision could occur depending on the circumstances. **3 The measures the facility will take or the systems it will alter to ensure that the problem does not recur:** a Maintenance to ensure all memory support doors and windows are secured routinely. b Routine observation and/or interventions (engage in activity, assist resident with calling family) for residents identified that are exit seeking. c Education provided to staff regarding residents that are at risk and observing for location on secured neighborhood. **4 How the facility will monitor its performance to make sure that solutions are sustained:** a Seven days/week audits x 4 weeks to ensure Memory Support doors and widows are secure then weekly audits x's 4 weeks. b Observations of residents identified for exit seeking behaviors are completed three times per shift and documented on audit tool for 6 weeks. c Audits will be reviewed in QAPI. Audit Tools are attached. **5 Date corrective action will be completed:** a Education to be completed by	

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	Maintenance Director indicated on 7/20/24, Resident B exited the facility through a window in a vacant apartment. The Maintenance Director indicated on 7/23/24, Resident B exited the facility through another window in another vacant apartment. The Maintenance Director placed small battery operated alarms on each window on the unit after Resident B exited on 7/23/24. On 8/23/24 at 9:30 a.m., the Administrator provided a copy of a facility policy, titled Elopements and Wandering Resident, dated 3/1/21, and indicated this was the current policy used by the facility. A review of the policy indicated the facility ensures that residents who exhibit wandering behavior, and/or are at risk for elopement, receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care. This citation relates to Complaint IN00440763.		9/16/24.	