

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



PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Amended 08/22/14</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21565 was conducted on 04/11/14 through 04/30/14 to determine the facility's compliance with Federal requirements. Complaint #KY 21565 was unsubstantiated with unrelated deficiencies cited at a Scope and Severity of a "D".</p> <p>On 03/14/14, the facility received an order for Resident #1 to receive Levothyroxine (Thyroid Hormone) 120 micrograms (mcg) by mouth (PO) daily. The pharmacy requested a clarification order and on 03/16/14, a clarification order was written for Levothyroxine 112 mcg one (1) tab po daily with 88 mcg tab = 120 mcg. The next line on the order read Levothyroxine 88 mcg one (1) tab po daily with 112 mcg = 120 mcg. Licensed Practical Nurse (LPN) #6 failed to identify Levothyroxine 112 plus 88 equaled 200 mcg not 120 mcg. LPN #6 transcribed the order to the Medication Administration Record (MAR) as written. In addition, the order was sent to the Pharmacy and the Pharmacist failed to identify the error. The Director of Nursing (DON) stated the Assistant Director of Nursing and Daytime Supervisor checked the telephone orders for accuracy against the MARs every morning but must have failed to identify the error. Registered Nurse (RN) #4 conducted the MAR change over documentation from March 2014 to April 2014 and failed to identify the error. RN #4 stated she checked some of the orders but not all of the orders for accuracy. Resident #1 received the 200 mcg of Levothyroxine daily (80 mcg more a day than ordered) from 03/16/14 through</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

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

TITLE

Administrator

(X5) DATE

8/23/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 04/01/14. One (1) Registered Nurse (RN) and three (3) LPNs administered the medication during this time and failed to identify the error. Resident #1's Physician stated she meant for the dosage to be 125 mcg and stated she did not remember ordering 200 mcg because that was not an amount that she would order. After consultation with the Centers for Medicare and Medicaid (CMS) the investigation was reopened 05/27/14 and a 483.20 Resident Assessment F281 was cited at a Scope and Severity of a "J". 483.25 Quality of Care F333 and 483.60 Pharmacy Services F425 Scope and Severity was raised from a "D" to a "J". An acceptable Allegation of Compliance was received on 06/02/14 alleging the removal of Immediate Jeopardy on 05/30/14. The State Survey Agency validated, on 06/02/14, that the Immediate Jeopardy was removed on 05/30/14, as alleged. The Scope and Severity was lowered to a "D" at 483.20 Resident Assessment, F-281; 483.25 Quality of Care, F-333 and 483.60 Pharmacy Services F425 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.	F 000			
F 281 SS=J	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 281	F281 1. Resident # 1 expired at Franklin-Simpson Nursing & Rehab Center on 04/06/2014, and according to the coroner's report, he died of natural causes. 2. On 04/30/2014 the Director of Nursing completed an audit of all current residents physicians' orders written in the past thirty (30) days to assure all orders for current residents were accurate in that they contained a dosage, route, frequency, and any mathematical equations were accurate. Any identified concerns had immediate physician notification for direction	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 2</p> <p>the facility's policy/procedure, and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) 14, it was determined the facility failed to ensure care that meets professional standards of quality was provided for one (1) of four (4) sampled residents (Resident #1), related to failing to ensure medication was administered at the right dose to Resident #1.</p> <p>On 03/14/14, the facility received an order for Resident #1 to receive Levothyroxine (Thyroid Hormone) 120 micrograms (mcg) by mouth (PO) daily. The pharmacy requested a clarification order and on 03/16/14, and a clarification order was written for Levothyroxine 112 mcg one (1) tab po daily with 88 mcg tab = 120 mcg. The next line on the order read Levothyroxine 88 mcg one (1) tab po daily with 112 mcg = 120 mcg. Licensed Practical Nurse (LPN) #6 failed to identify Levothyroxine 112 plus 88 equaled 200 mcg not 120 mcg. LPN #6 transcribed the order to the Medication Administration Record (MAR) as written. Resident #1 received the 200 mcg of Levothyroxine daily (80 mcg more a day than ordered) from 03/16/14 through 04/01/14. One (1) Registered Nurse (RN) and three (3) LPNs administered the medication during this time and failed to identify the wrong dose error.</p> <p>The facility's failure to identify a significant medication error has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/16/14, and was determined to exist on 04/06/14.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing Advisory Opinion Statements (AOS) 16, 04/2007,</p>	F 281	<p>(F 281 cont.)</p> <p>3. On 04/17/2014 the Director of Nursing was re-educated by the Regional Nurse Consultant on 04/17/2014 related to the process for writing a correct and accurate order which included assuring orders contained a dosage, route, frequency, and that any mathematical equations were accurate and that verbal orders should be repeated back for accuracy. All Licensed Nurses were re-educated on the process for writing a correct and accurate order by the Regional Nurse Consultant and the Director of Nursing on 04/17/2014 which included assuring orders contained a dosage, route, frequency, and that any mathematical equations were accurate and that verbal orders should be repeated back for accuracy. After this initial training ongoing training on writing a correct and accurate order will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager with no licensed nurse working after 04/30/2014 without having had this re-education on writing a correct and accurate order. In addition to this previous training, the facility has re-trained all licensed nurses and CMT(Certified Medication Technician) on medication administration including the 5 rights of medication administration using our Silverchair, online training system. On 05/29/2014 the Director of Nursing reviewed this training electronically and validated that all licensed nurses and CMT had completed this education. The Silverchair system provides electronic training and testing and no nurse or CMT will work after 05/29/2014 without having received the medication administration training and passing the test within Silverchair.</p>	6/3/14

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 3</p> <p>revealed Licensed Practical Nursing practice and Registered Nursing practice holds all nurses individually accountable and responsible for their nursing decisions and actions and their practice includes the administration of medication and treatment as prescribed by a physician, physician assistant, or advanced practice nurse. Components of medication administration include, but are not limited to; Preparing and giving the medication in the prescribed dosage, route, and frequency.</p> <p>Review of the facility's "Medication Administration Policy", (undated), revealed the center strives to provide safe administration of all medications. The licensed nurse and/or medication assistant will administer medications according to state specific regulation and will check the following when administering medications: Right medication, Right dose, Right dosage form, Right route, Right resident, and Right time. The policy further revealed for staff to read the MARs (Medication Administration Record) for the ordered medication, dose, dosage form, route, and time and to verify the correct medication, expiration date, dose, dosage form, route, and time again by comparing to the MARs before administering.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Chronic Airway Obstruction, Diabetes Mellitus II, Muscle Weakness, Dysphagia, Oral Phase, Artherosclerosis, Late Effect Cerebral Vascular Disease, and Dementia with Behavior Disturbance.</p> <p>Review of a Physician's Telephone Order, dated 03/14/14, revealed to discontinue Levothyroxine</p>	F 281	<p>(F281 cont.)</p> <p>4. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five times per week for twelve (12) weeks to assure orders are written correctly and accurately. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will perform medication observations five (5) times a week for twelve (12) weeks to assure that the staff are performing the 5 rights of medication administration properly. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee by the Administrator for review monthly for three months. These audits, the physician orders audit, and the medication observations, will provide the facility with a way to monitor its performance and ensure that solutions are sustained. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance (QPI) was held on 04/30/2014 to review the alleged deficient practice with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office Manager in attendance.</p> <p>Completion Date: June 3, 2014</p>	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 4</p> <p>112 mcg PO daily, change dosage to Levothyroxine 120 mcg PO daily. However, review of the Mosby's 2014 Nursing Drug Reference, revealed dosages of Levothyroxine tablets to be only available in 25 mcg, 50 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, and 300 mcg. There was no 120 mcg tablet and no tablets that could be given together to equal 120 mcg.</p> <p>Interview with RN #1, on 04/28/14 at 1:50 PM, revealed she received the order from the physician on 03/14/14 for Resident #1 stating to discontinue Levothyroxine 112 mcg PO daily and to change to Levothyroxine 120 mcg PO daily. She stated she faxed the order to the pharmacy, and she did not know why they did not fill that order. She stated she did not identify the medication was ordered in a dose that was not available.</p> <p>Interview with Pharmacist #1, on 04/30/14 at 11:45 AM, revealed he called the facility and asked them to obtain a clarification order due to the medication being ordered for 120 mcg but did not know if one was received or not. Review of a Clarification Physician Telephone Order for the 03/14/14 order, dated 03/16/14, and signed by Licensed Practical Nurse (LPN) #6, revealed Levothyroxine 112 mcg one (1) tab PO every morning given with a 88 mcg one tab =120 mcg. However, Levothyroxine 88 mcg plus 112 mcg tablets equaled 200 mcg instead of 120 mcg. Further review of the physician orders revealed there was no documented evidence the order was clarified due to this discrepancy.</p> <p>Interview with LPN #6, on 04/28/14 at 2:59 PM, revealed she wrote the 03/16/14 clarification</p>	F 281		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 5</p> <p>order to clarify the 03/14/14 physician's order, but did not recall the specifics of the order.</p> <p>Review of Resident #1's March and April 2014 Medication Administration Records (MARs), revealed on 03/16/14 an order was initiated for Levothyroxine 88 mcg one (1) tab po daily with 112 mcg tab = 120 mcg, with the following line revealing Levothyroxine 112 mcg one (1) tab po daily with 88 mcg = 120 mcg. Documentation on the MARs revealed both dosages of medication were initialed as given on 03/16/14, 03/18/14 through 03/31/14; and 04/01/14, with dosage equaling 200 mcg instead of 120 mcg.</p> <p>Interviews with RN #1 on 04/28/14 at 1:50 PM, RN #3 on 04/25/14 at 11:13 AM, RN #5 on 04/27/14 at 9:41 AM, LPN #1 on 04/25/14 at 10:55 AM, and LPN #8 on 04/27/14 at 9:20 AM revealed to ensure medication was given correctly they followed the five (5) rights: right time, right dose, right route, right medication and right patient. They stated they should check to order to ensure the right dose of medication was going to be administered.</p> <p>Interview with RN #4, on 04/26/14 at 9:02 AM, revealed she utilized the five (5) rights when passing medications: right medication, right patient, right dose, right route, and right time.</p> <p>Interview with the DON, on 04/25/14 at 5:00 PM, revealed the five rights should be followed by the staff when administering medications; the right resident, the right dose, the right drug, the right time, and the right route. The DON stated the process for checking telephone orders was to take the order on the phone, fill out the telephone order, read it back to the person giving the order</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 6</p> <p>and write it on the MAR. The DON stated staff had not identified the medication error with the Levothyroxine, and the physician had signed off on it. The DON stated it would have been nice if the error had been caught by the staff administering the order and writing the order.</p> <p>Interview with Resident #1's Physician, on 04/25/14 at 3:10 PM, revealed she meant for the order written on 03/14/14 to be 125 mcg instead of 120 mcg and that was her error. However, she stated she did not recollect giving an order for 200 mcg of Levothyroxine, because she never writes an order for that dosage.</p> <p>Interview on 04/25/13 at 1:36 PM with Pharmacist #3 revealed the increased dose of Levothyroxine for sixteen (16)-seventeen (17) days could possibly affect the heart resulting in angina, palpitations, and edema, and when asked if it could cause heart failure the Pharmacist stated "yes."</p> <p>Interview with the Coroner, on 04/25/14 at 9:25 AM, revealed Resident #1's cause of death was Cardio-Respiratory Failure and Congestive Heart Failure.</p> <p>Interview with the Medical Director, on 04/28/14 at 2:21 PM, revealed he was not aware of Levothyroxine coming in 120 mcg. He stated most places do not have processes in place to check for medication errors on a daily basis. They usually only have processes to identify errors at points of transition when someone is coming or leaving a facility.</p> <p>**The facility implemented the following actions to</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 7 remove the Immediate Jeopardy:</p> <p>On 04/06/14, Resident #1 expired.</p> <p>On 04/30/14, the Director of Nursing (DON) completed an audit of physician orders written in the last thirty (30) days of all current residents, on the daily census report, to ensure accuracy in the containment of dosage, route, frequency and mathematical equations with any identified concerns immediately corrected and physician notified for further recommendations on 04/24/14.</p> <p>On 04/17/14, the DON was re-educated by the Regional Nurse Consultant on the process for accurate orders by verifying they contained dosage, route, frequency, and mathematical equations were accurate and verbal orders were read back and verified for accuracy.</p> <p>All Licensed Nurses were re-educated on the process for accurate orders by verifying they contained dosage, route, frequency, and mathematical equations were accurate and verbal orders were read back and verified for accuracy by the DON on 04/17/14, and all Licensed Nurses and Certified Medication Technicians (CMTs) were retrained on medication administration by the computerized online training course covering the five (5) rights of medication administration and required to take the medication test. No nurse worked without having the training after 05/29/14.</p> <p>Monitoring of the allegation of compliance will be performed by the DON, ADON, or Unit Manger by auditing of physician orders five (5) times per week for twelve (12) weeks to assure accuracy and correctness of written orders. Medication</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED. C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 8</p> <p>Pass Observations will be performed five (5) times a week times twelve (12) weeks to ensure staff are performing the five (5) rights of medication administration properly with results of audits being forwarded to facility's Quality Assurance Performance Improvement (QAPI) Committee for review for three (3) months. An Ad-Hoc meeting of QAPI was held on 04/30/14 to review alleged deficient practice with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office manager in attendance.</p> <p>The Pharmacy General Manager (GM) re-educated all order entry technicians by 05/20/14 related to accurate orders and flagging of inaccurate order to not be filled till clarification is made. The Pharmacy GM conducted training with the Pharmacist in Charge related to clarification orders and the process of clarification on questionable dosage. The Pharmacist in Charge or the Pharmacy GM conducted retraining with all other Pharmacist related to clarification orders and the process of clarification on questionable dosage with no Pharmacist working after 05/29/14 without training.</p> <p>The Administrator contacted the Medical Director on 05/29/14 to request retraining of Resident #1's Physician on both accuracy of administration of medications and proper dosage with the Medical Director contacting the physician and providing retraining on simplified dosage of medications, accurate administration of medications, and informed her of pharmacy assistance available to her with dosing.</p> <p>The Pharmacist will audit ten (10) order entries</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 9</p> <p>per week for twelve (12) weeks to assure any inaccurate physician orders were flagged and not filled till clarified. The Pharmacy GM will audit five (5) orders per week for twelve (12) weeks to insure the pharmacists are receiving proper order clarification when appropriate, with results of these audits forwarded to facility's QAPI for review for three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly. Monitoring of the allegation of compliance will be performed by the following: The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five (5) times per week for twelve (12) weeks to assure corrective and accurate written orders. with results of the audits being forwarded to the facility QAPI for review for three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly.</p> <p>On 04/17/14, a meeting of the Quality Assurance Committee (QPI) was held to review alleged deficient practice and plan for removal. In attendance, Administrator, DON, ADON, the two Unit Managers, and MDS Nurse, SSD, Admissions Coordinator and Business Office</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 10</p> <p>Manager. The Medical Director attended via conference call, with no other recommendations being made by the committee. QPI will meet weekly to review removal plan and monitor actions weekly until substantial compliance is achieved.</p> <p>Monitoring of the Allegation of Compliance (AOC) will be performed by the DON or ADON by auditing of all admissions weekly to assure that code status has been identified and a care plan initiated. Mock code drills to be conducted by the facility weekly one per each shift for four (4) weeks followed by one drill weekly for eight (8) weeks.</p> <p>Monitoring to be reviewed by the Quality Review Committee (QRC) if further recommendations are needed until Immediate Jeopardy is abated, with QRC convening to make further recommendations of any identified concerns. QRC consists at a minimum of the Administrator, DON, ADON, and SSD, with the Medical Director attending at least quarterly. Failure to comply with any of the above will result in individual re-training and as appropriate disciplinary action.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review revealed Resident #1 expired on 04/06/14.</p> <p>Review of physician orders in last thirty (30) days on Resident's #10, #11, #12, #13, #14, and #15 revealed no concerns with physician orders.</p> <p>Interview on 06/02/14 at 4:30 PM with the DON revealed she had reviewed all orders and any</p>	F 281		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 11 concerns identified were given to the physician and resolved.</p> <p>Review of an inservice training, dated 04/17/14, revealed the DON was inserviced by Regional Nurse Consultant on writing accurate & correct orders to include the five (5) rights, correct dosage, route, frequency, mathematical equation, and making sure you repeat back verbal orders for accuracy.</p> <p>Review of inservice training, dated 04/17/14 and 05/21/14 revealed licensed staff was inserviced by the DON on Physician orders, writing accurate, correct orders, to make sure they have the correct dosage, correct route, frequency, mathematical equation, 5 rights, medication administration, and to repeat back verbal orders for accuracy. Review of Certificate of Completion revealed fulfillment of the medication course on computerized program for all staff.</p> <p>Review on 06/02/14 of the May 2014 calendar, marked New Orders Audits revealed notations of audits on new orders completed by the DON and Assistant Director of Nursing (ADON) on 05/20/14-05/30/14.</p> <p>Interviews on 06/02/14 at 3:53 PM and 6:08 PM with the DON revealed she had been inserviced on the components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. The DON stated when looking at the physician orders she would look at the content, placement on the MARS/chart, and if the order was faxed to the pharmacy correctly and the order was reviewed twice-once in the morning and at the daily clinical review. The DON further</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 12</p> <p>revealed she inserviced the nursing staff on components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. She stated her or the ADON had audited the new physician orders for residents 05/20/14-05/30/14 and they did not find any concerns. The DON further stated that Medication Pass Observations had been initiated and provided the observation sheet. She stated an Action Plan Check sheet would be utilized if any concerns were noted in the medication pass or the audit of the resident's physician orders and would be taken to the Quality Assurance Performance Improvement Committee (QAPI) for monthly review; and the action plan would be reviewed to see if there were any issues, what had been done and suggestions would be heard.</p> <p>Interview on 06/02/14 at 2:19 PM with LPN #3, 2:39 PM with CMT #1, 2:40 PM with LPN #4, 2:51 PM with LPN #14, 3:01 PM with LPN #2, 3:20 PM with RN #3, and 3:40 PM with LPN #6 revealed an inservice by the DON on 04/17/14 was about the five (5) rights of medication administration, to ensure when get a verbal order to read back and verify the order by repeating it back to include the resident's name, frequency, route, medication strength, and reason used for. In addition, staff should call the doctor and clarify an order that was not clear and they received computerized online training and post test about the medication.</p> <p>Interview on 06/02/14 at 6:08 PM with ADON revealed she was involved in reviewing the medications, assists with the audits and she was familiar with the medication observation tool, the physician order audits, and the action plan tool utilized for concerns. The ADON further stated</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 13</p> <p>the action plan tool would be taken to the QAPI meetings for review, education purposes and input. The ADON revealed when looking at the physician orders she would look at content, placement on the MARS, placement on the chart, and ensure the order was correctly faxed to the pharmacy. She stated the physician orders were reviewed twice-once in the morning and at the daily clinical review.</p> <p>Review of Ad-Hoc meeting dated, 04/30/14 revealed the meeting was attended by the Medical Director (by phone), Administrator, Dietary Manager, Business Office Manager, DON, and Social Services Director (SSD) to review the deficient practice.</p> <p>Interview on 06/02/14 at 5:13 PM with Dietary Manager, at 5:25 PM with the Social Service Director, and at 5:30 PM with the Business Office Manager, revealed they participated in the 04/30/14 Ad-Hoc QAPI meeting about medication errors, monitoring of charts, and audit tools.</p> <p>Interview, on 06/02/14 at 4:16 PM and 4:35 PM with Pharmacist #2, revealed he had been inserviced by the General Manager (GM) on clarification of orders and documentation. He stated if there is a question about an order then the facility should be called and clarification received from the nurse of the resident the order is about, and document the name of the nurse spoken to. Pharmacist #2 revealed he then educated other pharmacists on the training.</p> <p>Review of inservicing sheet revealed Pharmacist #2 was educated on the clarification of orders and the process of clarification of questionable orders on 05/29/14 at 1:30 PM by the Pharmacy General</p>	F 281		
-------	--	-------	--	--

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 14 Manager (GM).</p> <p>Review of inservicing verified Pharmacists at the pharmacy were educated by Pharmacist #2 on documentation of clarifications on 05/29/14 at 3:00 PM.</p> <p>Interview on 06/02/14 at 4:24 PM with Pharmacist #5 and at 4:25 PM with Pharmacist #1, revealed they received training from Pharmacist #2 on clarification of questionable orders and documentation.</p> <p>Review of inservicing verified Order Entry Technicians and the Front End Lead and Operations Manager were educated by the Pharmacy GM on clarification of orders on 05/20/14 at 1:10 PM.</p> <p>Interview on 06/02/14 at 4:27 PM with Order Entry Technician #1 and at 4:30 PM with Order Entry Technician #2 revealed they received training by the GM on 05/20/14 on clarification of new orders and documentation. The training included to obtain a name if talking with someone, making sure a name is on the clarification orders, and if not sure of an order then send it back to the pharmacy and get clarification.</p> <p>Interview on 06/02/14 at 4:54 PM with Administrator revealed an Ad-Hoc meeting for QAPI Committee was held on 04/30/14 to discuss the medication allegation related to the Synthroid and processes the facility was going to put in place to keep an incident from reoccurring. The Administrator stated he and the Medical Director were discussing the process off and on, and had two meeting before 04/30/14. The Administrator</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 15</p> <p>revealed the meeting May was related to the CPR concern, medications, audits and education. The Administrator stated the QAPI meetings will continue until the audits are completed and if there are any issues identified they will be corrected and they will continue to monitor for issues. The Administrator revealed the Medical Director had been contacted about training Resident #1's physician related to the Levothyroxine.</p> <p>Interview on 06/02/14 at 5:20 PM with Medical Director revealed he had been involved in the Ad-Hoc meeting on 04/30/14 and had an ongoing discussion with Administrator throughout this process. The Medical Director further stated he had educated Resident #1's Physician on the simplification of the dosages for Synthroid, monitoring and clearly stating the orders. He stated changes were made for medication monitoring by making sure the doses and orders are checked at least five (5) times a week and discrepancies are communicated to the pharmacy to clarify.</p> <p>Interview on 06/02/14 at 5:37 PM with Resident #1's Physician revealed she had received training by the Medical Director around May 29 th on the correct dose and obtaining confirmations of the correct dose, communicating with the nurses, checking chart/MARs/ medication list of residents, reconciliation of the medication of the residents, and obtaining confirmation of the order and if there is a discrepancy to call the facility and pharmacy if needed.</p> <p>Review of the Pharmacy Order Entry Audit, dated 05/22/14 and 05/29/14, revealed there was no documented evidence of concerns and "No" was</p>	F 281			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16 marked in problem section.	F 281		
F 333 SS-J	<p>Interview on 06/02/14 at 4:54 PM with the Administrator revealed the clarification audits by the Pharmacy GM will be completed going forward related to the training of the staff being completed on 05/29/14. The Administrator stated QAPI meetings will be held to verify audits were completed and to address any concerns that are identified with the audits.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's "Medication Administration" policy and procedure, it was determined the facility failed to have an effective system in place to ensure one (1) of four (4)-sampled residents (Resident #1) was free of significant medication errors.</p> <p>On 03/14/14, the facility received an order for Resident #1 to receive Levothyroxine 120 micrograms (mcg) by mouth (PO) daily. The pharmacy requested a clarification order and on 03/16/14 a clarification order was written for Levothyroxine 112 micrograms (mcg) one (1) tab by mouth (PO) daily with 88 mcg tab = 120 mcg. The next line on the MAR read Levothyroxine 88 mcg one (1) tab po daily with 112 mcg = 120 mcg.</p>	F 333	<p>F333</p> <p>1. Resident # 1 expired at Franklin-Simpson Nursing & Rehab Center on 04/06/2014, and according to the coroner's report, he died of natural causes.</p> <p>2. On 4/30/2014 the Director of Nursing completed an audit of all current residents physicians' orders written in the past thirty (30) days to assure all orders for current residents were accurate in that they contained a dosage, route, frequency, and any mathematical equations were accurate. Any identified concerns had immediate physician notification for direction by the DON, ADON or Unit Manager.</p>	6/3/14

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 17</p> <p>Licensed Practical Nurse (LPN) #6 failed to identify Levothyroxine 112 plus 88 equals 200 mcg. LPN #6 transcribed the order to the Medication Administration Record as written. The Director of Nursing (DON) stated the Assistant Director of Nursing and Daytime Supervisor checked the telephone orders for accuracy against the MARs every morning but must have failed to identify the error. Registered Nurse (RN) #4 conducted the MAR change over documentation from March 2014 to April 2014 and failed to identify the error. RN #4 stated she checked some of the orders but not all of the orders for accuracy. Resident #1 received the 200 mcg of Levothyroxine daily (80 mcg more than ordered) from 03/16/14 through 04/01/14. One (1) Registered Nurse (RN) and three (3) LPNs administered the medication and failed to identify the error. Resident #1's Physician stated she meant for the dosage to be 125 mcg and stated she did not remember ordering 200 mcg because that was not an amount that she would order.</p> <p>The facility's failure to ensure a resident was free of a significant medication error has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/16/14, and was determined to exist on 04/06/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Administration Policy", (not dated), revealed the center strives to provide safe administration of all medications. The licensed nurse and/or medication assistant will administer medication according to state specific regulation. The licensed nurse and/or</p>	F 333	(F333.cont.) 3. The Director of Nursing was re-educated by the Regional Nurse Consultant on 04/17/2014 related to the process for writing a correct and accurate order which included assuring orders contained a dosage, route, frequency, and that any mathematical equations were accurate and that verbal orders should be repeated back for accuracy. All Licensed Nurses were re-educated on the process for writing a correct and accurate order by the Regional Nurse Consultant and the Director of Nursing on 04/17/2014 which included assuring orders contained a dosage, route, frequency, and that any mathematical equations were accurate and that verbal orders should be repeated back for accuracy. This training, related to the process for writing a correct and accurate order which included assuring orders contained a dosage, route, frequency, and that any mathematical equations were accurate and that verbal orders should be repeated back for accuracy, will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager with no licensed nurse working after 04/30/2014 without having had this re-education on writing a correct and accurate order. In addition to this previous training, the facility has re-trained all licensed nurses and CMT (Certified Medication Technician) on medication administration including the five rights of medication administration using our Silverchair, online training system. The Silverchair system provides electronic training and testing and no nurse or CMT will work after 05/29/2014 without having received the medication pass training and passing the test within Silverchair. On 05/29/2014 the DON validated all current licensed nurses and CMT had completed this education on medication administration.	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 18</p> <p>medication assistant will check the following to administer medication: Right medication, Right dose, Right dosage form, Right route, Right resident, and Right time. The policy further revealed for staff to read the MARs for the ordered medication, dose, dosage form, route, and time and verify the correct medication, expiration date, dose, dosage form, route, and time again by comparing to MAR (Medication Administration Record) before administrating.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Chronic Airway Obstruction, Diabetes Mellitus II, Muscle Weakness, Dysphagia Oral Phase, Lack of Coordination, Arthrosclerosis, Late Effects Cerebrovascular Disease, and Dementia with Behavior Disturbance.</p> <p>Review of Resident #1's Thyroid Stimulating Hormone (TSH) Laboratory Report, dated 03/11/14, revealed a TSH of 0.641 one millionth of a International Unit per milliliter (uIU/ml) indicating the lab was normal (normal 0.340-5.600 uIU/ml). Further review revealed documentation from the physician to increase the resident's Levothyroxine from 112 mcg to 120 mcg every day.</p> <p>Review of a Physician's Telephone Order, dated 03/14/14, revealed to discontinue Levothyroxine 112 mcg PO daily. Change to Levothyroxine 120 mcg PO daily. Recheck Thyroid Stimulating Hormone (TSH) in six (6) weeks, with the order signed by Registered Nurse (RN) #1. A high or low TSH level would indicate the thyroid may not be functioning correctly.</p> <p>Review of a Physician Telephone Order, dated</p>	F 333	<p>(F 333 cont.)</p> <p>4. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five times per week for twelve (12) weeks to assure orders are written correctly and accurately. Starting the first of June, The Director of Nursing, Assistant Director of Nursing, or Unit Manager will perform medication observations five (5) times a week for twelve (12) weeks to assure that the staff are performing the 5 rights of medication administration properly. The results of these audits will be forwarded by the Administrator to the facility Quality Assurance Performance Improvement Committee for review monthly for three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance (QPI) was held on 04/30/2014 to review the alleged deficient practice with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office Manager in attendance.</p> <p>Completion Date: June 3, 2014</p>	6/3/14

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 19</p> <p>03/16/14 and signed by Licensed Practical Nurse (LPN) #6, which was a clarification order for the 03/14/14 order, revealed an order that read on line one (1): Levothyroxine 112 mcg one (1) tab po every morning with 88 mcg =120 mcg. On line two (2) it read: Levothyroxine 88 mcg po Q morning with 112 mcg = 120 mcg. Line three (3) of the telephone order revealed discontinue Levothyroxine 120 mcg. However, further review revealed the two tablets added together, the Levothyroxine 112 mcg tab and the 88 mcg tab equaled 200 mcg instead of 120 mcg, as the order read.</p> <p>Review of Resident #1's March and April 2014 Medication Administration Records (MAR), revealed on 03/16/14 an order was initiated for Levothyroxine 88 mcg one (1) tab po daily with 112 mcg tab = 120 mcg. The next line on the MAR read Levothyroxine 112 mcg one (1) tab po daily with 88 mcg = 120 mcg. Both dosages of medication were initialed as given on 03/16/14, 03/18/14 through 03/31/14; and, on 04/01/14, but this dosage equaled 200 mcg instead of the 120 mcg.</p> <p>Review of a Laboratory Report, dated 03/25/14, revealed a TSH of 0.065 uIU/m indicating a low reading and the facility wrote on the report the resident was receiving Levothyroxine 120 mcg daily instead of the 200 mcg the resident was receiving. The physician wrote on the lab report to decrease the order from 120 mcg to 100 mcg.</p> <p>Review of a Physician's Telephone Order, dated 04/01/14 and written by LPN #5, revealed to discontinue Levothyroxine 120 mcg po daily and administer Levothyroxine 100 mcg po daily with LPN #5 writing the order.</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) JD 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 333	<p>Continued From page 20</p> <p>Interview with RN #1, on 04/28/14 at 1:50 PM, revealed she received the order from the physician on 03/14/14 for Resident #1 and faxed it to the pharmacy. RN #1 stated she did not know why the pharmacy did not fill the order and if staff had to give two (2) pills to equal a certain strength they needed to pay attention to make sure it was given correctly. RN #1 further revealed she followed the " five rights" when passing medications.</p> <p>Interview with LPN #6, on 04/28/14 at 2:59 PM, revealed she clarified the physician's order dated 03/14/14, on 03/16/14 but stated she did not remember why she clarified the order or the specifics of the order.</p> <p>Interview with LPN #5, on 04/26/14 at 5:00 PM, revealed she obtained an order to discontinue the Levothyroxine 120 mcg on 04/01/14 because of the results of Resident #1's TSH level results received on 03/25/14.</p> <p>Interviews with RN #2, RN #5, LPN #1, and LPN #8 on 04/25/14 at 10:55 AM, on 04/27/14 at 9:20 AM and 9:41 AM, and on 04/28/14 at 2:30 PM, revealed to ensure medication was given correctly they followed the five (5) rights: right time, right dose, right route, right medication and right patient. LPN #1 stated when a nurse received an order she should enter it in the computer and the orders should be checked the next day by the Assistant Director of Nursing (ADON) or the day shift supervisor for accuracy of the orders against the MARS to make sure it was transcribed correctly. LPN #1 revealed the monthly physician orders were printed out at the end of the month and were checked by the</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 21</p> <p>Director of Nursing (DON), ADON, the shift supervisors (RN #2 and RN #3) and RN #4 before the orders go on the floor.</p> <p>Interview with RN #4, on 04/26/14 at 9:02 AM, revealed she utilized the five (5) rights when passing medications: right medication, right patient, right dose, right route, and right time. RN #4 stated she checked the old MARs against the new MARs for accuracy when doing change over at the end of the month and signed the new month's physician orders. RN #4 revealed she checked some of the orders if she thought there was a discrepancy, but she did not verify all orders for accuracy because the ADON and shift supervisors should have already checked them.</p> <p>Interview with RN #3, on 04/25/14 at 11:13 AM, revealed the process for taking off telephone orders and transferring to the MARs was to write the order on the MAR and put the order into the computer so it would print out on the monthly MARs and physician orders. A copy of the order was picked up by management and checked for accuracy. RN #3 stated monthly change over was completed by the Administrator, DON, ADON, and shift supervisors.</p> <p>Interview with the DON, on 04/25/14 at 5:00 PM, revealed staff should administer medications by the five (5) rights: the right resident, the right dose, the right drug, the right time, and the right route. The DON stated the process for checking telephone orders was to take the order on the phone, fill out the telephone order, read it back to the person giving the order and then write it on the MAR. The DON further revealed the Assistant Director of Nursing (ADON) and the daytime supervisor checked the telephone orders</p>	F 333		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 22</p> <p>for accuracy against the MARs. The DON stated staff had not identified the medication error with the Levothyroxine, and the physician had signed off on it. The DON revealed a medication error report was not completed on Resident #1's Levothyroxine until 04/24/14. The DON stated it would have been nice if the error had been caught by the staff administering the order, writing the order, checking the MARS, checking the telephone orders and during monthly changeover and by the pharmacy. She revealed there was a break in the system and changes would be made.</p> <p>Interview with Pharmacist #1 and Pharmacist #2, on 04/30/14 at 11:45 AM and 12:10 PM respectively, revealed their system for checking an order if they had a question was to call the facility. Pharmacist #1 stated he called the facility and asked them to obtain a clarification order but did not know if one was received or not. Pharmacist #2 said he sent the medication for the Clarification Order written on 03/16/14 to the facility on 03/18/14.</p> <p>Interview with Resident #1's Physician, on 04/25/14 at 3:10 PM, revealed she meant for the order written on 03/14/14 to be 125 mcg instead of 120 mcg and that was her error. However, she stated she did not recollect giving an order for 200 mcg because she never orders that amount of Levothyroxine.</p> <p>Interview with Pharmacist #3, on 04/25/13 at 1:36 PM, revealed Levothyroxine administered at a higher dose than needed for sixteen (16)-seventeen (17) days could possibly affect the heart resulting in angina, palpitations, and edema, and when asked if it could cause heart</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 23</p> <p>failure the Pharmacist stated "yes." Interview with the Coroner, on 04/25/14 at 9:25 AM, revealed the cause of death for Resident #1 was determined to be Cardio-Respiratory Failure and Congestive Heart Failure.</p> <p>Interview with the Medical Director, on 04/28/14 at 2:21 PM, most places do not have processes in place to check for medication errors on a daily basis. They usually only have processes to identify errors at points of transition when someone is coming into a facility or leaving a facility.</p> <p>**The facility implemented the following actions to remove Immediate Jeopardy:</p> <p>Resident #1 expired on 04/06/14.</p> <p>On 04/30/14, the Director of Nursing (DON) completed an audit of physician orders written in the last thirty (30) days of all current residents, on the daily census report, to ensure accuracy in the containment of dosage, route, frequency and mathematical equations with any identified concerns immediately corrected and physician notified for further recommendations on 04/24/14.</p> <p>On 04/17/14, the DON was re-educated by the Regional Nurse Consultant on the process for accurate orders by verifying they contained dosage, route, frequency, and mathematical equations were accurate and verbal orders were read back and verified for accuracy.</p> <p>All Licensed Nurses were re-educated on the process for accurate orders by verifying they contained dosage, route, frequency, and</p>	F 333		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 24</p> <p>mathematical equations were accurate and verbal orders were read back and verified for accuracy by the DON on 04/17/14, and all Licensed Nurses and Certified Medication Technicians (CMTs) were retrained on medication administration by the computerized online training course covering the five (5) rights of medication administration and required to take the medication test. No nurse worked without having the training after 05/29/14.</p> <p>Monitoring of the allegation of compliance will be performed by the DON, ADON, or Unit Manger by auditing of physician orders five (5) times per week for twelve (12) weeks to assure accuracy and correctness of written orders. Medication Pass Observations will be performed five (5) times a week times twelve (12) weeks to ensure staff are performing the five (5) rights of medication administration properly with results of audits being forwarded to facility's Quality Assurance Performance Improvement (QAPI) Committee for review for three (3) months. An Ad-Hoc meeting of QAPI was held on 04/30/14 to review alleged deficient practice with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office manager in attendance.</p> <p>The Pharmacy General Manager (GM) re-educated all order entry technicians by 05/20/14 related to accurate orders and flagging of inaccurate order to not be filled fill clarification is made. The Pharmacy GM conducted training with the Pharmacist in Charge related to clarification orders and the process of clarification on questionable dosage. The Pharmacist in Charge or the Pharmacy GM conducted</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 25</p> <p>retraining with all other Pharmacist related to clarification orders and the process of clarification on questionable dosage with no Pharmacist working after 05/29/14 without training.</p> <p>The Administrator contacted the Medical Director on 05/29/14 to request retraining of Resident #1's Physician on both accuracy of administration of medications and proper dosage with the Medical Director contacting the physician and providing retraining on simplified dosage of medications, accurate administration of medications, and informed her of pharmacy assistance available to her with dosing.</p> <p>The Pharmacist will audit ten (10) order entries per week for twelve (12) weeks to assure any inaccurate physician orders were flagged and not filled till clarified. The Pharmacy GM will audit five (5) orders per week for twelve (12) weeks to insure the pharmacists are receiving proper order clarification when appropriate, with results of these audits forwarded to facility's QAPI for review for three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly. Monitoring of the allegation of compliance will be performed by the following: The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five (5) times per week for twelve (12) weeks to assure corrective and accurate written orders. with results of the audits being forwarded to the facility QAPI for review for</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 26</p> <p>three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review revealed Resident #1 expired on 04/06/14.</p> <p>Review of physician orders in last thirty (30) days on Resident's #10, #11, #12, #13, #14, and #15 revealed no concerns with physician orders.</p> <p>Interview on 06/02/14 at 4:30 PM with the DON revealed she had reviewed all orders and any concerns identified were given to the physician and resolved.</p> <p>Review of an inservice training, dated 04/17/14, revealed the DON was inserviced by Regional Nurse Consultant on writing accurate & correct orders to include the five (5) rights, correct dosage, route, frequency, mathematical equation, and making sure you repeat back verbal orders for accuracy.</p> <p>Review of inservice training, dated 04/17/14 and 05/21/14 revealed licensed staff was inserviced by the DON on Physician orders, writing accurate,</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 27</p> <p>correct orders, to make sure they have the correct dosage, correct route, frequency, mathematical equation, 5 rights, medication administration, and to repeat back verbal orders for accuracy. Review of Certificate of Completion revealed fulfillment of the medication course on computerized program for all staff.</p> <p>Review on 06/02/14 of the May 2014 calendar, marked New Orders Audits revealed notations of audits on new orders completed by the DON and Assistant Director of Nursing (ADON) on 05/20/14-05/30/14.</p> <p>Interviews on 06/02/14 at 3:53 PM and 6:08 PM with the DON revealed she had been inserviced on the components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. The DON stated when looking at the physician orders she would look at the content, placement on the MARS/chart, and if the order was faxed to the pharmacy correctly and the order was reviewed twice-once in the morning and at the daily clinical review. The DON further revealed she inserviced the nursing staff on components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. She stated her or the ADON had audited the new physician orders for residents 05/20/14-05/30/14 and they did not find any concerns. The DON further stated that Medication Pass Observations had been initiated and provided the observation sheet. She stated an Action Plan Check sheet would be utilized if any concerns were noted in the medication pass or the audit of the resident's physician orders and would be taken to the Quality Assurance Performance Improvement</p>	F 333			

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

PRINTED: 06/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 28</p> <p>Committee (QAPI) for monthly review; and the action plan would be reviewed to see if there were any issues, what had been done and suggestions would be heard.</p> <p>Interview on 06/02/14 at 2:19 PM with LPN #3, 2:39 PM with CMT #1, 2:40 PM with LPN #4, 2:51 PM with LPN #14, 3:01 PM with LPN #2, 3:20 PM with RN #3, and 3:40 PM with LPN #6 revealed an inservice by the DON on 04/17/14 was about the five (5) rights of medication administration, to ensure when get a verbal order to read back and verify the order by repeating it back to include the resident's name, frequency, route, medication strength, and reason used for. In addition, staff should call the doctor and clarify an order that was not clear and they received computerized online training and post test about the medication.</p> <p>Interview on 06/02/14 at 6:08 PM with ADON revealed she was involved in reviewing the medications, assists with the audits and she was familiar with the medication observation tool, the physician order audits, and the action plan tool utilized for concerns. The ADON further stated the action plan tool would be taken to the QAPI meetings for review, education purposes and input. The ADON revealed when looking at the physician orders she would look at content, placement on the MARS, placement on the chart, and ensure the order was correctly faxed to the pharmacy. She stated the physician orders were reviewed twice-once in the morning and at the daily clinical review.</p> <p>Review of Ad-Hoc meeting dated, 04/30/14 revealed the meeting was attended by the Medical Director (by phone), Administrator, Dietary Manager, Business Office Manager,</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 29</p> <p>DON, and Social Services Director (SSD) to review the deficient practice.</p> <p>Interview on 06/02/14 at 5:13 PM with Dietary Manager, at 5:25 PM with the Social Service Director, and at 5:30 PM with the Business Office Manager, revealed they participated in the 04/30/14 Ad-Hoc QAPI meeting about medication errors, monitoring of charts, and audit tools.</p> <p>Interview, on 06/02/14 at 4:16 PM and 4:35 PM with Pharmacist #2, revealed he had been inserviced by the General Manager (GM) on clarification of orders and documentation. He stated if there is a question about an order then the facility should be called and clarification received from the nurse of the resident the order is about, and document the name of the nurse spoken to. Pharmacist #2 revealed he then educated other pharmacists on the training.</p> <p>Review of inservicing sheet revealed Pharmacist #2 was educated on the clarification of orders and the process of clarification of questionable orders on 05/29/14 at 1:30 PM by the Pharmacy General Manager (GM).</p> <p>Review of inservicing verified Pharmacists at the pharmacy were educated by Pharmacist #2 on documentation of clarifications on 05/29/14 at 3:00 PM.</p> <p>Interview on 06/02/14 at 4:24 PM with Pharmacist #5 and at 4:25 PM with Pharmacist #1, revealed they received training from Pharmacist #2 on clarification of questionable orders and documentation.</p> <p>Review of inservicing verified Order Entry</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 30</p> <p>Technicians and the Front End Lead and Operations Manager were educated by the Pharmacy GM on clarification of orders on 05/20/14 at 1:10 PM.</p> <p>Interview on 06/02/14 at 4:27 PM with Order Entry Technician #1 and at 4:30 PM with Order Entry Technician #2 revealed they received training by the GM on 05/20/14 on clarification of new orders and documentation. The training included to obtain a name if talking with someone, making sure a name is on the clarification orders, and if not sure of an order then send it back to the pharmacy and get clarification.</p> <p>Interview on 06/02/14 at 4:54 PM with Administrator revealed an Ad-Hoc meeting for QAPI Committee was held on 04/30/14 to discuss the medication allegation related to the Synthroid and processes the facility was going to put in place to keep an incident from reoccurring. The Administrator stated he and the Medical Director were discussing the process off and on , and had two meeting before 04/30/14. The Administrator revealed the meeting May was related to the CPR concern, medications, audits and education. The Administrator stated the QAPI meetings will continue until the audits are completed and if there are any issues identified they will be corrected and they will continue to monitor for issues. The Administrator revealed the Medical Director had been contacted about training Resident #1's physician related to the Levothyroxine.</p> <p>Interview on 06/02/14 at 5:20 PM with Medical Director revealed he had been involved in the Ad-Hoc meeting on 04/30/14 and had an ongoing</p>	F 333			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	Continued From page 31 discussion with Administrator throughout this process. The Medical Director further stated he had educated Resident #1's Physician on the simplification of the dosages for Synthroid, monitoring and clearly stating the orders. He stated changes were made for medication monitoring by making sure the doses and orders are checked at least five (5) times a week and discrepancies are communicated to the pharmacy to clarify. Interview on 06/02/14 at 5:37 PM with Resident #1's Physician revealed she had received training by the Medical Director around May 29 th on the correct dose and obtaining confirmations of the correct dose, communicating with the nurses, checking chart/MARs/ medication list of residents, reconciliation of the medication of the residents, and obtaining confirmation of the order and if there is a discrepancy to call the facility and pharmacy if needed. Review of the Pharmacy Order Entry Audit, dated 05/22/14 and 05/29/14, revealed there was no documented evidence of concerns and "No" was marked in problem section. Interview on 06/02/14 at 4:54 PM with the Administrator revealed the clarification audits by the Pharmacy GM will be completed going forward related to the training of the staff being completed on 05/29/14. The Administrator stated QAPI meetings will be held to verify audits were completed and to address any concerns that are identified with the audits.	F 333			
F 425 SS=J	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEBY 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 425	<p>Continued From page 32</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, pharmacy interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure pharmaceutical services to include procedures for the accurate acquiring, receiving, dispensing, and administering of medications met the needs of one (1) of four (4) sampled residents (Resident #1).</p> <p>On 03/14/14, the facility received an order for Resident #1 to receive Levothyroxine 120 micrograms (mcg) by mouth (PO) daily. The pharmacy requested a clarification order and on 03/16/14 a clarification order was written for Levothyroxine 112 mcg one (1) tab po daily with</p>	F 425	<p>F425</p> <p>1. Resident # 1 expired at Franklin-Simpson Nursing & Rehab Center on 04/06/2014, and according to the coroner's report, he died of natural causes.</p> <p>2. On 4/30/2014 the Director of Nursing completed an audit of all current residents physicians' orders written in the past thirty (30) days to assure all orders for current residents were accurate in that they contained a dosage, route, frequency, and any mathematical equations were accurate. Any identified concerns had immediate physician notification for direction.</p>	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 33</p> <p>88 mcg tab = 120 mcg. The next line on the order read Levothyroxine 88 mcg one (1) tab po daily with 112 mcg = 120 mcg. However, 112 mcg plus 88 mcg equals 200 mcg, not 120 mcg. The order was sent to the Pharmacy and the Pharmacist failed to identify the error. Resident #1 received Levothyroxine from 03/16/14 through 03/31/14; and, on 04/01/14, with dosage equaling 200 mcg instead of the 120 mcg as stated on the order. The DON revealed there was a break in their system and it would have been nice if pharmacy staff had identified the error. Resident #1 expired at the facility on 04/06/14, five days after receiving the last dose of 200 mcg of Levothyroxine. Resident #1 was given the wrong dosage of Levothyroxine (thyroid hormone) for sixteen (16) days.</p> <p>The facility's failure to provide pharmaceutical services to meet the needs of each resident has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/16/14, and was determined to exist on 04/06/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Administration Policy", (not dated), revealed the center strives to provide safe administration of all medications. The licensed nurse and/or medication assistant will administer medication according to state specific regulations. The licensed nurse and/or medication assistant will check the following to administer medication: Right medication, Right dose, and licensed staff is to read the MARs for the ordered medication, dose and verify the correct medication.</p>	F 425	(F425 cont.) 3. The Pharmacy General Manager will complete re-education with all order entry technicians related to accurate order and flagging of inaccurate orders to not be filled until clarified. This will be completed by 05/20/2014 with no order entry technician working after 05/20/2014 without having received this re-education. The Pharmacy General Manager on 05/29/2014 conducted training with the Pharmacist in Charge related to clarification orders and the process of clarifications on questionable dosage. The Pharmacist in Charge or the General Manager conducted re-training with all the other Pharmacist related to clarification orders and the process of clarifications on questionable dosage with no Pharmacist working after 05/29/2014 without the training. The Administrator contacted the Medical Director on 05/29/2014 and asked him to retrain the attending physician for Resident #1 on both accuracy of administration of medications and proper dosage. The Medical Director contacted the attending physician for resident #1 on 05/29/2014 and provided retraining on simplified dosage of medications, accurate administration of medications, and Informed her of pharmacy assistance available to her with dosing.	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 34</p> <p>Review of the facility's policy, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy", revised 01/01/12, revealed the Pharmacy will hold medication orders until the Physician/Prescriber is able to clarify the order. The facility should contact the Physician/Prescriber, document the clarification, and document any new orders received and then communicate the result to Pharmacy. The facility should acquire an order from the Physician/Prescriber when the Physician/Prescriber asks the Pharmacist to provide appropriate dosing for medications that may be dependent on lab results or other pharmaceutical calculations. Facility staff should acquire the Physician/Prescriber's order and communicate it to Pharmacy before the medication is dispensed, and the Pharmacist will notify the facility staff of the recommended dose.</p> <p>Review of the facility's policy, "Reordering, Changing, and Discontinuing Orders", revised 01/01/13, revealed the facility is encouraged to follow verbal orders with a faxed copy to the pharmacy. If the pharmacy indicates follow-up is required then the pharmacy will contact the facility. The policy further states, the pharmacy should receive a discontinuation order before a new order reflecting a change is filled. If the pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand, the pharmacy should discontinue the original order. The facility Physician/Prescriber should write the new order with directions and the facility should enter the new order on the appropriate forms.</p> <p>Record review revealed the facility admitted</p>	F 425	<p>(F425 cont.)</p> <p>4. The pharmacist will audit ten (10) order entries per week for twelve (12) weeks to assure any inaccurate physician orders were flagged and not filled until clarified. Also, the Pharmacy General Manager will audit five (5) orders per week for twelve (12) weeks to insure the Pharmacist are receiving proper order clarification when appropriate. The results of these audits will be forwarded by the Administrator to the facility Quality Assurance Performance Improvement Committee for review monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five times a week for twelve (12) weeks to assure orders are written correctly and accurately. The results of these audits will be forwarded by the Administrator to the facility Quality Assurance Performance Improvement committee for review monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>Completion Date: June 3, 2014</p>	6/3/14	

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 35</p> <p>Resident #1 on 07/01/12 with diagnoses which included Chronic Airway Obstruction, Diabetes Mellitus II, Muscle Weakness, Dysphagia Oral Phase, Lack of Coordination, Arthrosclerosis, Late Effects Cerebrovascular Disease, and Dementia with Behavior Disturbance.</p> <p>Review of a Physician's Telephone Order, dated 03/14/14, revealed to discontinue Levothyroxine 112 micrograms (mcg) by mouth (PO) daily. Change to Levothyroxine 120 mcg PO daily. Recheck Thyroid Stimulating Hormone (TSH) in six (6) weeks, with the order signed by Registered Nurse (RN) #1. A high or low TSH level would indicate the thyroid may not be functioning correctly or used to monitor drug therapy in resident with hypothyroidism.</p> <p>Interview with Pharmacist #1, on 04/30/14 at 11:45 AM, revealed he received an order, on 03/14/14, to discontinue Levothyroxine 112 mcg for Resident #1 and it was changed to Levothyroxine 120 mcg. He stated the system for checking an order if anything was in question was to notify the facility. Pharmacist #1 stated he called the facility and asked them to obtain a clarification order but did not know if one was received or not.</p> <p>Review of a Physician's Clarification Telephone Order for the 03/14/14 order, dated 03/16/14, revealed an order that read on line one (1): Levothyroxine 112 mcg one (1) tab po every morning with 88 mcg = 120 mcg. On line two (2) it read: Levothyroxine 88 mcg po Q morning with 112 mcg = 120 mcg. Line three (3) of the telephone order revealed discontinue Levothyroxine 120 mcg. However, further review revealed the two (2) tablets added together, the</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 36</p> <p>Levothyroxine 112 mcg tab and the 88 mcg tab equaled 200 mcg instead of 120 mcg as the order read.</p> <p>Interview with LPN #6, on 04/28/14 at 2:59 PM, revealed she clarified the physician's order dated 03/14/14, on 03/16/14, but stated she did not remember why she clarified the order or the specifics of the order.</p> <p>Interview with Pharmacist #2, on 04/30/14 at 12:10 PM and on 05/27/14 at 1:27 PM, revealed the pharmacy's (unwritten) policy for a question on an order was to call the facility, speak to the nurse providing care to the patient for which the order was written, and ask for a clarification to be faxed to the pharmacy. He stated when a different pharmacist sees a clarification order it means it has been clarified. He revealed a clarification order, dated 03/16/14, for Levothyroxine was faxed to the pharmacy and the order indicated both dosages so he disregarded the math. He stated it was written down clearly on that order to discontinue the 120 mcg so he determined it meant to disregard the 120 mcg. He revealed he sent the medication for the Clarification Order written on 03/16/14 to the facility on 03/18/14.</p> <p>Review of Resident #1's March and April 2014 Medication Administration Records (MAR), revealed Resident #1 received Levothyroxine 88 mcg one (1) tab po daily and 112 mcg tab daily which equaled 200 mcg instead of the 120 mcg ordered by the physician. The resident received this medication on 03/16/14, 03/18/14-03/31/14 and, on 04/01/14.</p> <p>Review of Resident #1's Thyroid Stimulating</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 37</p> <p>Hormone (TSH) Laboratory Report, dated 03/11/14, revealed a TSH of 0.641 one millionth of a International Unit per milliliter (uIU/ml) which was normal. The normal range is 0.340-5.600 uIU/ml. However, review of a Laboratory Report, dated 03/25/14, after Resident #1 had received nine (9) doses of the 200 mcg instead of the 120 mcg. revealed a TSH of 0.065 uIU/m.</p> <p>Review of a Physician's Telephone Order, dated 04/01/14 and written by LPN #5, revealed to discontinue Levothyroxine 120 mcg po daily and administer Levothyroxine 100 mcg po daily with LPN #5 writing the order.</p> <p>Interview with RN #1, on 04/28/14 at 1:50 PM, revealed she received the order from the physician on 03/14/14 for Resident #1 and faxed it to the pharmacy. RN #1 stated she did not know why the pharmacy did not fill the order and if staff had to give two (2) pills to equal a certain strength they needed to pay attention to make sure it was given correctly. RN #1 further revealed she followed the " five rights" when passing medications.</p> <p>Interview with LPN #5, on 04/26/14 at 5:00 PM, revealed she obtained an order to discontinue the Levothyroxine 120 mcg on 04/01/14 because of the results of Resident #1's TSH level results received on 03/25/14.</p> <p>Interviews with RN #2, RN #5, LPN #1, and LPN #8, on 04/25/14 at 10:55 AM, on 04/27/14 at 9:20 AM and 9:41 AM, and on 04/28/14 at 2:30 PM, respectively, revealed to ensure medication was given correctly they followed the five (5) rights: right time, right dose, right route, right medication and right patient. LPN #1 stated when a nurse</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 38</p> <p>received an order she should enter it in the computer and the orders should be checked the next day by the Assistant Director of Nursing (ADON) or the day shift supervisor for accuracy of the orders against the MARs to make sure it was transcribed correctly. LPN #1 revealed the monthly physician orders were printed out at the end of the month and were checked by the Director of Nursing (DON), ADON, the shift supervisors (RN #2 and RN #3) and RN #4 before the orders go on the floor.</p> <p>Interview with RN #4, on 04/26/14 at 9:02 AM, revealed she utilized the five (5) rights when passing medications: right medication, right patient, right dose, right route, and right time. RN #4 stated she checked the old MARs against the new MARs for accuracy when doing change over at the end of the month and signed the new month's physician orders. RN #4 revealed she checked some of the orders if she thought there was a discrepancy, but she did not verify all orders for accuracy because the ADON and shift supervisors should have already checked them.</p> <p>Interview with RN #3, on 04/25/14 at 11:13 AM, revealed the process for taking off telephone orders and transferring to the MARs was to write the order on the MAR and put the order into the computer so it would print out on the monthly MARs and physician orders. A copy of the order was picked up by management and checked for accuracy. RN #3 stated monthly change over was completed by the Administrator, DON, ADON, and shift supervisors.</p> <p>Interview with the DON, on 04/25/14 at 5:00 PM, revealed staff should administer medications by the five (5) rights: the right resident, the right</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	<p>Continued From page 39</p> <p>dose, the right drug, the right time, and the right route. The DON stated the process for checking telephone orders was to take the order on the phone, fill out the telephone order, read it back to the person giving the order and then write it on the MAR. The DON further revealed the Assistant Director of Nursing (ADON) and the daytime supervisor checked the telephone orders for accuracy against the MARs. The DON stated staff had not identified the medication error with the Levothyroxine, and the physician had signed off on it. The DON revealed a medication error report was not completed on Resident #1's Levothyroxine until 04/24/14. The DON stated it would have been nice if the error had been caught by the staff administering the order, writing the order, checking the MARS, checking the telephone orders and during monthly changeover and by the pharmacy. She revealed there was a break in the system and changes would be made.</p> <p>Interview with Resident #1's Physician, on 04/25/14 at 3:10 PM, revealed she meant for the order written on 03/14/14 to be 125 mcg instead of 120 mcg and that was her error. However, she stated she did not recollect giving an order for 200 mcg because she never orders that amount of Levothyroxine.</p> <p>Interview with the Medical Director, on 04/28/14 at 2:21 PM, revealed he was not aware of Levothyroxine coming in 120 mcg. He stated most places do not have processes in place to check for medication errors on a daily basis. They usually only have processes to identify errors at points of transition when someone is coming into a facility or leaving a facility.</p>	F 425		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 40</p> <p>**The facility implemented the following actions to remove Immediate Jeopardy:</p> <p>Resident #1 expired on 04/06/14.</p> <p>On 04/30/14, the Director of Nursing (DON) completed an audit of physician orders written in the last thirty (30) days of all current residents, on the daily census report, to ensure accuracy in the containment of dosage, route, frequency and mathematical equations with any identified concerns immediately corrected and physician notified for further recommendations on 04/24/14.</p> <p>On 04/17/14, the DON was re-educated by the Regional Nurse Consultant on the process for accurate orders by verifying they contained dosage, route, frequency, and mathematical equations were accurate and verbal orders were read back and verified for accuracy.</p> <p>All Licensed Nurses were re-educated on the process for accurate orders by verifying they contained dosage, route, frequency, and mathematical equations were accurate and verbal orders were read back and verified for accuracy by the DON on 04/17/14, and all Licensed Nurses and Certified Medication Technicians (CMTs) were retrained on medication administration by the computerized online training course covering the five (5) rights of medication administration and required to take the medication test. No nurse worked without having the training after 05/29/14.</p> <p>Monitoring of the allegation of compliance will be performed by the DON, ADON, or Unit Manger by auditing of physician orders five (5) times per week for twelve (12) weeks to assure accuracy</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 41</p> <p>and correctness of written orders. Medication Pass Observations will be performed five (5) times a week times twelve (12) weeks to ensure staff are performing the five (5) rights of medication administration properly with results of audits being forwarded to facility's Quality Assurance Performance Improvement (QAPI) Committee for review for three (3) months. An Ad-Hoc meeting of QAPI was held on 04/30/14 to review alleged deficient practice with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Services Manager, and Business Office manager in attendance.</p> <p>The Pharmacy General Manager (GM) re-educated all order entry technicians by 05/20/14 related to accurate orders and flagging of inaccurate order to not be filled till clarification is made. The Pharmacy GM conducted training with the Pharmacist in Charge related to clarification orders and the process of clarification on questionable dosage. The Pharmacist in Charge or the Pharmacy GM conducted retraining with all other Pharmacist related to clarification orders and the process of clarification on questionable dosage with no Pharmacist working after 05/29/14 without training.</p> <p>The Administrator contacted the Medical Director on 05/29/14 to request retraining of Resident #1's Physician on both accuracy of administration of medications and proper dosage with the Medical Director contacting the physician and providing retraining on simplified dosage of medications, accurate administration of medications, and informed her of pharmacy assistance available to her with dosing.</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 42</p> <p>The Pharmacist will audit ten (10) order entries per week for twelve (12) weeks to assure any inaccurate physician orders were flagged and not filled till clarified. The Pharmacy GM will audit five (5) orders per week for twelve (12) weeks to insure the pharmacists are receiving proper order clarification when appropriate, with results of these audits forwarded to facility's QAPI for review for three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly. Monitoring of the allegation of compliance will be performed by the following: The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new physician orders five (5) times per week for twelve (12) weeks to assure corrective and accurate written orders. with results of the audits being forwarded to the facility QAPI for review for three (3) months. If any concerns are identified than QAPI committee will convene to review and make further recommendations as needed. QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, dietary Services manager and Business office manager with the Medical Director attending at least quarterly.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	<p>Continued From page 43</p> <p>Record review revealed Resident #1 expired on 04/06/14.</p> <p>Review of physician orders in last thirty (30) days on Resident's #10, #11, #12, #13, #14, and #15 revealed no concerns with physician orders.</p> <p>Interview on 06/02/14 at 4:30 PM with the DON revealed she had reviewed all orders and any concerns identified were given to the physician and resolved.</p> <p>Review of an inservice training, dated 04/17/14, revealed the DON was inserviced by Regional Nurse Consultant on writing accurate & correct orders to include the five (5) rights, correct dosage, route, frequency, mathematical equation, and making sure you repeat back verbal orders for accuracy.</p> <p>Review of inservice training, dated 04/17/14 and 05/21/14 revealed licensed staff was inserviced by the DON on Physician orders, writing accurate, correct orders, to make sure they have the correct dosage, correct route, frequency, mathematical equation, 5 rights, medication administration, and to repeat back verbal orders for accuracy. Review of Certificate of Completion revealed fulfillment of the medication course on computerized program for all staff.</p> <p>Review on 06/02/14 of the May 2014 calendar, marked New Orders Audits revealed notations of audits on new orders completed by the DON and Assistant Director of Nursing (ADON) on 05/20/14-05/30/14.</p> <p>Interviews on 06/02/14 at 3:53 PM and 6:08 PM</p>	F 425		

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 44</p> <p>with the DON revealed she had been inserviced on the components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. The DON stated when looking at the physician orders she would look at the content, placement on the MARS/chart, and if the order was faxed to the pharmacy correctly and the order was reviewed twice-once in the morning and at the daily clinical review. The DON further revealed she inserviced the nursing staff on components of physician orders and reading back to the physician to verify verbal orders, and to make sure that dosages were correct. She stated her or the ADON had audited the new physician orders for residents 05/20/14-05/30/14 and they did not find any concerns. The DON further stated that Medication Pass Observations had been initiated and provided the observation sheet. She stated an Action Plan Check sheet would be utilized if any concerns were noted in the medication pass or the audit of the resident's physician orders and would be taken to the Quality Assurance Performance Improvement Committee (QAPI) for monthly review; and the action plan would be reviewed to see if there were any issues, what had been done and suggestions would be heard.</p> <p>Interview on 06/02/14 at 2:19 PM with LPN #3, 2:39 PM with CMT #1, 2:40 PM with LPN #4, 2:51 PM with LPN #14, 3:01 PM with LPN #2, 3:20 PM with RN #3, and 3:40 PM with LPN #6 revealed an inservice by the DON on 04/17/14 was about the five (5) rights of medication administration, to ensure when get a verbal order to read back and verify the order by repeating it back to include the resident's name, frequency, route, medication strength, and reason used for. In addition, staff</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEBY 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 425	<p>Continued From page 45</p> <p>should call the doctor and clarify an order that was not clear and they received computerized online training and post test about the medication.</p> <p>Interview on 06/02/14 at 6:08 PM with ADON revealed she was involved in reviewing the medications, assists with the audits and she was familiar with the medication observation tool, the physician order audits, and the action plan tool utilized for concerns. The ADON further stated the action plan tool would be taken to the QAPI meetings for review, education purposes and input. The ADON revealed when looking at the physician orders she would look at content, placement on the MARS, placement on the chart, and ensure the order was correctly faxed to the pharmacy. She stated the physician orders were reviewed twice-once in the morning and at the daily clinical review.</p> <p>Review of Ad-Hoc meeting dated, 04/30/14 revealed the meeting was attended by the Medical Director (by phone), Administrator, Dietary Manager, Business Office Manager, DON, and Social Services Director (SSD) to review the deficient practice.</p> <p>Interview on 06/02/14 at 5:13 PM with Dietary Manager, at 5:25 PM with the Social Service Director, and at 5:30 PM with the Business Office Manager, revealed they participated in the 04/30/14 Ad-Hoc QAPI meeting about medication errors, monitoring of charts, and audit tools.</p> <p>Interview, on 06/02/14 at 4:16 PM and 4:35 PM with Pharmacist #2, revealed he had been inserviced by the General Manager (GM) on clarification of orders and documentation. He stated if there is a question about an order then</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 46</p> <p>the facility should be called and clarification received from the nurse of the resident the order is about, and document the name of the nurse spoken to. Pharmacist #2 revealed he then educated other pharmacists on the training.</p> <p>Review of inservicing sheet revealed Pharmacist #2 was educated on the clarification of orders and the process of clarification of questionable orders on 05/29/14 at 1:30 PM by the Pharmacy General Manager (GM).</p> <p>Review of inservicing verified Pharmacists at the pharmacy were educated by Pharmacist #2 on documentation of clarifications on 05/29/14 at 3:00 PM.</p> <p>Interview on 06/02/14 at 4:24 PM with Pharmacist #5 and at 4:25 PM with Pharmacist #1, revealed they received training from Pharmacist #2 on clarification of questionable orders and documentation.</p> <p>Review of inservicing verified Order Entry Technicians and the Front End Lead and Operations Manager were educated by the Pharmacy GM on clarification of orders on 05/20/14 at 1:10 PM.</p> <p>Interview on 06/02/14 at 4:27 PM with Order Entry Technician #1 and at 4:30 PM with Order Entry Technician #2 revealed they received training by the GM on 05/20/14 on clarification of new orders and documentation. The training included to obtain a name if talking with someone, making sure a name is on the clarification orders, and if not sure of an order then send it back to the pharmacy and get clarification.</p>	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 47 Interview on 06/02/14 at 4:54 PM with Administrator revealed an Ad-Hoc meeting for QAPI Committee was held on 04/30/14 to discuss the medication allegation related to the Synthroid and processes the facility was going to put in place to keep an incident from reoccurring. The Administrator stated he and the Medical Director were discussing the process off and on , and had two meeting before 04/30/14. The Administrator revealed the meeting May was related to the CPR concern, medications, audits and education. The Administrator stated the QAPI meetings will continue until the audits are completed and if there are any issues identified they will be corrected and they will continue to monitor for issues. The Administrator revealed the Medical Director had been contacted about training Resident #1's physician related to the Levothyroxine. Interview on 06/02/14 at 5:20 PM with Medical Director revealed he had been involved in the Ad-Hoc meeting on 04/30/14 and had an ongoing discussion with Administrator throughout this process. The Medical Director further stated he had educated Resident #1's Physician on the simplification of the dosages for Synthroid, monitoring and clearly stating the orders. He stated changes were made for medication monitoring by making sure the doses and orders are checked at least five (5) times a week and discrepancies are communicated to the pharmacy to clarify. Interview on 06/02/14 at 5:37 PM with Resident #1's Physician revealed she had received training by the Medical Director around May 29 th on the correct dose and obtaining confirmations of the	F 425			

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

PRINTED: 08/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2014
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 48</p> <p>correct dose, communicating with the nurses, checking chart/MARs/ medication list of residents, reconciliation of the medication of the residents, and obtaining confirmation of the order and if there is a discrepancy to call the facility and pharmacy if needed.</p> <p>Review of the Pharmacy Order Entry Audit, dated 05/22/14 and 05/29/14, revealed there was no documented evidence of concerns and "No" was marked in problem section.</p> <p>Interview on 06/02/14 at 4:54 PM with the Administrator revealed the clarification audits by the Pharmacy GM will be completed going forward related to the training of the staff being completed on 05/29/14. The Administrator stated QAPI meetings will be held to verify audits were completed and to address any concerns that are identified with the audits.</p>	F 425			