

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

PRINTED: 01/13/2016  
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  R 01/14/2016
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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 01/14/16, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185331	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 1/14/2016
Name of Facility FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTE	Street Address, City, State, Zip Code 414 ROBEY ST. FRANKLIN, KY 42135	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0164</u> Reg. # <u>483.10(e), 483.75(l)(4)</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix <u>F0241</u> Reg. # <u>483.15(a)</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed <u>01/14/2016</u>
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(l)</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____	Correction Completed <u>01/14/2016</u>
ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>01/14/2016</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DAH</u>	Date: <u>01/13/16</u>	Signature of Surveyor: <u>Deborah Anderson</u>	Date: <u>01/13/16</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

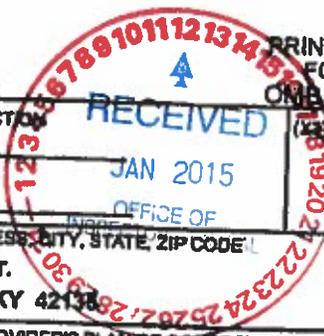
Followup to Survey Completed on:  
12/11/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42138
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F 000	INITIAL COMMENTS	F 000		
F 184 SS=D	<p>A Recertification Survey was conducted on 12/09/15 through 12/11/15 with deficiencies cited at the highest Scope and Severity of a "E".</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 184	<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 allegation 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> <p>F 164</p> <p>It is the practice of this facility to maintain resident privacy during the provision of care and services.</p> <p>CNA # 2 was provided with 1:1 instruction by the Assistant Director of Nursing 12/17/15 regarding pulling the curtain during the provision of resident care and services in order to maintain privacy for residents.</p>	

*Date of compliance*  
1/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jana Davis</i>	TITLE <i>Administrator</i>	(X6) DATE 1/11/16
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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.

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F 164	<p>Continued From page 1</p> <p>by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure privacy during care for one (1) of sixteen (16) sampled residents (Resident #7). Staff failed to pull the privacy curtain between Resident #7 and his/her roommate during catheter care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Quality of Life-Dignity", last revised 10/2009, revealed residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his/her self-esteem and self-worth. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnosis which included Neurogenic bladder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/17/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. Further review of the quarterly MDS assessment, revealed the resident had an indwelling catheter.</p> <p>Observation, on 12/10/15 at 11:30 AM, revealed Certified Nurse Aide (CNA#2) failed to pull the privacy curtain between Resident #7 and his/her roommate while providing urinary catheter care. The roommate was present in the room while</p>	F 164	<p>II Facility nursing staff will provide privacy to residents during the provision of personal care and services by pulling curtains and closing doors as indicated.</p> <p>III The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an educational review of F 164 to all nursing staff as it relates to resident privacy to include, but may not be limited to, pulling the curtain between residents during the provision of personal care / services. This educational review will be completed by 1/11/16. Review of F 164 has been incorporated into the facilities new hire orientation program.</p> <p>IV The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct a audit of five randomly chosen resident's to validate that privacy is being maintained during the provision of care and services.</p> <p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p>	<p><i>Date of Compliance</i> 1/14/16</p>	

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F 164	Continued From page 2 personal care was being provided by CNA #2.  Interview with CNA #2, on 12/10/15 at 11:45 AM, revealed she should have pulled the privacy curtain between Resident #7 and his/her roommate to provide privacy during personal care.  Interview CNA #4, on 12/10/15 at 12:10 PM, revealed privacy curtains should always be pulled when providing any type of care that would expose the resident.  Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed she would expect the privacy curtain to be pulled between all residents when providing care to ensure exposure of the resident's skin or personal self did not occur.  Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed she would expect all residents to be provided privacy during any care that would expose the resident, even if the resident was not aware of their surroundings, especially during a treatment that would expose the resident's skin or personal self. Further interview revealed, all residents deserve privacy with personal care.	F 164	Any discrepancy noted during the audit will be corrected at that time with the immediate provision of privacy for the resident and Impromptu education for the staff member as indicated.  The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F 241  It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Date of Compliance 1/14/16	

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F 241	<p>Continued From page 3</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 promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individually for one (1) of sixteen (16) sampled residents (Resident #7). Observation revealed Resident #7's urinary catheter bag was not in a dignity bag and visible from the hallway.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Quality of Life-Dignity", last revised 10/2009, revealed residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his/her self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnosis which included Neurogenic Bladder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/17/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. Further review of the quarterly MDS assessment, revealed the resident had a indwelling catheter.</p>	F 241	<p>i. The urinary catheter bag for Resident # 7 was placed into a dignity bag as soon as it was identified.</p> <p>ii. Facility nursing staff will provide and maintain resident dignity by placing and maintaining urinary catheter bags in privacy bags as indicated. All other residents identified as having a foley catheter were assessed by the Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse to ensure catheters were in privacy bags as soon as the concern was identified.</p> <p>iii. The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an educational review of F 241 to all nursing staff as it relates to dignity to include, but may not be limited to, placing and maintaining catheter drainage bags in privacy bags. This educational review will be completed by 1/11/16. Review of F 241 has been incorporated into the facilities new hire orientation program</p>	Date of Compliance 1/14/16

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F 241	Continued From page 4 Review of the November 2015 Physician Orders revealed an order for an eighteen (18) french urinary catheter to bed side drainage with ten (10) milliliter balloon and catheter care every shift.  Observations, on 12/09/15 at 10:00 AM and 11:20 AM, revealed a urinary catheter drainage bag with yellowish-tinged urine, lying on the floor, visible from the hallway.  Interviews on 12/10/15 with Certified Nurse Aide (CNA) #2 at 11:45 AM, and with CNA #4 at 12:10 PM, revealed all residents with a urinary drainage bag should have a dignity bag and if not, the urinary drainage bag should not be facing the doorway for the public to see.  Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed she would expect all residents with an indwelling catheter to have a dignity bag in place when in bed or up in a wheelchair to provide dignity, and the only time a dignity bag may not be used would be if the resident was in bed and the urinary drainage bag was facing the wall not visible to visitors.  Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed she would expect all urinary drainage bags to be in a dignity bag to promote dignity and if not in a dignity bag the urinary drainage bag should be facing the wall out of view of the public eye. Further interview revealed it was the facility policy urinary drainage bags were in a dignity bags.	F 241	IV The Director of Nursing and/or and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an audit of resident's with Foley catheters to validate that dignity is being maintained by the use of privacy bags for the urinary draining bags.  This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.  Any discrepancy noted during the audit will be corrected at that time with the immediate provision of a dignity bag for the resident and impromptu education for the staff member as indicated.  The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and	F 253	F 253 It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	Date of Completion 1/14/16	

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F 253	<p>Continued From page 5</p> <p>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to provide a safe and sanitary environment related to bath basins, bed pans, and urinals not being labeled or stored appropriately in six (6) rooms.</p> <p>The findings include:</p> <p>Review of facility standard of practice, "Lippincott's Textbook for Nursing Assistants-A Humanistic Approach to Caregiving, 3rd Edition," revealed residents' bath basins, bedpans, and other care equipment should be stored in lower drawers or shelves of residents storage units.</p> <p>Observations during the Initial Tour on 12/09/15 at 9:40 AM, revealed:</p> <ol style="list-style-type: none"> <li>1. A urinal on the sink in the bathroom of Room 201 that was not labeled or bagged.</li> </ol> <p>Interview with Licensed Practical Nurse (LPN), on 12/09/15 at 9:55 AM, revealed urinals should be labeled with name and room number and put in a bag.</p> <ol style="list-style-type: none"> <li>2. A bath basin on the floor under the bedside commode of Room 202 that was not labeled or bagged</li> <li>3. Two (2) bath basins and a bed pan on the bath tub in the bathroom in Room 205 not labeled and</li> </ol>	F 253	<p>i.</p> <p>The urinal on the sink in the bathroom of Room 201 was discarded and replaced with a new urinal which was labeled with the resident name and placed in a plastic bag.</p> <p>The bath basin on the floor under the bedside commode of room 202 was discarded and replaced with a new bath basin which was labeled with the resident name and placed in a plastic bag.</p> <p>The (2) two bath basins and the bed pan on the bath tub in the bathroom in room 205 was discarded and were replaced with new items which were labeled with the residents name and placed in a plastic bag.</p> <p>The specimen hat on the back of the commode in the bathroom in Room 210 was discarded.</p> <p>The (2) two bed pans noted on the floor by the commode in room 211 were discarded and replaced with new items which were labeled with the residents name and placed in plastic bags.</p> <p>The bath basin found on the floor under the bed in Room 212 was discarded and replaced with a new bath basin which was labeled with the residents name and placed in a plastic bag.</p>	<p>Date of Compliance 1/14/16</p>	

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F 253	Continued From page 6 bagged.  4. A specimen hat on the back of the commode in the bathroom in Room 210 not labeled or bagged.  5. Two (2) bed pans on the floor by the commode in Room 211 not labeled or bagged.  6. A bath basin on the floor under the bed in Room 212 not labeled or bagged.  Interviews on 12/11/15 with Certified Nurse Aide (CNA) #3 at 1:15 PM and CNA #5 at 1:22 PM, revealed bath basins, bed pans, and urinals should be labeled with name and room number and put in a plastic bag on each resident's side of the closet.  Interview with LPN #2, on 12/09/15 at 10:07 AM, revealed a specimen hat should not be in the bathroom and the bath basins should be labeled.  Interviews on 12/11/15 with Registered Nurse (RN) #2 at 1:25 PM and RN #1 at 1:40 PM, revealed bath basins, bed pans, and urinals should be labeled with the resident's name and room number and stored in a plastic bag.  Interview on 12/09/15 at 10:18 AM and 10:37 AM with Assistant Director of Nursing revealed urinals, bath basins and bedpans need to be labeled with residents name on it and put in a bag.	F 253	ii. Facility nursing staff will provide a safe and sanitary environment by labeling and storing bath basins, bed pans, specimen hats and urinals appropriately. All Rooms were inspected by the Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse on 12 /10/15 to ensure there were no other bed pans, basins, or urinals not labeled or stored appropriately.  iii. The Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse will conduct an educational review of F 253 to all nursing staff as it relates to safe and sanitary environment to include, but may not be limited to: dating; labeling and storing resident personal equipment properly. This educational review will be completed by 1/11/16. Review of F 253 has been incorporated into the facilities new hire orientation program  iv. The Director of Nursing and/or nursing management team member will conduct an audit of 5 random resident's personal equipment (wash basins , urinals, bed pans and specimen hats) to validate that they are labeled and stored appropriately.		
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	F 280		Date of Compliance 1/14/16	

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
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F 280	<p>Continued From page 7</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an 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 facility policy review It was determined the facility failed to revise the care plan for one (1) of sixteen (16) sampled residents (Resident #7). The facility failed to include an intervention on Resident #7's care plan to ensure a leg strap was in place to anchor the urinary catheter.</p> <p>Review of facility policy entitled, "Care Planning-Interdisciplinary Team", undated, revealed assessments of the residents were ongoing and care plans were revised as information about the resident and the resident's condition changes.</p> <p>Review of facility policy titled, "Urinary Catheter</p>	F 280	<p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time with the immediate replacement as indicated and/or labeling /dating of the equipment as well as impromptu education for the staff member as indicated.</p> <p>The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.</p> <p style="text-align: right;">F 280</p> <p>It is the practice of this facility to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment and periodically review and revise the care plan after each assessment.</p>	<p><i>Date of Completion</i> 1/14/16</p>	

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F 280	<p>Continued From page 8</p> <p>Care", last revised 10/2010, revealed the facility staff was responsible to ensure the catheter remained secured with a leg strap to reduce friction and movement at the insertion site and to ensure the catheter tubing and drainage bag were kept off the floor.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnosis which included Neurogenic Bladder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/17/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview of Mental Status (BIM's) score of three (3), which indicated the resident was not interviewable. Further review of the quarterly MDS, revealed the resident had an indwelling catheter.</p> <p>Observation, on 12/10/15 at 11:30 AM during observation of catheter care, revealed Resident #7's catheter tubing was not secured with a leg strap.</p> <p>Review of the Comprehensive Care Plan for Risk for Complications related to Foley Catheter use due to Neurogenic Bladder, dated 08/18/15, revealed to keep urinary drainage tubing free from kinks, however, there was no intervention to address securing tubing with a leg anchor per facility policy.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed care plans were not accessible to the nurses on the floor, and are kept in the Director of Nursing's (DON) office or the Assistant Director of Nursing's (ADON) office, therefore, there was no way for the floor nurses to update the care plans. Further interview</p>	F 280	<p>I. The Foley catheter tubing for Resident # 7 was secured with a leg strap. The care plan for Resident # 7 was updated with an intervention to include use of an anchoring device for catheters.</p> <p>II. The Director of Nurses compiled a list of residents with Foley catheters and conducted an audit of those residents to validate that the anchoring device were in place and the care plans were reviewed to reflect use of a Foley catheter anchoring device. The care plans have been moved to the nursing units to allow nurses to have immediate access to care plans for review and revision as indicated. Foley catheter anchoring devices will be utilized to secure the Foley to help prevent dislodgment. If a resident refuses use of an anchoring device, the refusal will be care planned.</p> <p>III. The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse</p>	Date of Compliance 1/14/16	

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F 280	<p>Continued From page 9</p> <p>revealed, she would expect the leg strap to be care planned because it was an important part of the residents care and should have been on the nurse aide care plan as well.</p> <p>Interview with LPN #4, on 12/11/15 at 9:15 AM, revealed care plan books were kept in the nursing administration's office and when the care plan needed to be updated or changed the nursing administration (DON, ADON, or Minimum Data Set (MDS) Assessment nurse) was responsible. Further interview revealed, the nurse aide plan of care should have reflected the use of a leg strap as well.</p> <p>Interview with Registered Nurse (RN) #1 on 12/11/15 at 9:15 AM, revealed whenever a resident has a indwelling catheter, there should always be some type of anchor to secure the tubing from causing friction or trauma to the resident, and some how it was missed being put on the comprehensive care plan and nurse aide care plan. She stated an update or revision to the care plan can be at any time the nurses or administrative staff deem it necessary, but at least quarterly. Further interview revealed, she was hired at the end of November 2015 and was not apart of the review of Resident #7's care plan, but could verify there should have been an update to include the leg strap.</p> <p>Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed she expected any and all nurses to update and revise resident care plans as the need arises, and all licensed staff have access the resident care plans. However, she stated the facility was in a transition period with a brand new MDS nurse and things are going to get better with our care plans. Further</p>	F 280	<p>will conduct an educational review of F 280 to all nursing staff as it relates to anchoring Foley catheter tubing , updating care plans to reflect the use of an anchoring device , maintaining the care plans at the desk for licensed nurse access and review/revision as indicated and documentation of resident refusals to use an anchoring device. This educational review will be completed by 1/11/16. Review of F 280 has been incorporated into the facilities new hire orientation program</p> <p style="text-align: right;">IV</p> <p>The Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse will conduct an audit of residents' with Foley catheters to (1) validate that the catheter tubing has an anchoring device, as resident allows and (2) the device is care planned as an intervention.</p> <p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time with the immediate provision of an anchoring devices, update to the care plan and impromptu education for the staff member as indicated.</p>	<p>Date of Compliance 1/14/16</p>	



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F 281	<p>Continued From page 11</p> <p>Resident #7's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. Further review of the quarterly MDS assessment, revealed the resident had an indwelling catheter.</p> <p>Review of the November 2015 Physician's Order, revealed an order for an eighteen (18) french urinary catheter to bed side drainage with ten (10) milliliter balloon and catheter care every shift.</p> <p>Observation on 12/10/15 at 11:30 AM, while observing catheter care, revealed Resident #7's catheter tubing was not secured with a leg strap.</p> <p>Interviews on 12/10/15 with Certified Nurse Aide (CNA) #2 at 11:45 AM and with CNA #4 at 12:20 PM, revealed all catheter tubing should be secured with leg strap to prevent friction and tension. Further interview, revealed all nurse aide's know that a leg strap should be in place for comfort and to prevent the tubing from possibly being pulled out.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed she would expect all residents that have an indwelling catheter to have the tubing secured with a leg strap of some type to prevent friction and tension as it is a nursing and nurse aide standard of practice to provide a leg anchor.</p> <p>Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed the use of a leg strap with an indwelling catheter is a standard of nursing practice. She stated she would expect all nursing staff licensed or non-licensed to know that all residents with a indwelling catheter should</p>	F 281	<p>ii.</p> <p>The Director of Nurses compiled a list of residents with Foley catheters and conducted an audit of those residents to validate that anchoring devices were in place and the care plans were reviewed to reflect use of a Foley anchoring device the care plans have been moved to the nursing units to allow nurses to have immediate access to care plans for review and revision as indicated. Foley catheter anchoring devices will be utilized to secure the Foley to help prevent dislodgment. If a resident refuses use of an anchoring device, the refusal will be care planned.</p> <p>iii.</p> <p>The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an educational review of F 281 for all nursing staff as it relates to :</p> <ul style="list-style-type: none"> <li>*anchoring Foley catheter tubing</li> <li>*updating care plans to reflect the use of an anchoring device</li> <li>*maintaining the care plans at the desk for licensed nurse access and review/revision as indicated and</li> <li>*documentation of resident refusals to use an anchoring device.</li> </ul> <p>This educational review will be completed By 1/11/16.</p> <p>Review of F 281 has been incorporated into the facilities new hire orientation program.</p>	Date of completion 1/14/16	

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F 281  F 316 SS=D	<p>Continued From page 12 have a leg strap or some type of anchor device to secure the tubing.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>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 ensure a resident, with a catheter, receives the appropriate care and services to prevent infections to the extent possible for two (2) of sixteen (16) sampled residents (Resident #7 and Resident #2). Staff failed to secure a leg strap for a indwelling catheter for Resident #7 and failed to keep the indwelling catheter tubing off the floor for Resident #7 and Resident #2.</p> <p>The findings include:  Review of facility policy, entitled "Urinary Catheter Care", last revised 10/2010, revealed staff should ensure the catheter remains secured with a leg strap to reduce friction and movement at the</p>	F 281  F 316	<p>The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an audit of residents' with Foley catheters to validate that the catheter tubing has an anchoring device, as resident allows and the device is care planned as an intervention.</p> <p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time with the immediate provision of an anchoring devices, update to the care plan and impromptu education for the staff member as indicated.</p> <p>The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.</p>	Date of Completion 1/14/16

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F 315	<p>Continued From page 13</p> <p>insertion site and be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnosis which included Neurogenic bladder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/17/15, revealed the facility assessed Resident #7's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. Further review of the quarterly MDS assessment, revealed the resident had an indwelling catheter.</p> <p>Review of the Comprehensive Care Plan for Risk for Complications related to Urinary Catheter due to Neurogenic Bladder, dated 08/18/15, revealed to keep urinary drainage tubing free from kinks; however, the care plan did not address the use of a leg anchor or to keep the tubing off the floor.</p> <p>Review of the November 2015 Physicians Orders revealed an order for an eighteen (18) french urinary catheter to bed side drainage with ten (10) milliliter balloon and catheter care every shift.</p> <p>Observations, on 12/09/15 at 10:00 AM and 11:20 AM, revealed Resident #7's indwelling urinary catheter drainage bag and tubing with yellowish-tinged urine, were laying on the floor visible from the hallway.</p> <p>Observation, on 12/10/15 at 11:30 AM, while observing catheter care provided by CNA #2, revealed Resident #7's catheter tubing was not secured with a leg strap.</p> <p>2. Record review revealed Resident #2 was</p>	F 315	<p>F 315</p> <p>It is the practice of this facility to ensure that a resident, with a catheter, receives the appropriate care and services to prevent infections to the extent possible.</p> <p>The Foley catheter tubing for Resident # 7 was secured with a leg strap. The care plan for Resident # 7 was updated with an intervention to include use of an anchoring device. The indwelling catheter tubing for residents # 7 and # 2 was removed from the floor.</p> <p>ii. The Director of Nursing compiled a list of residents with Foley catheters and conducted an audit of those residents to validate that anchoring devices were in place, the care plans were reviewed to reflect use of a Foley anchoring device and the catheter tubing was not touching the floor.</p> <p>Foley catheter anchoring devices will be utilized to secure the Foley to help prevent dislodgment. If a resident refuses use of an anchoring device, the refusal will be care planned. Foley catheter tubing will be positioned off the floor.</p>	Date of Completion 1/14/16	

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F 315	<p>Continued From page 14</p> <p>admitted to the facility on 07/24/13 with diagnoses which included Vascular Dementia with Depression, Senile Dementia, and Hemiplegia. Review of the Quarterly MDS assessment, dated 10/12/15, revealed the facility assessed Resident #2's cognition as severely impaired with a BIMS score of five (5).</p> <p>Observation, on 12/09/15 at 9:50 AM and 2:07 PM and on 12/10/15 at 2:00 PM, revealed Resident #2's catheter tubing was on the floor.</p> <p>Interviews, on 12/10/15 with Certified Nurse Aide (CNA) #2 at 11:45 AM and with CNA #4 at 12:20 PM, revealed all catheter tubing should be secured with a leg strap to prevent friction and tension and urinary drainage tubing should be up off the floor to prevent the potential of infection.</p> <p>Interviews on 12/11/15 with CNA #3 at 1:15 PM and with CNA #5 at 1:22 PM revealed urinary catheter tubing should not be on the floor because it could cause infection.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed she would expect all residents with a indwelling catheter to be provided a leg strap to prevent tension or possible trauma, and there is a potential of spreading infection when the tubing is on the floor, therefore keeping the tubing and the drainage bag off the floor is very important.</p> <p>Interviews on 12/11/15 with Registered Nurse (RN) #1 at 1:40 PM and with RN #2 at 1:25 PM, revealed urinary catheter tubing should not come into contact with the floor because it could cause infection. In addition, RN #2 stated the catheter tubing should be strapped to the resident's leg.</p>	F 315	<p>III.</p> <p>The Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse will conduct an educational review of F 315 for all nursing staff as it relates to anchoring Foley catheter tubing and maintaining catheter tubing off the floor. This educational review will be completed by 1/11/16. Review of F 315 has been incorporated into the facilities new hire orientation program.</p> <p>IV</p> <p>The Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse will conduct an audit of residents' with Foley catheters to validate that the catheter tubing has an anchoring device, as resident allows that the device is care planned as an intervention and the catheter tubing is off the floor.</p> <p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time with the immediate provision of an anchoring devices, update to the care plan,</p>	Date of Compliance 1/14/16	

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F 315	Continued From page 15	F 315	repositioning of the catheter tubing and impromptu education for the staff member as indicated.		
F 323 SS=E	<p>Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed the use of a leg strap with an indwelling catheter is a standard of nursing practice and she expected all nursing staff licensed or non-licensed to know that all residents with an indwelling catheter should have a leg strap or some type of anchor device to secure the tubing without it being on the care plan. She also stated it would be a infection control issue if the catheter tubing and drainage bag was on the floor.</p> <p>483.26(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 policy, it was determined the facility failed to ensure the environment was as free from accident hazards as possible. Observations revealed an unlocked medication cart, medication on a resident's bedside table and bleach stored under the bedside commode. In addition, the Soiled Utility Rooms were unlocked.</p> <p>Review of a list of wandering residents provided by the facility revealed there were twelve (12) residents that wandered.</p>	F 323	<p>The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.</p> <p>F 323 It is the practice of this facility that the resident environment remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistance device to prevent accidents.</p> <p>1. The soiled utility room doors were locked and education was initiated by the director of nurses and/or Assistant Director of nursing, Unit manager or wound care nurse prior to survey exit on locking the utility room doors and the code to the rooms. The maintenance director placed a new lock on the 200 wing soiled utility room door.</p>	Date of completion 1/14/16	

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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 16</p> <p>The findings include:</p> <p>1. Interview with the Administrator, on 12/11/15 at 3:50 PM, revealed there was no facility policy that addressed the locking of Soiled Utility Rooms; however, she expected the staff to have the rooms locked at all times.</p> <p>Observations during an environmental tour of the facility, with the Maintenance Director and the Housekeeping Supervisor, on 12/11/15 at 10:25 AM, revealed the Soiled Utility Rooms on the 100 and 200 Wings were unlocked and both rooms contained hazardous waste materials and soiled linens. In addition, the doors were equipped with a push button code lock and the staff were not aware of the combination.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 12/11/15 at 3:40 PM, revealed the Soiled Utility Room doors had been unlocked at least a week and stated she had only been working at the facility for one (1) week and was not aware of the code to unlock the doors.</p> <p>Interview with CNA #6, on 12/11/15 at 1:55 PM, revealed the door had not been locked before today and she had worked at the facility for one (1) month and was not aware of the code.</p> <p>Interview with CNA# 7, on 12/11/15 at 2:00 PM, revealed she had been employed since August 2015 and had just received the code for the door and stated it had not been locked.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/11/15 at 10:35 AM, revealed the door on the 200 Wing, had a non-functioning lock "for</p>	F 323	<p>LPN # 6 immediately locked the medication cart. LPN # 6 was provided with 1:1 educational review by the Director of Nursing on 12/9/15 for locking the medication cart as part of the Medication Administration General Guidelines.</p> <p>The tubes of Calazime Skin Protectant was removed from resident room 115-A. resident # 11 had purchased the bleach their self and brought it into the facility. Resident # 11 was educated on 12/9/15 by the Assistant Director of Nursing regarding not having bleach or other chemicals in his room.</p> <p>ii. Facility staff will keep the doors to the soiled utility room closed and locked. Doors which would expose residents to hazardous waste materials will be kept locked. Locks on doors will be maintained in good working order. The maintenance director conducted an audit of doors with locks to validate that there were no other locks in the facility that were in need of immediate attention or replacement.</p> <p>Licensed staff will keep the medication and treatment carts locked when not in direct view of the licensed nurse. The DON validated at the time that there were no other medication or treatment carts unlocked and unattended.</p>	<p><i>Date of Completion</i> 1/14/16</p>

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F 323	<p>Continued From page 17</p> <p>some time" and she had "told someone about this," but was unsure who and stated she did not fill out a Maintenance Requisition Form to notify the Maintenance Director there was a problem.</p> <p>Interview with the Maintenance Director, on 12/11/15 at 10:25 AM, revealed he was not aware the doors were not locked or that the 200 Wing Soiled Utility Room Door had a malfunctioned. He stated he had not received a work order for this.</p> <p>Interview with the Administrator, on 12/11/15 at 3:50 PM, revealed she was not aware the doors were not being locked and stated they would be locked "from now on."</p> <p>2. Review of the facility's policy titled, "Medication Administration General Guidelines", dated 12/12, revealed medication carts should be kept closed and locked when out of site of the medication nurse. The cart must be clearly visible to the personnel administering medicine medications when unlocked.</p> <p>Observation, on 12/10/15 at 10:15 AM, revealed a Medication Cart left unattended and unlocked at the nursing station accessible to residents. The contents in the cart included crushable gastrostomy tube medications used for crushing. There were no staff observed within the site of the medication cart at the time of the observation.</p> <p>Interview with LPN #6, on 12/09/15 at 10:20 AM, revealed she was responsible for the unlocked medication cart and she was not in site of the cart. She stated the medication cart not being locked could result in a resident having access to</p>	F 323	<p>An audit of resident rooms was completed to identify any other residents with medication at the bedside without a physician order. The audit identified no other residents with medications at bedside without a physician order.</p> <p>An audit of resident rooms was conducted to identify if there were any other residents with chemicals, to include bleach, at the bedside. The audit identified no other residents with chemicals at the bedside.</p> <p>A resident council meeting was held on 12/30/15 which included a review of the regulation as it relates to having chemicals such as bleach locked up.</p> <p>III.</p> <p>The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an educational review for licensed staff of:</p> <ul style="list-style-type: none"> <li>Maintaining the medication and treatment cart in locked status unless within direct observation of the nurse.</li> <li>Keeping ordered treatments and/or medications in the medication or treatment</li> </ul> <p>cart unless there is an order which reads 'may keep at bedside' in which case the medication will be maintained securely in the resident drawer.</p>	Date of Compliance 1/14/16	

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F 323	<p>Continued From page 18 the medications.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 12/09/15 at 10:30 AM, revealed she expected the medication cart to be locked when the nurse was not in attendance or within site of the cart. She stated an unlocked medication cart enabled resident, staff or visitors to have access to the medication and this could cause injury.</p> <p>Interview with the Director of Nursing (DON), on 12/10/15 at 2:58 PM, revealed she expected all medication carts to be locked at all times when out of site of the medication staff. She stated the medication cart not being locked enabled residents, staff or visitors to have access to the medications.</p> <p>Interview with the Administrator, on 12/10/15 at 3:01 PM, revealed she expected all medication carts to remain locked at all times when out of site of the medication staff. She stated the medication cart not being locked enabled residents, staff or visitors to have access to the medications in the cart.</p> <p>3. Review of the facility's policy titled, "Self-Administration of Drugs", last revised 12/11, revealed self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications will be stored on a central medication cart or in the medication room. Nursing will transfer the medication to the resident when the resident requests them.</p> <p>Observation during the initial tour on 12/09/15 at 10:08 AM and a second observation at 2:25 PM, revealed two tubes of Calazime Skin Protectant</p>	F 323	<p>The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an educational review for facility staff on:</p> <ul style="list-style-type: none"> <li>Keeping chemicals locked up and monitoring resident rooms for chemicals; removing chemicals which may be found and notification to the facility DON and/or Nursing Home Administrator of chemicals found at bedside.</li> <li>Filling out work orders for needed repairs</li> </ul> <p>The facility administrator will provide residents and/or their respective Responsible party education regarding regulation F 323 and the requirement to have chemicals secure and out of the reach of residents by 1/11/15. Review of F 323 has been incorporated into the facilities new hire orientation program.</p> <p style="text-align: right;">IV</p> <p>The Director of Nursing and/or Assistant Director of nursing, Unit manager or wound care nurse will conduct an audit of residents' rooms and common areas to validate that there are no chemicals available to residents.</p>	<p><i>Date of Compliance</i> 1/14/16</p>

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F 323	<p>Continued From page 19</p> <p>Paste with Zinc Oxide on the bedside table of resident room #115-A. The tubes contained no pharmacy label.</p> <p>Interview with CNA #1, on 12/11/15 at 2:50 PM, revealed medicated creams should not be kept on a bedside table and if kept in the resident's rooms, creams should be stored in drawers. CNA #1 stated some creams are also kept on the treatment cart.</p> <p>Interview with LPN #1, on 12/11/15 at 2:41 PM, revealed if a resident's doesn't have an order to keep medicated creams at the bedside, they are to be kept on a locked treatment cart. LPN #1 further revealed if the resident had an order to keep a medicated cream at the bedside it should be stored in the resident's drawer because with wandering residents it could possibly be harmful if ingested.</p> <p>Interview with the DON, on 12/11/15 at 9:51 AM, revealed some creams may be left at the bedside per physician's order, but that they should be stored in the resident's drawer.</p> <p>4. Review of facility documentation provided on 12/10/15 by Administraoctr revealed the facility does not have a policy specific to having bleach in residents' rooms.</p> <p>Review of Clorox Regular Bleach Safety Data Sheet from The Clorox Company website, last revised 06/12/15, revealed the chemical is classified as hazardous and can cause skin corrosion/irritation, and serlous eye damage/eye irritation. The Safety Data Sheet revealed responses to internal intake was to immediately call a poison center or doctor, if swallowed; rinse</p>	F 323	<p>This audit will be conducted across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time.</p> <p>The Director of Nursing  and/or Assistant Director of nursing , Unit manager or wound care nurse will conduct an audit of medication carts to ensure they are locked.</p> <p>This will be a random audit of all Medication carts and will be conducted across all 3 shifts, conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.</p> <p>The maintenance director or Maintenance assistant will Do random audits on all doors Across all three shifts for 5 days Then weekly for 3 weeks, then Monthly for 2 months.</p> <p>Any discrepancy noted during the audit will be corrected at that time.</p>	Date of Compliance 1/14/16

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F 323	Continued From page 20 mouth; and to not induce vomiting. Further review revealed if on skin or hair to take off all contaminated clothing immediately, rinse skin with water and wash contaminated clothing before reuse. If inhaled to remove person to fresh air and keep comfortable for breathing, and if in eyes to rinse cautiously with water for several minutes. Further review of the Safety Data Sheet revealed to store chemical locked up.  Observation on 12/09/15 at 9:43 AM revealed a bottle of bleach beneath a bedside commode in Resident#11's room.  Interview with LPN #2, on 12/09/15 at 9:45 AM, revealed the container of bleach under Resident #11's bedside commode was not supposed to be in the room.  Interview with Registered Nurse (RN) #1, on 12/11/15 at 1:40 PM, revealed bleach should never be in a resident's room and a resident should never have access to it. She stated a confused resident (not cognitively intact and/or has poor safety awareness) may wander into the room and try to drink it or get it on them.	F 323	The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.	
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.	F 441	F 441  It is the practice of this facility to maintain an infection control program designed to help prevent the development and transmission of infection.  i. The soiled washcloths were removed to the soiled linen bin. The over bed table was cleaned using a sanitizing agent.  C N A # 2 was provided with a 1:1 educational review by the Assistant Director of Nursing	<i>Date of completion</i> 1/14/16

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F 441	Continued From page 21  (a) Infection Control Program The facility must establish an Infection Control 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 STANDARD is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to maintain an Infection Control	F 441	on infection control practices and handling of soiled items on 12/17/15.  II. Facility nursing staff will follow infection control guidelines when handling soiled linens and/or clothing.  III. The Director of Nursing and/or Assistant Director of nursing , Unit manager or wound care nurse conducted an educational review for the nursing staff regarding F 441 as it relates to infection control and handling of linens. This education will be completed by 1/11/16.  IV The Director of Nursing will conduct an audit of care as it is being provided to validate that infection control measures are being followed when handling soiled items.  This audit will be conducted by the Director of nursing and/or Assistant Director of nursing , Unit manager or wound care nurse on 5 resident care opportunities with at least 5 different staff across all 3 shifts, and will be conducted 5 days per week for 1 week, then weekly for 3 weeks, then monthly for 2 months.  Any discrepancy noted during the audit will be corrected at that time with impromptu education for staff members as indicated.	Date of Compliance 1/14/16

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F 441	<p>Continued From page 22</p> <p>Program designed to help prevent the development and transmission of infection for one (1) of sixteen (16) sampled residents (Resident #7). Staff failed to ensure soiled linen was placed into a designated container per facility policy.</p> <p>The findings include:</p> <p>Review of facility policy, entitled "Urinary Catheter Care", last revised 10/2010, revealed to place soiled linen into designated container.</p> <p>Record review revealed the facility admitted Resident #7 on 07/01/12 with diagnosis which included Neurogenic bladder.</p> <p>Observation on 12/10/15 at 11:30 AM while observing catheter care provided by Certified Nurse Aide (CNA) #2, revealed four (4) soiled wash cloths placed directly on Resident #7's bedside table and not placed in a plastic bag until care had been completed.</p> <p>Interview with CNA #2, on 12/10/15 at 11:45 AM, revealed she should have used a plastic bag to place soiled wash cloths in and should not have placed the soiled washcloths directly on the resident's bedside table.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/10/15 at 2:05 PM, revealed she would expect anyone providing personal hygiene care to use a plastic bag to store soiled linens and soiled linen should never be placed directly on any residents bedside table. Further interview, revealed placing soiled linens directly on the residents bedside table would be a infection control concern.</p>	F 441	<p>The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director,</p> <p>Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.</p>	date of compliance 1/14/16	

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F 441	Continued From page 23  Interview with the Director of Nursing (DON), on 12/11/15 at 1:15 PM, revealed it would be a infection control issue if soiled linen was being stored directly on a resident's bedside table. Further interview revealed she would have expected the staff to have placed soiled linens in a plastic bag during and after direct care was being provided.	F 441		<i>Date of Compliance</i> 4/14/16	

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NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>414 ROBEY ST.</b> <b>FRANKLIN, KY 42135</b>		
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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance 01/14/16, as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185331	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 1/14/2016
Name of Facility FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTE	Street Address, City, State, Zip Code 414 ROBEY ST. FRANKLIN, KY 42135	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0062	Correction Completed 01/14/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0143	Correction Completed 01/14/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 01/14/2016
ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 01/14/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0154	Correction Completed 01/14/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>DH</i>	Date: <i>01/13/16</i>	Signature of Surveyor: <i>Deborah C. Helder-Nelzok</i>	Date: <i>01/13/16</i>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/10/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2016  
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  12/10/2015
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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBNEY ST. FRANKLIN, KY 42135
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(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
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K 000	<p><b>INITIAL COMMENTS</b></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 12/10/15. 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 eighty (80) 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 Fire).</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 allegation 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>	
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Date of Compliance  
1/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Leona J. Daves</i>	TITLE <i>Administrator</i>	(X8) DATE 1/11/16
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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.

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
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K 000  K 062 SS=F	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, NFPA 13, NFPA 25, 9.7.5</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, residents, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was eighty (80).</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 12/10/15 at 11:30 AM with the Maintenance Director, revealed the facility failed to provide documentation that the interior pipe inspection for the sprinkler system had been performed within the last five (5) years. The last quarterly sprinkler inspection performed on 11/04/15 stated that the date of the last interior pipe inspection was "n/a" (not applicable).</p> <p>Interview on 12/10/15 at 11:31 AM with the Maintenance Director revealed that he was</p>	K 000  K 062	<p>K 062</p> <p>It is the practice of this facility to maintain the sprinkler system in accordance with the (NFPA) National Fire Protection Association standards.</p> <p>I. Validation of completion of the required inspection of the interior pipe inspection for the sprinkler system was located.</p> <p>The documentation of completion of a full flow trip test was obtained.</p> <p>II. The maintenance director will maintain copies of required inspections in a binder for easy retrieval and review.</p> <p>III The facility administrator (NHA) conducted an educational review on 1/4/16 for the maintenance director regarding K 062 and the requirements therein.</p> <p>IV. The facility administrator (NHA) will audit the required inspection reports monthly to validate that required NFPA inspections are completed per regulation and that a copy of the inspection is available for review. Any discrepancy noted during the audit will be addressed at that time.</p>	<p>Date of Completion 1/14/16</p>

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
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K 062	Continued From page 3 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Full flow trip test 3 years 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.	
K 143 SS=D	Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance	K 143	It is the practice of this facility to transfer liquid oxygen in accordance with (NFPA) National Fire Protection Association requirements.  I. The light in the oxygen transfilling room was replaced. The DON completed an educational review for the Hospitality Aide on 12/17/15.  II. Facility staff will transfill oxygen containers in accordance with (NFPA) National Fire Protection Association requirements.	<i>Date of Compliance 1/14/16</i>

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K 143	<p>Continued From page 4 with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to transfer liquid oxygen in accordance with National Fire Protection Association (NFPA) requirements. The deficiency had the potential to affect one (1) of five (5) smoke compartments, staff and seven (7) residents. The facility has the capacity for ninety-eight (98) beds and at the time of the survey, the census was eighty (80).</p> <p>The findings include:</p> <p>Observation and interview on 12/10/15 at 9:55 AM with the Maintenance Director and a Hospitality Aide revealed that staff holds the corridor door to the oxygen transfilling room open with their foot while transfilling oxygen containers. This was due to no light and/or not enough room in the oxygen storage room. The Maintenance Director and the Hospitality Aide revealed that staff was trained on the requirements of transfilling oxygen.</p> <p>The census of eighty (80) was verified by the Administrator on 12/10/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/10/15.</p>	K 143	<p>III. The facility administrator (NHA) completed an educational review, for the Maintenance Director, of the regulation K 143 as well as the (NFPA) National Fire Protection association requirement for liquid oxygen. This education was completed on 1/4/16. The director of nursing and/or the assistant director of nursing, unit manager or wound nurse will complete inservices with all c.n.a's , aides and LN's by 1/11/16.</p> <p>IV. The Maintenance director will audit the filling of liquid oxygen containers to validate that required NFPA requirements are followed by staff when filling the oxygen containers to include having a working light in the room as well as having the door shut when transfilling the oxygen.</p> <p>This audit will be conducted daily, 5 days per week for 1 week across all 3 shifts, then weekly across all 3 shifts times 3 weeks, then monthly times two (2) months.</p> <p>Any discrepancy noted during the audit will be addressed at that time.</p> <p>The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director,</p>	<i>Date of completion</i> 1/14/16	

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K 143	Continued From page 5  Reference: NFPA 99 (1999 Edition).  8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities. NFPA 101 LIFE SAFETY CODE STANDARD	K 143	Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.	
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	It is the practice of this facility to maintain the emergency generator in accordance with (NFPA) National Fire Protection Agency standards.  I. Past non-compliance with the required time limit for the load test cannot be corrected.	Dated of Compliance 1/14/16

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K 144	Continued From page 6  This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the emergency generator set in accordance with National Fire Protection Agency (NFPA) standards. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for ninety-eight (98) beds with a census of eighty (80) on the day of the survey.  The findings include:  During the Life Safety Code tour, on 12/10/15 at 10:05 AM with the Director of Maintenance (DOM), a record review of the facility's generator set revealed that during testing the generator's load test was fifteen (15) seconds, exceeding the required time limit of ten (10) seconds.  Interview with the DOM, on 12/10/15, at 10:05 AM, revealed he would be present at the generator when it started automatically on a weekly basis. The DOM stated he would observe the gauges on the generator to record the fifteen (15) seconds it would take to conduct the load test. The DOM was not aware the load test should not be more than ten (10) seconds.  The census of eighty (80) was verified by the Administrator on 12/10/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/10/15.	K 144	II. The maintenance director will follow (NFPA) National Fire Protection Agency recommendations to complete a load test with a required time frame of not more than 10 seconds.  III. The facility administrator (NHA) completed an educational review, for the Maintenance Director, of the regulation K 144 as it relates to the (NFPA) National Fire Protection agency requirement to load test the generator for no more than 10 seconds. This education was completed on 1/4/16.  IV. The facility Administrator ( NHA) will audit the completion of the generator load testing to validate that the NFPA requirements are followed .  This audit will be conducted monthly for 3 months.  Any discrepancy noted during the audit will be addressed at that time.	<i>Date of compliance 1/4/16</i>	

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K 144	Continued From page 7  Reference: NFPA 99 (1999 Edition).  3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. a. Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. b. Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.	K 144	The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	It is the practice of this facility to maintain electrical requirements in accordance with (NFPA) National Fire Protection Agency standards.	Date of Completion 1/14/16

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**K 147** Continued From page 8

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical requirements were maintained 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 twelve (12) residents. The facility has the capacity for ninety-eight (98) beds and at the time of the survey the census was eighty (80).

The findings include:

Observation, on 12/10/15 at 10:44 AM with the Maintenance Director, revealed daisy chained power strips (two power strips connected together) that were secured to the wall and serving as a substitute for permanent wiring in resident room #201.

Interview, on 12/10/15 at 10:45 AM with the Maintenance Director, revealed he was aware that power strips should not be connected together; however, he was not aware of the daisy chained power strips that were secured to the wall in resident room #201.

The census of eighty (80) was verified by the Administrator on 12/10/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/10/15.

Reference: NFPA 70 1999 edition

**K 147**

I.  
The power strip was removed from room 201.

II.  
The maintenance director and facility staff will follow (NFPA) National Fire Protection Agency recommendations regarding use of power cords. The maintenance director completed an audit of all resident rooms to ensure no other power strips are being used inappropriately on 1/10/16.

III.  
The facility administrator (NHA) completed an educational review, for the Maintenance Director, of the regulation K 147 as it relates to the (NFPA) National Fire Protection agency requirements related to the use of power strips. This education was completed on 1/4/16.

IV.  
The facility administrator (NHA) or maintenance director will make walking rounds to validate that electrical requirements are maintained per the NFPA guidelines.

This audit will be conducted 5 days per week over all 3 shifts, then weekly times 3 weeks, then monthly for 2 months.

Any discrepancy noted during the audit will be addressed at that time.

*Date of Compliance*  
1/14/15

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K 147	Continued From page 9  400-8. Uses Not Permitted Unless specifically permitted in Section 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 384-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code NFPA 101 LIFE SAFETY CODE STANDARD	K 147	The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.	
K 154 SS=F	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 154	K 154  It is the practice of this facility to ensure that fire watches are put into place when the automatic sprinkler system is out of service for more than 4 hours, and to notify the Authority having jurisdiction (AHJ) in accordance with (NFPA) National Fire Protection Agency standards.  1. Past non-compliance with notification to the AHJ upon implementation of a fire watch when the sprinkler system is out of service for more than 4 hours cannot be corrected.	Date of compliance 1/14/16

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

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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  12/10/2015
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 154	<p>Continued From page 10</p> <p>determined the facility failed to ensure a fire watch was conducted in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-eight (98) beds and at the time of the survey the census was eighty (80).</p> <p>The findings include:</p> <p>Observation and record review on 12/10/15 at 9:45 AM with the Maintenance Director revealed that the facility's Fire Watch Policy was implemented on 11/24/15 due to the facilities sprinkler system being out of service. The facility failed to notify the Authority Having Jurisdiction (AHJ) as required.</p> <p>Interview, on 12/10/15 at 9:46 AM with the Maintenance Director, revealed he was not aware of the requirement to notify the Authority Having Jurisdiction (AHJ) when the Fire Watch Policy is implemented.</p> <p>The census of eighty (80) was verified by the Administrator on 12/10/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/10/15.</p>	K 154	<p>ii. The maintenance director will follow (NFPA) National Fire Protection Agency recommendations to notify the AHJ when a fire watch is in place with documentation thereof any time the fire sprinkler system is out of service for more than 4 hours.</p> <p>iii. The facility administrator (NHA) completed an educational review, for the Maintenance Director, of the regulation K 154 as it relates to the (NFPA) National Fire Protection agency to set into place a fire watch and notification of the AHJ anytime the automatic sprinkler system is out of service for more than 4 hours. This education was completed on 1/4/16.</p> <p>iv. The facility administrator (NHA) will audit the notification of the AHJ and documentation of the fire watch whenever the automatic sprinkler system is out of service for more than 4 hours, to validate that the NFPA requirements are followed by the Maintenance Director.</p> <p>Any discrepancy noted during the audit will be addressed at that time. This audit will be conducted monthly The results of the audit will be submitted monthly to the Quality Assurance / Performance Improvement Committee for its review and recommendations. Members of the Quality Assurance / Performance Improvement team will consist of, at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services Manager, maintenance Director, Social services Director, Activity Director, and Business Office Manager with the Medical Director attending at least Quarterly.</p>	<i>Date of completion 1/14/16</i>