

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>**Amended**</p> <p>A Recertification/Abbreviated Survey (KY#22284 and KY#22249) was conducted on 10/01/14 through 10/03/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "D". KY#22249 was unsubstantiated with no deficiencies cited. KY#22284 was substantiated with deficiencies.</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS//INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged</p>	F 225	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *Deny Steubels* *Interim Administrator* 10/28/14

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.

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 225	<p>Continued From page 1</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's investigation and policy and procedures it was determined the facility failed to ensure all alleged violations were investigated to include assessing non-interviewable residents timely for signs and symptoms of abuse related to an allegation of abuse of one (1) of sixteen (16) sampled residents (Resident #9).</p> <p>The findings include:</p> <p>Review of the facility's policy Abuse and Neglect, not dated, revealed all incidents of alleged abuse or neglect would be summarized, trends would be identified, recommendations would be made, and action plans would be developed, implemented and follow up would ensure ongoing compliance. Further review of the policy revealed following an allegation, the facility would implement increased supervision and monitoring of residents as needed to ensure that all residents were safe from any further abuse.</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> 1. A skin assessment and interview for resident # 9 was conducted by a staff nurse on 9/12/14. The skin assessment for resident # 9 did not note any injuries or indication of abuse completed by Diane Crain on 9/14/14. The resident interview for resident # 9 was reported and noted in the submitted investigation with abuse being unsubstantiated. 2. All residents with a BIMs score of 8 or greater will be interviewed and will be completed by the Social Services Director, Assistant Social Services Director or Administrator by 11/14/14. All resident with a BIMs score less than 8 will have a skin assessment completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager and MDS Nurse by 11/14/14. Any suspicions of Abuse or Neglect will be reported to the appropriate agencies in a timely manner for through investigation. This will be completed by 11/14/14 3. The Regional Director of Operations will re-educate the Administrator and Director of Nursing by 11/14/14 on completing a thorough investigation including timely interviews and or skin assessments when appropriate. 	11/15/14	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 225	<p>Continued From page 2</p> <p>Review of the facility's final Investigation Report, dated 09/19/14, revealed on 9/12/14, Resident #1 reported he/she had been struck by a girl with a long ponytail the evening before. The staff member was identified (Certified Nurse Aide (CNA) #2) and was not working the evening of 09/11/14. CNA #2 was suspended immediately. Further review of the facility's investigation revealed residents with a Brief Interview of Mental Status score of below eight (8) were not assessed for signs and symptoms of abuse.</p> <p>Record review revealed Resident #1 was admitted to the facility on 07/01/12 with diagnosis which included Senile Dementia, Dementia with behavior disturbances, Bipolar, Anxiety Disorder, Schizophrenia, Diabetes, and Hypertension. Review of the annual Minimum Data Set (MDS) assessment, dated 08/30/14, revealed the facility assessed Resident #1's cognition as cognitively intact with a BIMS score of thirteen (13).</p> <p>Interview with Resident #1, on 10/02/14 at 1:25 PM, revealed a girl (staff member) hit him/her in the head approximately four (4) weeks ago. Resident #1 stated he/she does not remember the staff member's name. The resident described the staff member as having long black hair and very large. Further interview revealed the incident happened in the resident's room (215 A).</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 10/02/14 at 2:10 PM, revealed Resident #1 informed her, on 9/11/14 at 4:30 P.M., a girl (staff member) hit the resident in the head the other night. LPN #2 further revealed the Assistant Director of Nursing (ADON) was in the facility and she reported the allegation. Further interview revealed a skin assessment was performed on</p>	F 225	<p>4. The Administrator will review all investigations of abuse or neglect with the Social Services Director and Director of Nursing in the daily morning meeting for three months to assure investigations are complete and timely. Results of these reviews will be reviewed with the Quality Assurance Committee monthly for at least three months or until the Quality Assurance Committee deems appropriate. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Director and Activity Director with the Medical Director attending at least Quarterly. Compliance Date 11/15/14</p>		

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 225	Continued From page 3 Resident #1 without any bruising or injury noted. Interview with ADON, on 10/03/14 at 8:35 AM, revealed she interviewed Resident #1 and escorted CNA #2 out of the facility. Further interview revealed residents with a BIMS score of eight (8) or greater were interviewed. She stated residents with a BIMS score below 8 weekly skin assessments were reviewed beginning 09/11/14 and completed 09/15/14. Interview with Director of Nursing (DON), on 10/03/14 at 9:50 AM, revealed she was made aware of the allegation on 09/12/14. The DON revealed no skin assessments were initiated on the (8) non-interviewable residents. The DON further revealed the ADON started reviewing weekly skin assessments of the 8 non-interviewable residents on 09/12/14 when informed of the allegation. The DON stated she and the ADON finished reviewing the weekly skin assessments of (8) non interviewable residents on 09/15/14. The DON revealed skin assessments should have been conducted on the 8 non-interviewable residents when the allegation of abuse was reported.	F 225			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F280 1. The care plans for resident # 2 was reviewed by the Director of Nursing on 10/10/14 and noted that the care plan was up to date and appropriate that the resident was a two person assist without the use of a mechanical lift. Resident # 2 was observed by the Director of Rehabilitation on 10/28/14 and noted that a two person assist with transfer without a mechanical lift was appropriate.	11/15/14	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 280	<p>Continued From page 4</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to review and revise the care plan for one (1) of sixteen (16) sampled residents (Resident #2) regarding the use of a mechanical lift.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #2 on 04/11/14 with diagnoses which included Diabetes Mellitus, Hypertension, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Polymyalgia Rheumatica, and Hypothyroidism. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of "13" indicating the resident was interviewable.</p> <p>Review of the Nursing Care Plan, dated 04/11/14, revealed Resident #2 was care planned for falls</p>	F 280	<p>2. All current residents care plans will be reviewed by the Director of Nursing, Assistant Director of Nursing, MDs Nurse and Unit Managers, Social Services Director, Activity Director and Assistant Director of Activities as well as the Dietary Service Manager to assure all were up to date and reflected the resident current needs. This will be completed by 11/14/14 any needed corrections will be reflected on the plan of care. An audit of all current residents records will be completed to assure there is a safety device assessment for all safety devices including mechanical lifts. This will be completed by DON, ADON, UM and MDS Nurse by 11/14/2014. Any needing assessment will have an assessment completed by 11/14/14</p> <p>3. The Director of Nursing re-educated the MDS Nurse, Social Services Director, Activity Director and Dietary Service Manager on the process to review during care plan review the care plans to assure they are accurate and meet the needs of the resident as well as review of the AccuNurse system for level of transfer. This re-education will be completed by 11/14/14 All direct care staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Managers or MDS Nurse by 11/14/14 that the resident's care plan must be followed to include the use of a mechanical lift. If staff are unable to follow the care plan they are to report to the Nurse for direction. On 10/28/14 the Director of</p>	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 280	<p>Continued From page 5</p> <p>and had attempted transfers without assistance. The interventions included: ensure safe environment, ensure appropriate footwear when out of bed, call bell in reach, provide adequate lighting, bed alarm to alert staff of unassisted transfers, fall mat, bed against wall, clip alarm to bed, and bed alarm. Further review revealed no interventions to assist with transfers. The Activities of Daily Living (ADL) Plan of Care included Transfers, Cautions-Pain in back, Physical functioning-Level of support-two or more person physical assist, extensive assistance. Further review revealed there was no care plan intervention for use of a mechanical lift to assist Resident #2.</p> <p>Interview with Resident #2, on 10/01/2014 at 4:03 PM, revealed some staff members used a lift to assist him/her with transfers especially if there were not two (2) people to help him/her out of the bed. Observed lift sling beneath resident while sitting in wheelchair.</p> <p>Interview/Observation with Resident #2, on 10/2/14 at 9:15 AM, revealed Resident #2 was sitting up in wheelchair and the lift sling was beneath the resident. The resident stated the lift sling was removed whenever she returned to bed.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 10/02/14 at 1:10 PM, revealed some staff members use a lift to assist with Resident #2's transfers. CNA #1 stated she was unsure if Resident #2 was care planned for the use of the lift.</p> <p>Interview with the Director of Nursing (DON), on 10/02/14 at 1:29 PM, revealed all residents who</p>	F 280	<p>Nursing re-educated the Unit managers on the requirement to complete a safety device assessment for all devices including any resident who requires a mechanical device.</p> <p>4. The Director of Nursing will audit five (5) residents per month for three (3) months to assure the care plan are accurate and reflect the current needs of the resident and that the care plans are being followed and safety device assessments are completed for all safety devices including a mechanical lift. Results of these reviews will be reviewed with the Quality Assurance Committee monthly for at least three months or until the Quality Assurance Committee deems appropriate. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Director and Activity Director with the Medical Director attending at least quarterly.</p>		

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 280	Continued From page 6	F 280			
F 323 SS=D	<p>are transferred by lift should be care planned for a two-person transfer with or without the lift.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure the resident's environment remains as free of accident hazards as possible for one one (1) of sixteen (16) sampled residents (Resident #2). The facility failed to assess and care plan Resident #2 for the safe use of a mechanical lift prior to using it with the resident.</p> <p>The findings include: Review of the facility's "Safety Device Assessment" and "What UDA and When", undated, revealed a separate Safety Device Assessment was to be completed by a nurse manager on implementation and quarterly for all devices. Further review revealed the Nurse Manager walks staff through making a determination of enabler or restraint and encourages documentation of actual attempts at reduction.</p>	F 323	<p>F323</p> <p>1. The care plans for resident # 2 was reviewed by the Director of Nursing on 10/10/14 and noted that the care plan was up to date and appropriate resident was a two person assist without the use of a mechanical lift. Resident # 2 was observed by the Director of Rehabilitation on 10/28/2014 and noted that a two person assist with transfer without a mechanical lift was appropriate.</p> <p>2. All current residents care plans were reviewed by the Director of Nursing, Assistant Director of Nursing, MDs Nurse and Unit Managers, Social Services Director, Activity Director and Assistant Director of Activities as well as the Dietary Service Manager to assure all were up to date and reflected the resident current needs. This will be completed by 11/14/14 any needed corrections will be reflected on the plan of care. An audit of all current residents records will be completed to assure there is a safety device assessment for all safety devices including mechanical lift This will be completed by the DON, the ADON, UM and the MDS Nurse by 11/14/14. Any needing assessment will have an assessment completed by 11/14/14</p>	11/15/14	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 323	<p>Continued From page 7</p> <p>Record review revealed the facility admitted Resident #2 on 04/11/14 with diagnoses, which included Diabetes Mellitus, Hypertension, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Polymyalgia Rheumatica, and Hypothyroidism. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of "13" indicating the resident was interviewable.</p> <p>Review of the Safety Device Flow Sheet, dated September 2014 and October 2014, revealed they did not include the Hoyer lift. Further review revealed there was no assessment for the use of a Hoyer lift.</p> <p>Review of the Nursing Care Plan, dated 04/11/14, revealed Resident #2 was care planned for falls and had attempted transfers without assistance. The interventions included: ensure safe environment, ensure appropriate footwear when out of bed, call bell in reach, provide adequate lighting, bed alarm to alert staff of unassisted transfers, fall mat, bed against wall, clip alarm to bed, and bed alarm. The Activities of Daily Living (ADL) Plan of Care included Transfers, Cautions-Pain in back, Physical functioning-Level of support-two or more person physical assist, extensive assistance. Further review revealed there was no care plan intervention for use of a mechanical lift to assist Resident #2.</p> <p>Interview with Resident #2, on 10/01/14 at 4:03 PM, revealed when there was only one aide to transfer him/her, some staff members would use a lift to assist him/her with the transfers. A lift sling</p>	F 323	<p>3. The Director of Nursing re-educated the MDS Nurse, Social Services Director, Activity Director and Dietary Service Manager on the process to review during care plan review the care plans to assure they are accurate and meet the needs of the resident as well as review of the AccuNurse system for level of transfer. This re-education will be completed by 11/14/14 All direct care staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Managers or MDS Nurse by 11/14/14 that the resident's care plan must be followed to include the use of a mechanical lift. If staff are unable to follow the care plan they are to report to the Nurse for direction. On 10/29/14 the Director of Nursing re-educated the Unit managers on the requirement to complete a safety device assessment for all devices including any resident who requires a mechanical device.</p> <p>4. The Director of Nursing will audit five (5) residents per month for three (3) months to assure the care plan are accurate and reflect the current needs of the resident and that the care plans are being followed and safety device assessments are completed for all safety devices including a mechanical lift. Results of these reviews will be reviewed with the Quality Assurance Committee monthly for at least three months or until the Quality Assurance Committee deems appropriate. The Quality Assurance Committee will</p>		

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 323	Continued From page 8 was observed beneath the resident in the wheelchair. Interview/Observation with Resident #2, on 10/2/14 at 9:15 AM, revealed Resident #2 had a lift sling beneath him/her in the wheelchair. The resident stated when staff returned him/her to bed they would remove the lift sling. Interview with Certified Nurse Aide (CNA) #1, on 10/02/14 at 1:10 PM, revealed some of the staff would use the lift to transfer him/her when there was not two (2) staff to transfer him/her. CNA #1 stated she did not know if Resident #2 had been assessed for the safe use of the lift or is she had a care in place for the use of the lift. Interview with Social Services on 10/02/14 at 1:15 PM, revealed residents should have an assessment for safe use of lift and the care plan should include lift use. Interview with the Director of Nursing (DON), on 10/02/14 at 1:29 PM, revealed all residents should be assessed and care planned for the safe use of a lift prior to the resident being transferred with the lift.	F 323	consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Director and Activity Director with the Medical Director attending at least quarterly. Results	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	F441 1. An observation of Resident # 7 during Foley Catheter care and skin assessment on 10/28/14 by the Director of Nursing noted that RN # 1 practiced appropriate infection control practices including changing gloves and washing hands between skin assessment and catheter care and after catheter care prior to touching clean linens.	11/15/14

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 441	Continued From page 9 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedures, it was determined the facility failed to maintain an effective infection control program to provide a sanitary and safe environment related to the failure to wash hands and change gloves in between skin assessment and incontinent care for one (1) of sixteen (16) sampled residents	F 441	2. By 10/31/14, the Director of Nursing will observe skin assessments and Foley catheter care on all current residents with a Foley catheter, any infractions with infection control., will result in immediate re-education of the licensed nurse (s). 3. All Licensed Staff and Nursing Assistants will be re-educated by 11/14/14 by the Director of Nursing, Assistant Director of Nursing, hand hygiene and Foley catheter care. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) skin assessments and five (5) Foley catheter care per week for four (4) weeks then five (5) skin assessments and Foley catheter care observations per month for two (2) months. Results of these reviews will be reviewed with the Quality Assurance Committee monthly for at least three months or until the Quality Assurance Committee deems appropriate. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Director and Activity Director with the Medical Director attending at least quarterly.		

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 441	<p>Continued From page 10 (Resident #7).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Indwelling Catheter Care/Disposable Wipes" , (no date), revealed the facility's purpose of this procedure was to prevent infection of the resident's urinary tract. Further review revealed the procedure as follows: 17. Wash and dry your hands thoroughly. 20. Put on gloves. 27. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 28. Reposition the catheter and bed covers. Make the resident comfortable.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnoses, which included Diabetes Mellitus, Hyperlipidemia, Gout, Pernicious Anemia, Depressive Disorder, Alzheimer 's, Neuropathy, Hypertension, Atrial Fibrillation, Congestive Heart Failure, Gastroesophageal Reflux Disease, Urinary Tract Infection and Contracture Left Leg. Review of the annual Minimum Data Set (MDS) Assessment, dated 04/26/14, revealed the facility assessed Resident #7's cognition as cognitively intact with a Brief interview for Mental Status (BIMS) score of "12" indicating the resident was interviewable.</p> <p>Review of the hospital History and Physical, dated 08/31/14, revealed Resident #7 was admitted to local hospital facility and treated for complex urinary tract infection.</p> <p>Observation of catheter care, on 10/02/14 at 9:50 AM, revealed Registered Nurse (RN) #1 and the Unit Manager (200 Hall) washed hands and</p>	F 441		

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBNEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 441	Continued From page 11 donned gloves and completed a head to toe skin assessment of Resident #7. RN #1 proceeded to provide catheter care without washing hands and changing gloves. Further review revealed RN #1 pulled linens and blanket over Resident #7 prior to removing gloves and washing hands. Interview with RN #1, on 10/02/14 at 10:10 AM, revealed she should have removed gloves and washed hands after the skin assessment and before providing catheter care. Interview with Unit Manager (200 Hall), on 10/02/14 at 10:15 AM, revealed she expected RN #1 to change gloves and wash hands after skin assessment and before providing catheter care and to remove gloves and wash hands after catheter care and prior to positioning bed covers.	F 441			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to obtain laboratory services to meet the needs of the resident for one (1) of sixteen (16) sampled residents (Resident #2). The physician ordered a Urinalysis and Culture and Sensitivity for Resident #2 and the facility failed to obtain the labs. The findings Include:	F 502	F502 1. On 10/03/14 the physician was notified by A wing UM on the missed Urinalysis with culture and sensitivity with further direction given. 2. By 11/14/14 the DON, the ADON, UM and the MDs nurse will complete an audit of all current residents' physician orders for the past thirty (30) days to determine if labs ordered were completed. Any noted as not completed as ordered the physician was immediately notified for further direction.	11/15/14	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 502	<p>Continued From page 12</p> <p>Record review revealed the facility admitted Resident #2 on 04/11/14 with diagnoses, which included Diabetes Mellitus, Hypertension, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Polymyalgia Rheumatica, and Hypothyroidism. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/24/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of "13" indicating the resident was interviewable.</p> <p>Review of the Situation, Background, Assessment and Recommendation (SBAR), dated 09/22/14, revealed orders for Diflucan 150 milligrams (mg), Urinalysis, and culture and sensitivity.</p> <p>Review of the Pharmacy Service Comprehensive Physician's Order sheet, dated 09/22/14, revealed an order for Diflucan 150 mg every three (3) days for three (3) doses but there was no order for the Urinalysis and Culture and Sensitivity.</p> <p>Review of Laboratory Result sheets in the clinical record, revealed there were no results for the urinalysis or culture and sensitivity that was written on the SBAR, dated 09/22/14. Further review revealed there were no documented evidence the lab was notified of the urinalysis and culture and sensitivity order.</p> <p>Interview with the "A" Hall Unit Manager, on 10/02/14 at 3:20 PM, revealed the lab orders should be transcribed from the SBAR to the comprehensive physician's order sheet and requested. The Unit Manager was unable to locate the urinalysis and culture and sensitivity reports in the chart. The Unit Manager stated the</p>	F 502	<p>3. By 10/29/14 the Director of Nursing will re-educate the Unit Managers on the lab process to include verifying any lab orders were placed on the lab log and validation that labs on the lab log were completed.</p> <p>4. The Director of Nursing will audit five (5) resident records per week for twelve (12) weeks to assure labs were processed as ordered. Results of these reviews will be reviewed with the Quality Assurance Committee monthly for at least three months or until the Quality Assurance Committee deems appropriate. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Director and Activity Director with the Medical Director attending at least quarterly.</p>	

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F 502	Continued From page 13 urinalysis and culture and sensitivity report were not located in the lab logbook. Interview with Director of Nursing, on 10/03/14 at 3:50 PM, revealed the labs for Resident #2 were missed and she expected staff to schedule lab requests as they were taught.	F 502			

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 33 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1992.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/01/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-eight (98) beds with a census of seventy-eight (78) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Interim Administrator* (X6) DATE *10/29/14*

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.

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 000	Continued From page 1 Fire).	K 000		
K 038 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress was maintained at exit doors in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, forty (40) residents, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was seventy-eight (78).</p> <p>The findings include:</p> <p>Observation, on 10/01/14 at 3:45 PM with the Maintenance Director, revealed the exit door located in the front of A Wing failed to release when the delayed egress lock was tested. The door was equipped with a key pad to release the lock; which did function when tested. Further</p>	K 038	<p>K038</p> <p>The panel on the front door of the a wing was repaired on 10/21/14 by Vanguard Alarms so that the delayed egress lock would functioning properly.</p> <p>All exit doors with keypads will be checked by 11/14/14 by the Maintenance Director to ensure the delayed egress walk is functioning properly.</p> <p>The Maintenance Director will perform monthly checks on the doors with keypads with delayed egress locks by 11/14/14 to ensure they are functioning properly.</p> <p>Any issues or non-conformance with the delayed egress locks will be repaired immediately by the Maintenance Director and reported to the QAPI committee.</p>	11/15/14

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 038	<p>Continued From page 2</p> <p>observation, revealed staff that was asked at random to open the door using the key pad was successful.</p> <p>Interview, on 10/01/14 at 3:46 PM with the Maintenance Director, revealed he was not aware the delayed egress lock had stopped working.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 10/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than</p>	K 038			

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 038	Continued From page 3 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.	K 038		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 038	Continued From page 4 (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038			
K 062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K062 A full flow trip test of the sprinkler system was conducted by Eagle Fire Protection on 10/9/14. A full flow trip test of the sprinkler system will be conducted by an approved inspection company as required every three years.	11/15/14	

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 062	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was seventy-eight (78).</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 10/01/14 at 1:50 PM with the Maintenance Director, revealed the facility failed to conduct a full flow trip test every third year as required on the sprinkler system. The last partial trip test was conducted on 06/18/13 and the last full flow trip test was performed on 06/27/11.</p> <p>Interview, on 10/01/14 at 1:51 PM with the Maintenance Director, revealed he relied on his Sprinkler Company to ensure the system was inspected properly as required.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 10/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to</p>	K 062	<p>The Maintenance Director will maintain a log beginning 11/1/14 to track and ensure a full flow trip test of the sprinkler system is conducted at least once every three years.</p> <p>Any non-compliance will be corrected immediately by the Maintenance Director and reported to do QAPI committee.</p>	

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 062	Continued From page 6 determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2	K 062			

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 062	<p>Continued From page 7</p> <p>Sprinklers Test At 50 years and every 10 years thereafter</p> <p>2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p> <p>Component Activity Frequency Reference</p> <p>Control Valves</p> <p>Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves</p> <p>Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2</p> <p>Check Valves</p> <p>Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves</p> <p>Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4</p> <p>Dry Pipe Valves/Quick-Opening Devices</p> <p>Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years</p>	K 062		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 062	Continued From page 8 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2	K 062		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42136	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 062	Continued From page 9 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K066 A fire extinguisher was installed in close proximity you to the outdoor smoking area on 10/28/14 by Booth Fire Safety. There is only one outdoor smoking area on the property, however, should other outdoor smoking areas be constructed, a fire extinguisher will be installed in close proximity to any newly constructed outdoor smoking area. The Maintenance Director will check the outdoor smoking area weekly beginning 11/8/14 to ensure the fire extinguisher remains in place and installed. If the fire extinguisher is missing, a new extinguisher will be installed immediately by the Maintenance Director and the missing extinguisher will be reported to the QAPI committee.	11/15/14

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 066	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the staff was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect staff using the smoking area. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was seventy-eight (78).</p> <p>The findings include:</p> <p>Observation, on 10/01/14 at 3:00 PM, with the Maintenance Director revealed the designated outdoor smoking area for staff did not have a fire extinguisher installed in close proximity.</p> <p>Interview, on 10/01/14 at 3:01 PM, with the Maintenance Director revealed he was not aware of the requirements for smoking areas.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 10/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment</p>	K 066		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 066	Continued From page 11 where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066			
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	K 068	K068 The fresh air vent serving the gas fired water heater located in the front hall mechanical room will be closed as of 10/27/14 by the Maintenance Director.	11/15/14	

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 068	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was seventy-eight (78). The findings include: Observation, on 10/01/14 at 3:54 PM, with the Maintenance Director revealed the fresh air vent serving the gas fired water heater located in the Front Hall Mechanical Room was open to the attic. Interview, on 10/01/14 at 3:55 PM with the Maintenance Director revealed he was aware of the requirements for building services. The census of seventy-eight (78) was verified by the Administrator on 10/01/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/01/14. Reference: NFPA 101 Life Safety Code (2000 edition)	K 068	All other water heater mechanical rooms will be inspected by the Maintenance Director by 11/8/14 to ensure that there are no other fresh air vents in place. Should other fresh air vents be found they will be immediately closed by the Maintenance Director. All water heater mechanical rooms will be inspected at least quarterly by the Maintenance Director beginning 11/8/14 to ensure no fresh air vents have been installed. Should any air vent be found it will be immediately closed off by the Maintenance Director and reported to the QAPI committee.	

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 068	Continued From page 13 Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, eighty-four (84) residents, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was seventy-eight (78). The findings include:	K 147	K147 The oxygen concentrator which is plugged into the power strip and room 212 has been plugged into a proper outlet as of 10/3/14 by the Maintenance Director. The refrigerator plugged into the power strip located in room 222 was has now been plugged into a proper outlet as of 10/3/14 by the Maintenance Director.. The extension cord which was in use in the business office has been removed as of 10/3/14 by the Maintenance Director.. The resident bed which is plugged into a power strip in room 140 has been plugged into a proper outlet as of 10/3/14 by the Maintenance Director.	11/15/14

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 147	<p>Continued From page 14</p> <p>Observation, on 10/01/14 at 2:15 PM with the Maintenance Director, revealed an oxygen concentrator was plugged into a power strip located in room #212.</p> <p>Interview, on 10/01/14 at 2:16 PM with the Maintenance Director, revealed he was not aware the power strip had been misused.</p> <p>Observation, on 10/01/14 at 2:20 PM with the Maintenance Director, revealed a refrigerator was plugged into a power strip located in room #222.</p> <p>Interview, on 10/01/14 at 2:21 PM with the Maintenance Director, revealed he was not aware the power strip had been misused.</p> <p>Observation, on 10/01/14 at 2:45 PM with the Maintenance Director, revealed an extension cord in use instead of permanent wiring located in the Business Office.</p> <p>Interview, on 10/01/14 at 2:46 PM with the Maintenance Director, revealed he was not aware the extension cord was in use.</p> <p>Observation, on 10/01/14 at 4:00 PM with the Maintenance Director, revealed a resident bed was plugged into a power strip located in room #140.</p> <p>Interview, on 10/01/14 at 4:01 PM with the Maintenance Director, revealed he was not aware the power strip had been misused.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 10/01/14. The findings were acknowledged by the Administrator and verified</p>	K 147	<p>All rooms will be checked by the Maintenance Director by 11/8/14 to ensure no oxygen concentrators, beds, or refrigerators are plugged into unapproved power strips.</p> <p>The Maintenance Director will conduct Monthly inspections of all rooms effective 11/8/14 to ensure no oxygen concentrators, beds, or refrigerators are plugged into unapproved power strips.</p> <p>Should electrical equipment be plugged into a power strip it will be immediately unplugged by the Maintenance Director, a proper outlet or approved power strip will be installed by the Maintenance Director and incident(s) will be reported to the QAPI committee.</p>	

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42136
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 15 by the Maintenance Director at the exit interview on 10/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		
-------	--	-------	--	--