



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

PRINTED: 06/25/2015  
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 06/11/2015
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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 42135
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An Abbreviated Survey investigating KY #23342 was conducted on 06/05/15 through 06/11/15. KY#23342 was substantiated with deficiencies cited at the highest Scope and Severity of a "D". 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jenna J. Ramea* TITLE Administrator (X6) DATE 8/5/15

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

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F 225	<p>Continued From page 1</p> <p>with State law (Including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's "Abuse and Neglect policy, it was determined the facility failed to report an allegation of abuse to the appropriate State Agencies for one (1) of four (4) sampled residents (Resident #1). Resident #2 was alleged to have sexually contact with Resident #1 and incompetent resident on 04/10/14 and 06/03/15; however, the facility failed to report the allegations to the appropriate state agencies.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Abuse and Neglect Policy", not dated, revealed the purpose of the policy was to maintain the residents right to be free from verbal, sexual, physical, and mental abuse. Employees must be trained on reporting information about allegations, and what constitutes abuse. The facility administration will notify state entities, and initiate the investigation process by interviewing residents and staff. Notification will be made to state entities at initiation and finalization of the investigation.</p> <p>Review of facility titled "Bill of Resident Rights, dated 07/01/09, revealed the facility should protect and promote the following rights: if a resident is judged Incompetent under laws of the state, the residents rights will be exercised by the</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> <li>1. Resident # 2 was discharged to home on 06/08/15 and did not return to the facility. Resident #1 received increased supervision while resident #2 was in the facility. Resident #1 has been reviewed by psychiatric services and does not exhibit changes from her/his baseline behaviors and does not recall the event.</li> <li>2. On 7/8/15 the social services director and the charge nurse interviewed all current residents with a BIMS score of 8 or greater to determine if there were any further allegations of abuse or neglect. No concerns were identified. On 6/4/15 the director of Nursing and charge nurse completed skin assessments on all current residents with a BIMS score of seven or less to identify any injury of unknown origin or suspicious in nature with no</li> </ol>	
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F 225	<p>Continued From page 2</p> <p>person appointed under state law to act on the behalf of the resident to the extent provided by state law. A resident has the right for a complaint to be filed with state entities concerning abuse, and the resident has the right to be free from verbal, sexual, physical and mental abuse.</p> <p>Record review revealed the facility admitted Resident #2 (alleged perpetrator) on 06/06/12 with diagnoses which included Senile Dementia, Muscle Weakness, Lumbago, and Back Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/23/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "12" which indicated the resident was interviewable and assessed the resident as independent with activities of daily living.</p> <p>Record review revealed the facility admitted Resident #1 (alleged victim) on 07/01/12 with diagnoses which included Muscle Weakness, Depressive Disorder, Dementia with Behavior Disturbance, Adjustment Disorder with Anxiety, Anxiety State, and Recurrent Depressive Psychosis. Review of the quarterly MDS assessment, dated 03/22/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a BIMS score of "9" which indicated the resident was interviewable and assessed the resident as requiring extensive assistance for activities of daily living.</p> <p>Review of a Disability Judgment, dated 11/16/11 revealed Resident #1 was determined to be wholly disabled in managing his/her personal and financial affairs; resident has impaired cognition function and makes decisions that put resident at risk with indefinite expiration of order.</p>	F 225	<p>concerns identified. The Administrator on 6/5/15 reviewed all resident concerns for the past 30 days to identify any allegations of abuse and neglect with no concerns identified.</p> <p>3. On 06/12/2015 the Regional Quality Manager and the Regional Director of Operations re-educated the Administrator on the facilities abuse and neglect policy specifically to reporting initial and final investigation reports to required agencies and ensuring that notification was received by those agencies as evidenced by a confirmation fax that reflects successful transmission. No other staff were identified as not following the reporting requirements.</p> <p>4. Beginning 06/12 /2015 the administrator will forward all documentation related to reportable events to the Regional Quality Manager and the Regional Director of Operations for review to ensure all required agencies have been notified and</p>	Date of completion 7/25/2015

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F 225	<p>Continued From page 3</p> <p>Review of Interdisciplinary (IDT) Progress Note, dated 04/10/15, revealed Licensed Practical Nurse (LPN) #1 documented she observed Resident #2 looking towards the nursing station then closing the door partially to his/her room. LPN #1 found Resident #1(Incompetent resident) in the room in a wheelchair embracing and kissing Resident #2 and Resident #2's hands were in Resident #1's pants. Further record review revealed there was no evidence the appropriate state agencies were notified of the incident.</p> <p>Interviews with Resident #1's Guardian #1 (from 09/07/11 through 07/23/14), on 06/08/15 at 11:33 AM and on 06/10/15 at 1:42 PM, revealed he had been informed Resident #1 was in Resident #2's room and Resident #2's hands were under the clothes of Resident #1 on 04/10/14. The Guardian stated the resident had a history of domestic violence and he would not allow consent for this type of relationship because there could not be a consensual sexual relationship.</p> <p>Interview with LPN #2, on 6/10/15 at 8:42 AM revealed she witnessed Resident #2 kissing Resident #1 with his/her hand in Resident #1's pants last year. LPN #2 stated she did not believe Resident #1 comprehended what was going on but she did think Resident #2 knew what he/she was doing and she had written the incident up and notified the Director of Nursing (DON) but did not know if anything else was done.</p> <p>Review of a facility Initial Investigation provided by facility, dated 06/05/15, revealed a sexual abuse allegation was received on 06/03/15.</p>	F 225	<p>that fax conformation is present for the notification. This will be completed by the Regional Quality nurse and the Regional Director of Operations as reportable files are created at time of occurrence .The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly.</p>	
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F 225	<p>Continued From page 4</p> <p>Resident #3 had reported Resident #2 was in Resident #1's (incompetent resident) room and was performing a sexually inappropriate act on Resident #1. Resident #1 confirmed Resident #2 had touched him/her inappropriately but Resident #2 denied the allegation. Further review revealed there was no documentation the allegation was made to the appropriate state agencies.</p> <p>Interview with Resident #1's Guardian #2 (07/23/14 to present time), on 06/08/15 at 2:06 PM and 06/10/15 at 12:39 PM revealed a past sexual encounter between Resident #1 and Resident #2 on 04/10/14 in which Resident #2 had his/her hands inside the clothes of Resident #1. The Guardian stated she did not think Resident #1 would be able to enter into a relationship and had been a victim of abuse from his/her marriage. The Guardian revealed Resident #1 had been declared incompetent and does not have the ability to consent to a relationship with someone that is competent.</p> <p>Interview with Registered Nurse (RN) #1, on at 06/09/15 at 9:08 AM, revealed Resident #1 admitted to her Resident #2 was in his/her room on 06/03/15, had touched him/her without his/her permission and he/she did not want Resident #2 in the room because it had made him/her uncomfortable. RN #1 revealed she had spoken with Resident #2 and he/she had stated he/she was just checking on Resident #1. RN #1 stated she had called Adult Protective Services but the hospital had reported it before the facility had.</p> <p>Interview with the Social Service Director (SSD), on 06/09/15 at 11:27 AM, revealed the 04/10/14 sexual abuse allegation findings were given to the Administrator at that time because he/she was</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>handling the investigation. The SSD stated Resident #2 was alert and oriented and had no behaviors other than pursuing Resident #1. The SSD revealed Resident #1 was a victim of domestic violence, and had a Guardian who was legally bound to make decisions on behalf of Resident #1 because the resident was deemed unable to make decisions regarding personal affairs. The SSD defined personal affairs as medical decisions, treatments, anything that would be considered an interaction with him/her.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP) #2, dated 06/10/15 at 2:10 PM, revealed she had been informed of the sexual abuse allegation that had occurred on 06/03/15 and had been informed by RN #1 that Resident #1 was scared of Resident #2. ARNP #2 further revealed she did not feel that Resident #1 was able to comprehend or give consent to the incident on 04/10/14 or 06/03/15; but she did feel that Resident #2 was aware of his/her actions.</p> <p>Interview with the Director of Nursing (DON), on 6/10/15 at 11:00 AM and on 06/11/15 at 8:07 AM, revealed there had been a sexual encounter between Resident #2 and Resident #1 on 04/10/14 with Resident #2 kissing, touching and trying to put his/her hand in Resident #1's pants. The DON stated the 04/10/14 incident had a limited investigation and was not reported because it was considered consensual because Resident #1 had said he/she had asked Resident #2 for a hug and kiss. The DON revealed Resident #3 had reported to staff that Resident #2 was in Resident #1's room on 06/03/15 and had been performing a sexual act on Resident #1. The DON stated the 06/03/15 sexual abuse</p>	F 225		
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F 225	Continued From page 6 allegation by Resident #3 had been reported, but she did not report it herself and there was no documentation of reporting to the state entity. The DON stated management (the Administrator and herself) was responsible for the care and safety of the residents.  Interview with the Administrator, on 08/10/15 at 4:54 PM, revealed she did not have any confirmation she had sent the 06/03/15 allegation of sexual abuse involving Resident #1 and Resident #2 to the State Survey Agency.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility "Abuse and Neglect policy, it was determined the facility failed to follow their policy on reporting an allegation of abuse to the appropriate State Agencies or one (1) of four (4) sampled residents (Resident #1). Resident #2 was alleged to have sexually abused Resident #1 on 04/10/14 and 06/03/15; however, the facility failed to report the allegations to the appropriate state agencies. Refer to F225  The findings include:  Review of facility policy titled, "Abuse and Neglect	F 226	F226  1. Resident # 2 was discharged to home on 06/08/2015 and did not return to the facility. Resident #1 received increased supervision while resident #2 was in the facility. Resident #1 has been reviewed by psychiatric services  and does not exhibit changes from her/his baseline behaviors.  2. A review of files that were created after 06/5/2015 and are related to occurrences required to be reported to states agencies was completed by Regional Quality Manager and the Regional Director of Operations on 06/30/15 with no concerns identified		

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F 226	<p>Continued From page 7</p> <p>Policy", not dated, revealed the purpose of the policy was to maintain the residents right to be free from verbal, sexual, physical, and mental abuse. Employees must be trained on reporting information about allegations, and what constitutes abuse. The facility administration will notify state entities, and initiate the investigation process by interviewing residents and staff. Notification will be made to state entities at initiation and finalization of the investigation.</p> <p>Record review revealed the facility admitted Resident #2 (alleged perpetrator) on 06/08/12 with diagnoses which included Senile Dementia, Muscle Weakness, Lumbago, and Back Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/23/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "12" which indicated the resident was interviewable and assessed the resident as independent with activities of daily living.</p> <p>Record review revealed the facility admitted Resident #1 (alleged victim) on 07/01/12 with diagnoses which included Muscle Weakness, Depressive Disorder, Dementia with Behavior Disturbance, Adjustment Disorder with Anxiety, Anxiety State, and Recurrent Depressive Psychosis. Review of the quarterly MDS assessment, dated 03/22/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a BIMS score of "9" which indicated the resident was interviewable and assessed the resident as requiring extensive assistance for activities of daily living.</p> <p>Review of Resident #1's Disability Judgment, dated 11/16/11, interviews with Resident #1's</p>	F 226	<p>3. On 06/12/2015 the Regional Quality Manager and the Regional Director of Operations re-educated the Administrator on the facilities abuse and neglect policy specifically to reporting initial and final investigation reports to required agencies and ensuring that notification was received by those agencies as evidenced by a confirmation fax that reflects successful transmission. No other staff were identified as not following the reporting requirements</p> <p>4. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly.</p>	Date of completion 7/25/2015
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F 226	<p>Continued From page 8</p> <p>Guardian #1 on 06/08/15 at 11:33 AM and on 06/10/15 at 1:42 PM, Guardian #2, on 06/08/15 at 2:06 PM and 06/10/15 at 12:39 PM, and with the Advanced Registered Nurse Practitioner (ARNP) #2, dated 06/10/15 at 2:10 PM, revealed Resident #1 was determined to be wholly disabled in managing his/her personal and financial affairs and was unable to give consent to a relationship with a competent resident.</p> <p>Review of Interdisciplinary (IDT) Progress Note, dated 04/10/15, and interviews with Licensed Practical Nurse (LPN) #2 on 06/10/15 at 8:42 AM, and the Social Service Director (SSD) on 06/09/15 at 11:27 AM, revealed Resident #1 (incompetent resident) was found in a room in a wheelchair embracing and kissing Resident #2 and Resident #2's hands were in Resident #1's pants. LPN #2 stated she had written the incident up and notified the Director of Nursing (DON) but did not know if anything else was done. The SSD stated the investigation was given to the Administrator. However, there was no documented evidence the appropriate state agencies were notified of the incident per the facility policy.</p> <p>Review of a facility Initial Investigation provided by facility, dated 06/05/15, and interview with Registered Nurse (RN) #1, on at 06/09/15 at 9:06 AM, revealed Resident #3 had reported Resident #2 was in Resident #1's (incompetent resident) room and was performing a sexually inappropriate act on Resident #1. Resident #1 confirmed Resident #2 had touched him/her inappropriately and made him/her feel uncomfortable but Resident #2 denied the allegation. RN #1 stated she had called Adult Protective Services but the hospital had reported</p>	F 226		
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F 226	Continued From page 9 it before the facility had. There was no evidence the State survey agency had been notified per facility policy.  Interview with the Director of Nursing (DON), on 6/10/15 at 11:00 AM and on 06/11/15 at 8:07 AM, revealed Resident #3 reported to staff that Resident #2 was in Resident #1's room on 06/03/15 and had been performing a sexual act on Resident #1. The DON stated there had also been a sexual encounter between Resident #2 and Resident #1 on 04/10/14 with Resident #2 kissing, touching and trying to put his/her hand in Resident #1's pants. The DON stated the 04/10/14 incident had a limited investigation and was not reported because it was considered consensual because Resident #1 had said he/she had asked Resident #2 for a hug and kiss. The DON further revealed the 06/03/15 sexual abuse allegation by Resident #2 against Resident #1 had been reported, but she did not report it herself and there was no documentation of reporting to the state entity. The DON stated management (the Administrator and herself) was responsible for reporting abuse allegations per facility policy.  Interview with the Administrator, on 06/10/15 at 4:54 PM, revealed she did not have any confirmation she had sent the 06/03/15 allegation of sexual abuse involving Resident #1 and Resident #2 to the the state survey agency per facility policy.	F 226			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F280  1. Resident # 2 was placed on 1:1 to ensure increased supervision was provided and no other resident would be inappropriately touched . Resident #2 was discharged to home on 06/08/2015 and did not return to the facility. Resident #1 received increased supervision while resident #2 was in the facility. Resident #1 has been reviewed by psychiatric services and does not exhibit changes from her/his baseline behaviors.		

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PRINTED: 06/25/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 10</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the plan of care was not revised for one (1) of four (4) sampled residents (Resident #2). Resident #2 had behaviors of having inappropriate sexual behaviors and the facility failed to revise the care plan to address the behaviors.</p> <p>The findings include:</p> <p>Review of facility policy with date of 09/08 and entitled, Resident Comprehensive Care Plan, revealed the comprehensive care plan should be viewed as an approach to manage the acute and chronic needs of residents; the resident care plans should have interventions to address the</p>	F 280	<p>2 The Director of Nursing, Assistant Director of Nursing, and MDS Nurse, Activity Director Dietary Manager and Social Services Director will audit all current residents care plans by 7-24-15 to review to determine if all problems and interventions are up to date to meet the needs of the resident. Any changes will be completed by 7-24-15 and reflected on care plan.</p> <p>3 By 07/24/2015 the Regional Quality Manager will re-educate the Director Of Nursing on the requirement to revise the plan of care in the daily stand up meeting.</p>		

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F 280	<p>Continued From page 11 residents' needs.</p> <p>Review of the facility "Abuse and Neglect Policy", not dated, revealed if resident to resident abuse was suspected the interdisciplinary team should review care plan and make revisions to insure safety of others.</p> <p>Record review revealed the facility admitted Resident #2 (alleged perpetrator) on 06/06/12 with diagnoses which included Senile Dementia, Muscle Weakness, Lumbago, and Back Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/23/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "12" which indicated the resident was interviewable and assessed the resident as independent with activities of daily living.</p> <p>Review of an Interdisciplinary (IDT) Progress Note, dated 04/10/15, revealed Licensed Practical Nurse (LPN) #1 documented she observed Resident #2 looking towards the nursing station then closing the door partially to his/her room. LPN #1 found Resident #1 in the room in a wheelchair embracing and kissing Resident #2 and Resident #2's hands were in Resident #1's pants. In addition, review of Psychiatric Evaluations dated 04/11/14 and 12/11/14 revealed Resident #2 being evaluated for inappropriately touching other residents at times.</p> <p>Review of Comprehensive Care Plan for "Exhibits Alteration in Mood/Behavior", last reviewed 03/11/15, revealed the resident exhibits periods of agitation with interventions to educate the resident regarding acceptable alternatives to</p>	F 280	<p>4. The DON or ADON or will review plans of care for five(5) residents for twelve ( 12) weeks to determine if interventions and problems are updated to meet the needs of the residents. The results of all audits will be reviewed with the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly.</p>	Date of completion 7/25/2015	

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F 280	<p>Continued From page 12 identified behaviors and document response/understanding of education, monitor whereabouts when wandering and redirect as needed, 1:1 as needed, refer to psych services as needed with exacerbation or inability to effectively redirect behaviors. However, there was no evidence the resident's sexually inappropriate behavior on 04/10/15 and /or interventions were initiated to address the resident's behavior.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 6/10/15 at 8:42 AM revealed she had witnessed Resident #2 kissing Resident #1 with his/her hand in Resident #1's pants last year. LPN #2 stated she did not believe Resident #1 comprehended what was going on but she did think Resident #2 knew what he/she was doing. LPN #2 stated Resident #2's care plan did not address Resident #2's seeking out the company of the opposite gender, the behaviors related to his/her sexual encounters/advances, or supervision. LPN #2 revealed due to Resident #2's history of sexually inappropriate behaviors the residents visits with the opposite gender should be monitored and it should be on the care plan so everyone would know that it was a behavior they should be watching for and know what care to provide.</p> <p>Review of a facility Initial Investigation provided by facility, dated 06/05/15, revealed a sexual abuse allegation was received on 06/03/15. Resident #3 had reported Resident #2 was in Resident #1's room and was performing a sexually inappropriate act on Resident #1. Resident #1 confirmed Resident #2 had touched him/her inappropriately but Resident #2 denied</p>	F 280		
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F 280	<p>Continued From page 13 the allegation.</p> <p>Interview with Registered Nurse (RN) #1, on at 06/09/15 at 9:06 AM, revealed Resident #1 admitted to her Resident #2 was in his/her room on 06/03/15, had touched him/her without his/her permission and he/she did not want Resident #2 in the room because it had made him/her uncomfortable. RN #1 revealed she had spoken with Resident #2 and he/she had stated he/she was just checking on Resident #1.</p> <p>Review of a 05/07/15 Psychiatric Evaluation revealed a family member reported Resident #2 wandered into a female resident's room. In addition, review of a Psychiatric Evaluation, dated 06/03/15, revealed staff reported the resident went into another resident room and was touching the resident in a sexually inappropriate area; with a diagnoses added as sexual deviant disorder.</p> <p>Further review of the Comprehensive Care Plan for "Exhibits Alteration in Mood/Behavior, last reviewed 03/11/15, revealed the facility failed to revise the care plan related to the resident's behavior of entering a female resident's room or the sexually inappropriate behavior on 06/03/15.</p> <p>Interview with the Director of Nursing (DON), on 6/10/15 at 11:00 AM, revealed she did not think there should be anything on Resident #2's care plan because the sexual abuse allegation on 04/10/14 was not considered inappropriate because it was consensual.</p> <p>Interview with the Administrator, on 06/10/15 at 11:54 AM, revealed she did not think there should be anything on Resident #2's care plan related to</p>	F 280			

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F 280	Continued From page 14 the sexual abuse allegation, because she believed the 04/10/14 incident was considered consensual.	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to ensure adequate supervision was provided to prevent accidents for one (1) of four (4) sampled residents. Resident #2 had been identified as having sexually inappropriate behavior with Resident #1 who was incompetent and unable to give consent for a sexual relationship; however, there was no evidence the facility had addressed this behavior to ensure the safety of residents. Refer to F225 and F280  The findings include:  Review of facility's "Abuse and Neglect Policy", not dated, revealed if resident to resident abuse was suspected the interdisciplinary team should review the care plan and make revisions to ensure safety of others.  Review of facility titled "Bill of Resident Rights,	F 323	F323  1. Resident # 2 was discharged to home on 06/08/2015 and did not return to the facility.  2. By 07/24/2015 the Director of Nursing, Assistant Director of Nursing, Social Services Director and Activity Director will review all current residents behaviors and current condition to determine if all are on the appropriate level of supervision. Any changes to supervision will be noted on the plan of care.  3. By 07/24/2015 all facility staff will be educated on the abuse and neglect policy including protection and supervision while under investigation for protection. This will be completed by the Administrator, Director Of Nursing, Assistant Director Of Nursing and the Social Services Director with no facility staff working after 7/24/15 without having had this re-education.		

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F 323	<p>Continued From page 15</p> <p>dated 07/01/09, revealed the facility should protect and promote the following rights: if a resident is judged incompetent under laws of the state, the residents rights will be exercised by the person appointed under state law to act on the behalf of the resident to the extent provided by state law. A resident has the right for a complaint to be filed with state entities concerning abuse, and the resident has the right to be free from verbal, sexual, physical and mental abuse. Record review revealed the facility admitted Resident #1 (alleged victim) on 07/01/12 with diagnoses which included Muscle Weakness, Depressive Disorder, Dementia with Behavior Disturbance, Adjustment Disorder with Anxiety, Anxiety State, and Recurrent Depressive Psychosis. Review of the quarterly MDS assessment, dated 03/22/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a BIMS score of "9" which indicated the resident was interviewable and assessed the resident as requiring extensive assistance for activities of daily living.</p> <p>Review of Resident #1's Disability Judgment, dated 11/16/11, and interviews with Resident #1's Guardian #1 on on 06/08/15 at 11:33 AM and on 06/10/15 at 1:42 PM, and Guardian #2, on 06/08/15 at 2:06 PM and 06/10/15 at 12:39 PM, revealed Resident #1 was determined to be wholly disabled in managing his/her personal and financial affairs and was unable to give consent to a relationship with a competent resident.</p> <p>Review of Interdisciplinary (IDT) Progress Note, dated 04/10/15, revealed Resident #1 (incompetent resident) was found in a room in a wheelchair embracing and kissing Resident #2 and Resident #2's hands were in Resident #1's</p>	F 323	<p>4. The Administrator or Social Services Director will complete a questionnaire with ten staff per week for twelve weeks, on abuse and neglect to including appropriate supervision. The results of all the Quality Assurance Committee questionnaires will be reviewed with weekly until substantial compliance is achieved and then monthly thereafter for at least three months. Any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Dietary Services Director, Maintenance Director, Activity Director and Business Office Manager Administrator, with the Medical Director attending at least quarterly.</p>	Date of completion 7/25/2015

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PRINTED: 08/25/2015  
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F 323	<p>Continued From page 16</p> <p>parts. However, further review revealed there was no evidence the incident was reported to the appropriate state agencies.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 6/10/15 at 8:42 AM revealed she had witnessed Resident #2 kissing Resident #1 with his/her hand in Resident #1's pants last year. LPN #2 stated she did not believe Resident #1 comprehended what was going on but she did think Resident #2 knew what he/she was doing. LPN #2 stated Resident #2's care plan did not address Resident #2's seeking out the company of the opposite gender, the behaviors related to his/her sexual encounters/advances, or supervision. LPN #2 revealed due to Resident #2's history of sexually inappropriate behaviors the residents visits with the opposite gender should be monitored and it should be on the care plan so everyone would know that it was a behavior they should be watching for and know what care to provide.</p> <p>Review of a facility Initial Investigation provided by facility, dated 08/05/15, revealed Resident #3 had reported Resident #2 was in Resident #1's room and was performing a sexually inappropriate act on Resident #1. Resident #1 confirmed Resident #2 had touched him/her inappropriately and made him/her feel uncomfortable but Resident #2 denied the allegation. However, further review revealed there was no documented evidence the incident was reported to the State Survey Agency.</p> <p>Interview with Resident #3, on 06/08/15 at 2:15 PM, revealed he/she had seen Resident #2 go in Resident #1's room and the curtain was closed. Resident #3 stated Resident #2 was performing a</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>sexual act on Resident #1. Resident #3 stated he/she told Resident #2 to stop four (4) times.</p> <p>Interview with Registered Nurse (RN) #1, on at 06/09/15 at 9:08 AM, revealed Resident #1 admitted to her Resident #2 was in his/her room on 06/03/15, had touched him/her without his/her permission and he/she did not want Resident #2 in the room because it had made him/her uncomfortable. RN #1 revealed she had spoken with Resident #2 and he/she had stated he/she was just checking on Resident #1.</p> <p>Record review revealed the facility admitted Resident #2 (alleged perpetrator) on 06/06/12 with diagnoses which included Senile Dementia, Muscle Weakness, Lumbago, and Back Disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/23/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "12" which indicated the resident was interviewable and assessed the resident as independent with activities of daily living.</p> <p>Review of a Psychiatric Evaluations dated 04/11/14 and 12/11/14 revealed Resident #2 was evaluated for inappropriately touching other residents at times. A 05/07/15 Psychiatric Evaluation revealed a family member reported Resident #2 wandered into a female resident's room. A Psychiatric Evaluation, dated 06/03/15, revealed staff reported the resident went into another resident room and was touching the resident in a sexually inappropriate area; with a diagnoses added as sexual deviant disorder.</p> <p>Review of Comprehensive Care Plan for "Exhibits Alteration in Mood/Behavior , last reviewed</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>03/11/15, revealed the resident exhibits periods of agitation with interventions to educate the resident regarding acceptable alternatives to identified behaviors and document response/understanding of education, monitor whereabouts when wandering and redirect as needed, 1:1 as needed, refer to psych services as needed with exacerbation or inability to effectively redirect behaviors. However, there was no evidence the resident's sexually inappropriate behaviors with an incompetent resident were addressed and/or interventions were initiated to address the resident's behavior to ensure the safety of residents in the facility.</p> <p>Interview with LPN #5, on 06/10/15 at 10:14 AM, revealed she did not expect anything to be on the care plans if it was a consensual relationship. LPN #5 stated when Resident #2 leaves his/her room he/she has a purpose, and she did not expect anything to be on the care plan if it was consensual because it was human nature to hunt for a relationship.</p> <p>Interview with the Social Services Director, on 06/11/15 at 8:10 AM, revealed she believed the sexual abuse allegation in 04/10/15 was deemed consensual because Resident #2 said he/she did not mean to do anything wrong and was just trying to appease Resident #1, because Resident #1 wanted the kiss. The SSD stated she informed Resident #2 to seek her guidance any time he/she had a desire to pursue this type of relationship and she would look up the cognition and the brief interview mental status (BIMs) scores of the resident.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP) #2, dated 06/10/15 at 2:10</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
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F 323	<p>Continued From page 19</p> <p>PM, revealed she had been informed of the sexual abuse allegation that had occurred on 06/03/15 and had been informed by RN #1 that Resident #1 was scared of Resident #2. ARNP #2 further revealed she did not feel that Resident #1 was able to comprehend or give consent to the incident on 04/10/14 or 06/03/15; but she did feel that Resident #2 was aware of his/her actions.</p> <p>Interviews with the Director of Nursing (DON), on 6/10/15 at 11:00 AM, and on 06/11/15 at 8:07 AM and 3:15 PM, revealed the 04/10/14 incident had a limited investigation and was not reported because it was considered consensual because Resident #1 had said he/she wanted a hug and kiss from Resident #2. The DON stated she was not aware of what the Psychiatric Evaluation Sheets revealed about the sexual behaviors of Resident #2. The DON revealed there was no reason Resident #2 could not go in and out of other resident rooms as he/she was not restricted to where he/she may visit. The DON stated she did not feel there should be anything on Resident #2's care plan because the incident was not considered inappropriate. The DON revealed a resident had reported to staff that Resident #2 was in Resident #1's room on 06/03/15 and being inappropriate with Resident #1. The DON stated she felt this incident was reported but had not reported it herself and there was no documentation of reporting to the state agency. The DON revealed the Administrator and herself were responsible for the care and safety of the residents.</p> <p>Interview with the Administrator, on 06/10/15 at 11:54 AM, revealed there was no documented evidence the 06/03/15 allegation of sexual abuse</p>	F 323			

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

PRINTED: 06/25/2015  
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 06/11/2015
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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
F 323	Continued From page 20 was reported to the state survey agency. The Administrator stated she did not think the 04/10/15 incident should be on Resident #2's care plan or the incident should have been reported because she believed the 04/10/14 incident was considered consensual. The Administrator stated Resident #1 was under guardianship and human contact was human contact, and the Administrator felt the interaction depended on whether Resident #1 wanted it or not.	F 323		