

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

PRINTED: 10/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 10/21/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS Based upon implementation of the PoC, the facility was deemed in compliance, 10/21/13, as alleged.	{K 000}			

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

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 33 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1992.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 09/05/2013. Franklin-Simpson Nursing & Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Eight (98) beds with a census of eighty-eight (88) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (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 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>	
		K025	<ol style="list-style-type: none"> 1) The smoke partition in the attic will be repaired before October 20, 2013 and the drywall will be placed on the other side so that the barrier meets the half hour rating per NFPA 101, 19.3.7.3. 2) All other partitions will be checked by the Maintenance Director before October 20, 2013 to ensure that they are all half hour rating per NFPA 101, 19.3.7.3. Any identified will be corrected by October 20, 2013. 3) The Maintenance Director or Maintenance staff will inspect all fire barriers on a monthly basis to insure that they meet the standard and that they stay in compliance with the half hour rating and the Maintenance Director and Maintenance Staff will be educated by the Administrator by October 20, 2013 on this new process 	10/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/26/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Fire).	K 000	<i>K025 (cont.)</i>		
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFWA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, forty-four (44) residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of eighty-eight (88) on the day of the survey. The facility failed to ensure one (1) smoke barrier had a ½ hour rating. The findings include: Observation, on 09/05/13 at 12:22 PM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next	K 025	4) The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months when the Quality Assurance Committee decides the deficiency has been corrected. At any time if a concern is identified, the Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. 5) Completion Date: October 21, 2013	10/21/13	

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NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42136		
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K 025	<p>Continued From page 2</p> <p>to restorative dining and the dining rooms was not properly rated. The barrier was constructed with one sheet of ½ " drywall on one side of the barrier and the framing studs exposed on the interior side of the barrier.</p> <p>Interview, on 09/05/13 at 12:22 PM with the Maintenance Supervisor, revealed he was not aware the barrier was not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025			

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K 025	Continued From page 3 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.	K 025			
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of eighty-eight (88) on the day of the survey. The facility failed to ensure smoke compartments were properly evacuated in case of a fire. The findings include: Fire Safety Plan review, on 09/05/13 at 1:05 PM with the Maintenance Supervisor, revealed the facility's Fire Safety Plan and Procedure Policy did not address the evacuation of smoke compartments located in the facility. Interview, on 09/05/13 at 1:05 PM with the Maintenance Supervisor, revealed he was unaware the fire safety plan did not address the evacuation of the smoke compartments. Further	K 048 K048	1) The facility's fire plan will be updated before October 20, 2013 to include the evacuation of smoke compartments. 2) The facility's Fire Plan will be updated before October 20, 2013 to include the evacuation of smoke compartments 3) The facility's Fire Plan will be updated before October 20, 2013 to include the evacuation of smoke compartments. All facility staff will be retrained on the updated Fire Safety Plan to include evacuation of the smoke compartment by October 20, 2013.	10/21/13	

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K 048	Continued From page 4 interview revealed the facility does address this procedure during their fire drills. Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure In Case of Fire.	K 048	K048(Conf.) 4) The fire drills and fire safety plan will be reviewed monthly for at least three (3) months by the Administrator to assure that the fire safety plan and fire drills include evacuation of the smoke compartment. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or when the Quality Assurance Committee decides the deficiency has been corrected. At any time if a concern is identified, the Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. 5) Completion Date: October 21, 2013	10/21/13

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K 048	<p>Continued From page 5</p> <p>19.7.2.1*</p> <p>For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy 's fire safety plan.</p> <p>19.7.2.2</p> <p>A written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>19.7.2.3</p> <p>All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:</p> <ol style="list-style-type: none"> (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system <p>Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and</p>	K 048		

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K 056 K 056 SS=E	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of eighty-eight (88) on the day of the survey. The facility failed to ensure eight (8) sprinkler heads were not blocked by light fixtures. The findings include: Observations, on 09/05/13 between 12:22 PM and 3:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in resident rooms numbered 114, 115, 112, 108, 109, 206, 205, and 208 were blocked by light fixtures, within one (1) foot of the sprinkler head, extending	K 056 K 056	K056 1) The light fixtures in Rooms 114, 115, 112, 108, 109, 205, 206 and 208 have been moved by the Maintenance Director to provide them with the proper distance from the sprinkler heads within the regulation . 2) The Maintenance Director will audit all the sprinkler heads in the building to insure proper compliance with NFPA 13. Any identified as not having the proper clearance will have adjustments made to assure they have the proper clearance by October 20, 2013. 3) The Maintenance Director was re-educated by the Administrator on September 26, 2013 on the requirement for sprinkler head spray coverage.	10/21/13

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K 056	<p>Continued From page 7 below the sprinkler heads.</p> <p>Interview, on 09/05/13 between 12:22 PM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures were blocking the sprinklers. The facility had many sprinklers moved from the previous survey and he was under the impression the facility was in compliance.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>Obstruction (in.)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056	<p><i>K056(cont.)</i></p> <p>4) The Maintenance Director will audit all sprinkler heads monthly for three (3) months to assure they are positioned to allow appropriate spray coverage. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months or when the Quality Assurance Committee decides the deficiency has been corrected. At any time if a concern is identified, the Quality Assurance committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>5) Completion Date: October 21, 2013</p>	10/21/13
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K 056	Continued From page 8	K 056		
K 066	For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). NFPA 101 LIFE SAFETY CODE STANDARD	K 066	K066	
SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4		1) The Maintenance Director placed a metal container with a self closing lid at the front of the facility and the back of the facility on September 27, 2013. The ashtrays identified at the kitchen area and the rear smoking area were removed by the Maintenance Director on September 23, 2013. 2) The Maintenance Director completed an audit of all smoke areas on September 23, 2013 to assure that all had a metal container with a self closing lid and approved ashtrays. No concerns were identified. 3) The Maintenance Staff will be re-trained by the Administrator by October 20, 2013 on the requirement for a metal container with a self closing lid and appropriate ashtrays in all smoking areas.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and			10/21/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	<p>Continued From page 9</p> <p>visitors. The facility is certified for Ninety-Eight (98) beds with a census of eighty-eight (88) on the day of the survey. The facility failed to ensure the smoking area had a self-closing metal container to dump ashtrays into at the gazebo smoking area and all ashtrays were of an approved type.</p> <p>The findings include:</p> <p>Observation, on 09/05/13 at 2:23 PM with the Maintenance Supervisor, revealed the smoking areas at the front of the building and the rear of the facility did not have a metal container with a self-closing lid to dispose of the cigarette butts. Further observation revealed one ashtray at the kitchen exit and one at the rear smoking area were of an unapproved type with an open top.</p> <p>Interview, on 09/05/13 at 2:23 PM with the Maintenance Supervisor, revealed he was unaware the smoking areas must have a self-closing metal bucket even with the smokers pole. Further interview revealed he was unaware open top ashtrays were not approved for use.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that</p>	K 066	<p><i>K066 (cont.)</i></p> <p>4) The Maintenance Staff will conduct an audit of all smoking areas monthly for three (3) months to assure to insure that non-approved containers are not utilized at the facility and that all smoking areas have a metal container with a self closing lid. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months or when the Quality Assurance Committee decides the deficiency has been corrected. At any time if a concern is identified, the Quality Assurance committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>5) Completion Date: October 21, 2013</p>	10/21/13

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185331	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/6/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITA'	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 283	<p>483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a recapitulation of the resident's stay and a final summary of the resident's status on a planned discharge from the facility for one (1) resident (#17), in the selected sample of seventeen (17) residents.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #17 to the facility on 05/07/13 with a diagnosis of Rehabilitation and Orthopedic aftercare.</p> <p>A review of the resident record revealed there was an incomplete discharge summary and no physician discharge summary in the record.</p> <p>An interview with the Director of Nursing (DON), on 09/06/13 at 2:20 PM and 2:45 PM, revealed the discharge nurse was responsible to gather the discharge information but the physician does not currently provide a discharge summary. The DON stated the facility does not have a policy that addresses the need for a discharge summary.</p> <p>An interview with the Administrator, on 09/06/13 at 3:50 PM, revealed discharged residents should have a discharge summary completed within 30 days of discharge and it should be placed on the chart by the medical records staff.</p> <p>An interview with the Medical Records Staff, on 09/06/13 at 7:33 PM, revealed it was her responsibility to ensure a discharge summary and paperwork was in the chart after a resident was discharged.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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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 09/06/2013
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NAME OF PROVIDER OR SUPPLIER FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42136
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification survey was conducted on 09/04/13 through 09/06/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S of a "D".	F 000	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 ten (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 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.	
F 281 SS=D	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 observation, interview, record review and facility policy review it was determined the facility failed to obtain a physician's order for oxygen (O2) therapy for one (1) resident (#2), in the selected sample of seventeen (17) residents. The findings include: A review of the facility's policy and procedure titled, "Oxygen Therapy and Devices", dated 02/2013, revealed oxygen is a drug which must be ordered by a physician. Record review revealed the facility admitted Resident #2 to the facility on 01/07/13 with diagnoses to include Chronic Bronchitis and Chronic Obstructive Pulmonary Disease. A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/13/13, revealed the facility assessed Resident #2's cognition as moderately impaired.	F 281	1) An order for oxygen was obtained on September 5, 2013 for Resident #2. 2) The facility's Director of Nursing or the Assistant Director of Nursing will review all the facility's current residents who receive oxygen therapy for proper orders. The review will be completed by October 20, 2013. Any residents identified as requiring oxygen but without physician orders will have MD notification for oxygen orders. 3) All of the facility's licensed staff nurses will be retrained prior to October 20, 2013 by either the Director of Nursing or the Assistant Director of Nursing on obtaining oxygen orders from the physician.	10/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 9/26/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 09/06/2013
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 1 Observations of Resident #2, on 09/04/13 at 10:30 AM, 2:44 PM and on 09/06/13 at 8:45 AM revealed the resident was receiving O2 therapy via nasal cannula at 2 liters/minute. A review of the August and September 2013 physicians' orders and interview with Charge Nurse #1 (CN), on 09/05/13 at 9:15 AM, revealed there was no physician's order for the O2 therapy. An interview with the Director of Nursing (DON), on 09/05/13 at 1:40 PM, revealed the O2 should have been written as a physician order on the monthly order sheet for Resident #2 but it was omitted from the orders.	F 281	<i>F281(cont.)</i> 4) The Director of Nursing or Assistant Director of Nursing will audit five (5) residents weekly on oxygen to validate there physician orders times twelve (12) weeks and report this audit to the Quality Assurance Committee. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months when the Quality Assurance Committee decides the deficiency has been corrected. At any time if a concern is identified, the Quality Assurance committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. 5) Completion Date: October 21, 2013	

10/21/2013