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

PRINTED: 06/12/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185331	B. WING _	B. WING		05/19/2020	
	ROVIDER OR SUPPLIER N-SIMPSON NURSING A	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 414 ROBEY STREET FRANKLIN, KY 42135	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 000	was initiated and con facility was found to be CFR 483.80 infection implemented the Cer Medicaid Services (CD Disease Control and recommended practic COVID-19. Total cens	d Infection Control Survey cluded on 05/19/2020. The control regulations and has nters for Medicare & CMS) and Centers for Prevention (CDC) ces to prepare for		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.

Facility ID: 100391

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		185331	B. WING _		05/	19/2020
NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY STREET FRANKLIN, KY 42135		
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E 000	Initial Comments  A COVID-19 Focused Survey was initiated a 05/19/2020. The facilit compliance with 42 C E-0024 (b)(6).	ity was found to be in	E	DETICIENCY)		

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

TITLE (X6) DATE

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Office of Inspector General

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	100391		B. WING	B. WING				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  O5/19/2020							
FRANKLI	FRANKLIN-SIMPSON NURSING AND REHABILITATIOI FRANKLIN, KY 42135							
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N 000	Initial Comments		N 000					
N 000	A COVID-19 Focused was initiated and cond	I Infection Control Survey cluded on 05/19/2020. The e in compliance pursuant to	N 000					
			1					

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