

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, and interview, the facility failed to accurately assess the use of antipsychotic medication for 1 of 6 (Residents #31) sampled residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the RAI Manual dated 10/2024, revealed .The RAI process has multiple regulatory requirements .the assessment accurately reflects the resident's status .SECTION N: MEDICATIONS .The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, two medication sections have been added. The first is an Antipsychotic Medication Review. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications .1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day lookback period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home .Code all high-risk drug class medications according to their pharmacological classification, not how they are being used .N0415A1 .Antipsychotic: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) .N0415A2 .Antipsychotic: Check if there is an indication noted for all antipsychotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days) .</p> <p>2. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with readmission on [DATE], with diagnoses including Epilepsy, Presence of Cerebrospinal Fluid Drainage Device, Hungry Bone Syndrome, Dementia, Schizophrenia, Anxiety Disorder, Traumatic Brain Injury, Unspecified Intellectual Disabilities, Obstructive Hydrocephalus, and History of Falls.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the Brief Interview for Mental Status (BIMS) assessment was not conducted due to Resident #31 was rarely/never understood. Further review revealed Resident #31 had not received antipsychotic medications within the last 7 days prior to the MDS completion date of 4/14/2025. Further review revealed Resident #31 had not received antipsychotic medications since admission/entry or readmission.</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: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan Report for Resident #31 revealed, .Focus .Receives .antipsychotic .medication r/t [related to] .psychosis, schizophrenia . initiated 1/25/2024, with revision on 1/10/2025.</p> <p>Review of an Internal Medicine Progress Note for Resident #31 dated 6/2/2025, revealed .Medications: Seroquel [medication to treat Schizophrenia] 100 mg [milligrams], Give 150 mg by mouth two times a day .</p> <p>Review of the Order Recap Report for Resident #31 dated 6/3/2025, revealed an active order with a start date of 12/30/2024, for .Seroquel Oral Tablet 100 mg (Quetiapine Fumarate) Give 150 mg by mouth two times a day .</p> <p>Review of the Medication Administration Record (MAR) revealed Resident #31 received, .Seroquel Oral Tablet 100 mg .Give 150 mg by mouth two times a day . at 8:00 AM and 8:00 PM during April 2025.</p> <p>During an interview on 6/4/2025, at 10:55 AM, the Regional Director of Clinical Services confirmed that Resident #31 received antipsychotic medications during the 7-day period prior to the MDS Assessment Reference Date of 4/14/2025 and the antipsychotic medications were not accurately coded on the MDS.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review, and interview, the facility failed to follow physician's orders and administer medications according to professional standards, as well as facility policy, for 1 of 6 (Resident #15) residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the undated facility policy titled, Medication Administration, revealed, .Medications are administered by license nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .10. Review MAR [Medication Administration Record] to identify medication to be administered .17. Sign MAR after administration .18. If medication is a controlled substance, sign narcotic book .20. Correct any discrepancies and report to nurse manager .</p> <p>Review of the undated facility policy titled, Controlled Substance Accountability, revealed, .It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances .1. General Protocols .h. The Controlled Drug Record serves the dual purpose of recording both narcotic disposition and patient administration .j. The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify: ii. Mediations removed from either the automated dispensing system or medication cart/cabinet have a documented physician order .</p> <p>2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with readmission on [DATE], with diagnoses including Parkinson's Disease, Sepsis, Chronic Obstructive Pulmonary Disease, Metabolic Encephalopathy, Depression, and Anxiety.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #15 was cognitively intact. Further review revealed Resident #15 received antianxiety, antidepressant, and opioid medications.</p> <p>Review of the physician's orders for Resident #15 revealed an order for .Clonazepam Oral Tablet 0.5 MG [milligram] Give 0.25 mg via G-Tube at bedtime for schizophrenia AND Give 0.25 mg via [by way of] G-Tube [A feeding tube inserted into the stomach to deliver nutrition and medication] every 12 hours as needed for anxiety ., with a start date of 7/29/2024 and was discontinued on 8/14/2024. Continued review revealed an order for, .clonazepam oral 0.5 mg (milligram) (Clonazepam) Give 0.25.mg via PEG [percutaneous endoscopic gastrostomy] Tube [A medical device that delivers nutrition directly to the stomach or small intestine through a flexible tube] two times a day for Anxiety . with a start date 8/16/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Controlled Drug Receipt Record/Disposition Form for Resident #15, received 7/29/2024, revealed a physician's order, printed at the top of the form, for .Clonazepam 0.5 mg Tabs (tablets) .Take 1/2 tablet via tube every 12 hours as needed; Give 1 tablet via tube at bedtime .(half tabs) . Continued review of the Controlled Drug Receipt Record/Disposition Forms received 7/29/2024 and 8/17/2024, revealed Clonazepam 0.5 mg (1/2 tablet x 2) were signed off as given at 9:00 PM on 9/2/2024, 9/5/2024, 9/6/2024, 9/7/2024, 9/8/2024, and 9/9/2024.</p> <p>Review of the Medication Administration Record (MAR), dated 9/1/2024-9/30/2024, revealed Resident #15 received Clonazepam 0.25 mg via PEG Tube two times daily at 9 AM and PM.</p> <p>During an interview on 6/4/2024 at 2:30 PM, the Regional Director of Clinical Services confirmed that the physician's order for Clonazepam located at the top of the Controlled Drug Receipt Record/Disposition Form received 7/29/2024 for Resident #15 had been discontinued and that the the most recent physician's order for Clonazepam 0.5 mg tablets-Take 1/2 tablet via tube every 12 hours started on 8/16/2024. She further confirmed that on the Controlled Drug Receipt Record/Disposition Forms, Clonazepam 0.5 mg (1/2 tablet) x 2 were signed out as given, at 9:00 PM on 9/2/2024, 9/5/2024, 9/6/2024, 9/7/2024, 9/8/2024, and 9/9/2024, and only 1 (1/2 tablet) should have been given per the physician's order that had started 8/16/2024.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interview, the facility failed to ensure 1 of 3 (Resident #10) sampled residents reviewed for accident hazards received adequate supervision to prevent elopement (a situation where a resident leaves the premises or safe area without necessary supervision). On 4/27/2024, at approximately 1:00 PM, Resident #10, a vulnerable and cognitively impaired resident with a history of wandering behaviors, eloped from the facility when the receptionist unlocked the main entrance door for a vendor to exit the building. Resident #10 followed the vendor out of the main entrance. A staff member observed the Resident on the sidewalk across a 2-lane street and assisted the Resident inside the facility within 2-3 minutes of his elopement. The facility failed to continue increased supervision after 4/30/2024 at 9:45 AM. On 5/5/2024, at approximately 9:00 PM, staff discovered Resident #10 was not accounted for during a head count, after a staff member heard the main entrance door alarming and determined no one was at the main entrance. Resident #10 eloped from the facility, undetected, through the main entrance. The Resident was found at a convenience store by a staff member, approximately 0.1 miles from the facility. The Resident returned to the facility with the staff member at 9:19 PM. The facility's failure to provide adequate supervision to Resident #10 resulted in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) for Resident #10 and placed 2 other residents identified as having the potential for elopement at risk for Immediate Jeopardy.</p> <p>The Administrator and Regional Director of Clinical Services were notified of the Immediate Jeopardy on 6/4/2025 at 5:35 PM, in the Administrator's office.</p> <p>The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J which constitutes Substandard Quality of Care.</p> <p>The IJ began on 4/27/2024 and continued through 5/8/2024. The facility's corrective actions were completed on 5/8/2024.</p> <p>An acceptable Removal Plan, which removed the immediacy of the Jeopardy for the past noncompliance, was received and validated on-site on 6/4/2025.</p> <p>The IJ was cited as past noncompliance for F-689 and the facility is not required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of the undated facility policy titled, Elopement Risk, revealed .This facility ensures that residents who exhibit unsafe 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 addressing the unique factors contributing to unsafe wandering or elopement risk .Elopement occurs when a resident leaves the premises or a safe area without authorization .supervision .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement .and monitoring for effectiveness and modifying interventions when necessary .Supervision will be provided to help prevent accidents or elopements .The effectiveness of interventions will be evaluated, and changes will be made as needed .Active exit seeking residents will be placed under staff supervision .The patient is always accompanied by the staff member .</p> <p>2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses including Dementia, Alzheimer's Disease, Restlessness, and Agitation.</p> <p>Review of an elopement Risk Assessment for Resident #10 dated 4/16/2024, revealed the Resident was a high risk for elopement.</p> <p>Review of a significant change in status Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severe cognitive impairment. Wandering behaviors were not identified on the MDS.</p> <p>Review of a nurse's progress note dated 4/27/2024 at 3:57 PM, revealed .At approximately 1pm, [Resident #10] went outside from the front lobby door. Staff immediately went after [Resident #10] and was able to safely escort [Resident #10] back into the building without incident. Vitals WNL [within normal limits]. Full head to toe assessment was done and resident has a small skin tear to lower right forearm. Measures 0.8cm [centimeters] X [by] 0.8cm. Area cleansed with normal saline and covered with a dry dressing. No complaints of pain voiced. Resident on 1:1 [one to one] supervision .</p> <p>Review of a comprehensive care plan for Resident #10 dated 4/27/2024, revealed .Resident is at risk for elopement r/t [related to] history of exit seeking behavior .4/27/24 [2024] Resident elopement from building . 1:1 supervision at time of incident [elopement] and then every 15 minute checks .</p> <p>Review of facility documents titled, 15 Minute Increments to Verify Intense Supervision with 1:1 Acuity, for Resident #10 revealed the Resident was on every 15 minute checks from 4/27/2024 at 1:15 PM - 4/30/2024 at 9:45 AM.</p> <p>Review of Certified Nursing Assistant (CNA) R's written witness statement dated 4/27/2024, revealed .I was bringing my dirty dish cart to the dining area and looked out the door and saw [Resident #10] outside across the street .He was walking outside with clothes in hand across the street .Yelled out for others and notified them that [Resident #10] was outside .going after [Resident #10] during this time as well .</p> <p>Review of Housekeeper BB's written witness statement dated 4/27/2024, revealed .I heard [CNA R] call out Code Orange [elopement]. [Resident #10] went out the door. He crossed the road to the other side. Then I went .to grab him .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Receptionist S's written witness statement dated 4/27/2024, revealed .I was sitting at the front desk and let the lab tech [technician] out the door. [Resident #10] followed behind her with clothes in his hand as if he was a visitor. [Resident #10] was able to make it across the street unharmed. A nursing aid [CNA R] recognized him and went into action and secured him safely and walked him back into the building. The entire incident only lasted about 3 minutes .</p> <p>Review of a nurse's progress note for Resident #10 dated 5/6/2024 at 5:39 AM, revealed .[On 5/5/2025 at approximately 9:00 PM] Nurse responded to door alarm panel at the nurses [nurses '] station alerting the front door. Nurse did not see anyone at the door or outside the door. Nurse alerted all staff to do a head count of residents. Staff unable to locate [Resident #10] inside building or outside. [Licensed Practical Nurse-LPN T] got in vehicle and observed [Resident #10] ambulating at a fast pace down the street toward the convenience store. [Resident #10] Said 'hey how did you know I was here?' when [LPN T] called his name. [Resident #10] Stated he was headed to his apartment .Assisted into vehicle and back to the facility. No injuries noted. Mood pleasant. 1 on 1 care provided. Administrator, DON [Director of Nursing] MD [Medical Doctor], and wife notified .</p> <p>Review of a comprehensive care plan for Resident #10, revised 5/5/2024, revealed .5/5/24 Resident elopement from building .1:1's until discharge to another community .Door alarm company to come out and check all doors .</p> <p>Review of Licensed Practical Nurse (LPN) T's written witness statement dated 5/5/2024, revealed .At approximately 9 pm [9:00 PM] I heard the front door alarm sound on the panel at the nurses station. I immediately went to the front door. I did not see anyone in the front lobby or outside the front door or parking lot/road. I then went back to the floor to alert staff and do a head count. We were unable to locate [Resident #10]. While searching the building inside and outside the supervisor received a call that [Resident #10] was walking down the road. I got in my personal vehicle and drove towards [named boulevard]. I observed [Resident #10] walking at a fast pace on the side of the road towards the convenience store. I pulled over and called his name. [Resident #10] said 'hey! How did you know I was here?' I assisted [Resident #10] into my vehicle. Was in a pleasant mood without any distress noted. Said 'I was headed home to my apartment' . Reoriented to his home at [named facility] and taken to his room. 1 on 1 care provided for the remainder of the shift. [Resident #10] was assisted into my vehicle at 9:18 PM. The administrator, DON [Director of Nursing], MD [Medical Doctor], and his POA [Power of Attorney] was notified per supervisor .</p> <p>Review of Registered Nurse (RN) A's written witness statement dated 5/5/2024, revealed .At around [9:05 PM], I heard the door alarm sound. [Named LPN T] went to the front [and] found the door locked with no one outside or in the lobby. I and the other staff started a search .A search did not find [Resident #10] in the building. At this point I received a phone call informing me that he had been spotted outside. I went out to search for along with [Named LPN T].I continued to search for him until I received news from [Named LPN T] that she had [Resident #10] and was returning to the facility .</p> <p>Review of CNA Z's written witness statement dated 5/5/2024, revealed .[Resident #10] was hanging out in the front prior to eloping. In which I made him come to his room around [8:45 PM] so we could see him. [Resident #10] let us know that he opened the door by pushing it open. And was placed on 1:1 supervision for the rest of the night .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #10 revealed the resident remained on 1:1 supervision from the time he returned to the facility on 5/5/2025 at approximately 9:20 PM, until he was transferred to a different facility on 5/8/2024 at 12:00 PM.</p> <p>During an interview on 6/2/2025 at 2:00 PM, the Administrator confirmed Resident #10 had eloped on 4/27/2024 when the receptionist opened the door for a lab technician to exit the main entrance. The resident walked out of the facility behind the lab technician. The Administrator stated a staff member saw Resident #10 outside of the facility, immediately went to the resident, and brought him safely back into the facility. Resident #10 was taken to the nurse's station, where he could be monitored more closely, and was placed on every 15 minute checks. Following the incident, risk assessments were performed for every resident and the Administrator ensured warning postings were visible regarding not allowing anyone to follow visitors/vendors out of door as they leave. Resident photos in the elopement book at the receptionist desk were updated. All staff received education on the elopement policy. The Administrator stated the facility was in the process of finding placement for Resident #10 at a facility with a secure unit when the resident eloped again on 5/5/2024. The Administrator stated the Resident had been observed in the lobby at 8:45 PM and had been redirected and assisted back to his room. The Administrator stated, on 5/5/2024 at approximately 9:00 PM, a staff member heard the main entrance door alarm. A nurse (LPN T) went to the entrance, looked outside, checked the dining room and restroom, and saw no one. Other staff on duty did a head count and discovered Resident #10 was not accounted for. The Administrator stated an off-duty employee saw Resident #10 at a store .down the road . and notified the facility. LPN T drove to the store, picked up the resident, and returned the resident to the facility at 9:19 PM. Resident #10 was immediately placed on 1:1 supervision until he was discharged to a facility with a secure unit on 5/8/2024. On 5/6/2024, a contracted electric service verified the door's locking mechanism was receiving electricity and was working properly. On 5/7/2024, the facility's Regional Life Safety/Maintenance Director determined the door would close but bounced away from the doorframe not allowing the door's magnetic lock assembly to energize correctly and secure the door in the locked position. Adjustments were made to the door's self-closing device to prevent the door from bouncing away from the doorframe. Verification the locking mechanism was working correctly occurred on 5/8/2024. The facility ordered a system with wearable devices (bracelets) which tracked a resident's location and triggered alerts when they approached restricted areas or exit points on 5/8/2024. The Administrator confirmed Resident #10 eloped from the facility on 4/27/2024 and 5/5/2024.</p> <p>During a telephone interview on 6/2/2025 at 7:13 PM, CNA R stated Resident #10 eloped from the facility on 4/27/2024. CNA R stated .I know I recognized him [Resident #10], and it was my duty to get him back inside and keep him safe .I called a code [elopement code] and got some backup . CNA R stated [Housekeeper BB] went to Resident #10 and brought him back inside the facility. When asked if Resident #10 crossed the street, CNA R asked .what did my statement say . CNA R's statement was read verbatim .I was bringing my dirty dish cart to the dining area and looked out the door and saw the resident outside across the street . CNA R stated, .I gotta [got to] stick with whatever my statement said, cause my memory is not that vivid .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/3/2025 at 3:45 PM, Receptionist S stated she had looked at the elopement book when her shift started [4/27/2024] to see if anyone new had been added to the book. Receptionist S stated .I had never met or seen [Resident #10] before .only saw him in the book .On this particular day, someone came in to draw blood .Had families coming in and out .It's common for families to pick up laundry on the weekend .The picture [of Resident #10] in the book didn't look like him .When I was letting out the phlebotomist [lab technician], there was a man behind her with a bag and clothes over his arm . Receptionist S stated when she opened the door for the lab technician, Resident #10 went out behind her. One of the techs (CNA R) happened to walk by and recognized the resident who had walked across the street. Receptionist S stated Resident #10 was out of the facility for 2-3 minutes.</p> <p>Observation of the reception desk on 6/3/2025 at 4:00 PM, revealed an elopement book was located at the desk. Resident photos who were high risk for elopement were in the notebook.</p> <p>During a telephone interview on 6/3/2025 at 4:10 PM, LPN T stated .I heard the alarm [front door] go off [on 5/5/2024 at approximately 9:00 PM], so I went to the front door .didn't see anybody around it or outside .had everyone do a head count .discovered [Resident #10] wasn't in there .went down the road and found [Resident #10] .he was going toward the store .he was almost there [store] .got him back in the building .We did 1:1 .had a nurse sit with him all night . LPN T stated Resident #10 was discharged to a facility with a secure unit.</p> <p>During an observation and interview on 6/4/2025 at 10:00 AM, with the Maintenance Director, all doors were verified as in good working condition and locking mechanisms were working appropriately. The Maintenance Director stated the doors were checked monthly to ensure the locking mechanisms were working properly.</p> <p>During a telephone interview on 6/4/2025 at 4:41 PM, the Medical Director stated she was aware of Resident #10 eloping from the facility on 4/27/2024 and 5/5/2024. The Medical Director stated she participated in AdHoc (urgent meetings to address specific issues which require immediate attention) Quality Assurance and Performance Improvement (QAPI) Meetings after both of Resident #10's elopements and was involved in determining next steps to prevent further resident elopements.</p> <p>Observations by the survey team from 6/2/2025-6/4/2025 revealed residents who were high risk for elopement were wearing bracelets which alerted staff when a resident approached an exit point.</p> <p>The facility's corrective actions for the removal plan were issued to the state surveyors on 6/4/2025. The corrective action plan included the following:</p> <p>/5/2024 - Resident #10 returned to the facility with LPN T at 9:19 PM.</p> <p>A complete assessment was performed for Resident #10 upon return to the facility with no injuries or change in condition noted.</p> <p>Resident #10 was placed on 1:1 observation.</p> <p>Resident #10's spouse and physician were notified.</p> <p>Staff ensured all facility exits were locked properly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ad-Hoc QAPI call with leadership and Governing Board to discuss Resident #10's elopement.</p> <p>100% staff educated on facility's Elopement Policy with Post-Test and was ongoing.</p> <p>Elopement drills were conducted on day and night shifts for both rotations on 5/6/2024, 5/8/2024, 5/20/2024, and 6/4/2024 to ensure knowledge and compliance.</p> <p>Resident #10's care plan was updated by MDS to include 1:1 supervision until discharge.</p> <p>Resident #10 was evaluated by psychiatric services on 5/6/2024.</p> <p>Resident #10 was seen by physician on 5/7/2024.</p> <p>Ad-Hoc QAPI meeting was held on 5/6/2024 with QAPI Committee and leadership team in attendance.</p> <p>5/7/2024 - Verification electricity to the door locking mechanism was working properly and incident did not occur due to an electrical failure</p> <p>Ad-Hoc QAPI meeting was held on 5/7/2024 with Medical Director.</p> <p>Regional Life Safety/Maintenance Director determined the main entrance door would close, but bounced away from the doorframe, not allowing the door's magnetic lock assembly to secure the door in the locked position. Adjustments were made to the door's self-closing device. The door was tested numerous times, and the magnetic lock secured the door each time to lock securely.</p> <p>5/8/2024 - Contracted company verified the locking mechanism on the main entrance door was working correctly.</p> <p>5/8/2024 - Resident #10 remained on 1:1 supervision until he was discharged on 5/8/2024. Resident #10 was admitted to a facility with a secure unit as planned prior to the elopement on 5/5/2024.</p> <p>5/9/2024 - Follow-up with Governing Board was held.</p> <p>Maintenance department conducted random door audits to ensure the doors were locking properly with no concerns noted. Monthly audits were ongoing.</p> <p>Results of the random door audits were reported to the QAPI committee monthly for 3 months to ensure continued working compliance of door.</p> <p>The Removal Plan was validated onsite by the surveyors on 6/4/2025 which included review of the facility documentation to show each step was completed and staff interviews to confirm completed and ongoing actions, elopement education, and participation in elopement drills.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to ensure medications were stored and administered safely when medications were left unattended in resident's room during medication administration for 1 of 6 (Resident #5) residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the undated facility policy titled, Medication Storage, revealed, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .1. General Guidelines .c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p> <p>Review of the facility's undated policy titled, Medication Administration, revealed, .Medications are administered by license nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .15. Observe resident consumption of medication .</p> <p>2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with readmission on [DATE], with diagnoses including Unspecified Injury at C7 Level of Cervical Spinal Cord, Quadriplegia, Post Traumatic Stress Disorder, Cognitive Communication Deficit, Depression, and Anxiety.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #5 was cognitively intact. Further review revealed Resident #5 received antianxiety, antidepressant, anticonvulsant, and opioid medications.</p> <p>Review of the physician orders for Resident #5 dated 5/2/2024, revealed, .Oxycodone HCL [Hydrochloride] [A type of semi-synthetic opioid agonist used to relieve moderate to severe pain] oral tablet 15 mg [milligrams] Give 30 mg by mouth every 4 hours as needed for pain scale 9-10 .</p> <p>Review of the Previous Assistant Director of Nursing (ADON) Q's signed statement dated 9/10/2024, revealed .On this date resident (Resident #5) reported to me that a night nurse attempted to give her the wrong pain medication .Resident states that (RN [Registered Nurse]) A then exited the room leaving her medications on her overbed table .Resident left the medication on her table for me to view upon entrance to the building .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Franklin Wellness and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 West Main Street Franklin, TN 37064	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Detail of Complaint, statement for Resident #5 dated 9/11/2024, revealed .On the date of 9/10/2024 [Previous ADON Q] was called to the room of resident [Resident #5]. Upon entering resident's room, the resident stated that she had not received the correct Pain medication this morning. Resident stated the night shift nurse came into my room at 0600 [6:00 AM] this morning to give me my medication. She was trying to hurry me up to take my medications. I told the nurse that I must wake up before I can take medications. Then the nurse set the medication cup on the bedside table and left the room. When I looked in the cup, I noticed I had two pills that I wasn't supposed to take. I asked for the nurse to return to my room on 3 separate occasions and she never returned. I left the medication cup on the bedside table for the ADON to see .</p> <p>During a phone interview on 6/4/2025 at 2:19 PM, Previous ADON Q stated that Resident #5 had reported to her on 9/10/2024 that RN A had left her 6:00 AM medications in her room sitting on top of her bedside table for her to take at a later time. Previous ADON Q confirmed that she observed medications in a medication cup sitting on top of Resident #5's bedside table. Previous ADON Q stated, She had kept the pills for me to look at. Previous ADON Q stated, They (nurses) are not supposed to leave meds (medications) with patients. They are supposed to watch them take their meds, not leave them sitting in a cup.</p> <p>During an interview on 6/4/2024 at 3:03 PM, the Director of Nursing (DON) stated that when administering medications to residents, the nurse should Make sure they [residents] take their meds. They should not be left at the bedside for any reason.</p>		