STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185331	A. BUILDING _____ B. WING _____	**03/04/2016**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of emergency room Documentation of Transfer form and Discharge Summary, and review of the Centers For Medicare and Medicaid Services Federal Regulation F-Tag 157 it was determined the facility failed to ensure one (1) of three (3) sampled resident's (Resident #1) physician was notified when there was a potential need to alter treatment. Resident #1 had antibiotic therapy ordered due to the development of a rash and an increased temperature on 01/20/16. Resident #1 continued to have elevated temperatures, emesis, and poor fluid intake after the initial order to start antibiotic therapy. However, the facility failed to notify the physician of the potential need to alter treatment. Resident #1 was identified as unresponsive, lethargic, respirations shallow and skin turgor poor on 01/25/16 and was sent to the hospital. Resident #1 hospitalized for [REDACTED]. The findings include: Interview with the Director of Nursing (DON), on 03/04/16 at 11:05 AM, revealed the facility had no specific policy for physician notification and used the Centers For Medicare and Medicaid Services Federal Regulation F-Tag 157 for guidelines on notifying the physician. Review of the Medicare and Medicaid Services Federal Regulation F-Tag 157 revealed the facility must immediately consult with the resident's physician when there is a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Record review revealed the facility readmitted Resident #1 on 12/09/12 with diagnoses, which included Dementia, Anxiety, [MEDICAL CONDITION], Dysphagia, Muscle Weakness, Essential Hypertension, Abnormal Posture, and Cognitive Communication Deficit. Review of a Nurse's Note, dated 01/20/16 at 4:50 PM, revealed Resident #1 was noted to have a decline in alertness, a rash to the trunk and an elevated temperature. The physician was notified and an order was received for an antibiotic. Review of the Nurse's Notes, dated 01/21/16 at 3:31 AM, revealed Resident #1 had two (2) episodes of emesis. Further review revealed Resident #1 was assessed as having a temperature of 100.9 degrees Fahrenheit (F) (normal for resident: 97.3 degrees F), on 01/22/16 at 2:19 AM; 99.6 degrees F on 01/22/16 at 5:48 AM and on 01/22/16 at 3:57 PM; and, 99.4 degrees F on 01/24/16 at 2:25 PM. However, further review revealed there was no documented evidence the physician was made aware of the resident's continued increased temperature while on antibiotic therapy. Review of a Nurse's Note, dated 01/23/16 at 2:51 PM, revealed Resident #1 was fed by staff and only ate a few bites. Review of Resident #1's Consumption Records for 01/23/16, revealed Resident #1 did not consume any food or fluid intake at breakfast, lunch or dinner. Further review of the Nurse's Notes, revealed on 01/24/16 at 2:25 PM, Resident #1 had a temperature of 99.4 degrees F. Review of Resident #1's Consumption Record for 01/24/16, revealed the resident only consumed 120 Cubic Centimeters (cc), of fluid that day. However, there was no documented evidence the physician was notified of the resident's decreased intake. Review of the January 2016 Intake Records for Resident #1, revealed Resident #1's previous average daily fluid intake from 01/03/16 through 01/16/16 was 1,577 cc based on documented intakes. Review of a Nurse's Note, dated 01/25/16 at 2:00 PM, revealed Resident #1 was noted to be unresponsive, lethargic, respirations were shallow, and skin turgor was poor. The Advanced Practice Registered Nurse (APRN) was notified and an order was received to send Resident #1 to the emergency room (ER) for evaluation. Review of the emergency room (ER) Documentation of Transfer form, dated 01/25/16 at 3:00 PM, revealed Resident #1 was being transferred to the hospital from the ER due to [DIAGNOSES REDACTED]. Review of the Hospital Discharge Summary, dated 02/03/16, revealed Resident #1 was treated for [REDACTED]. Further review of the Discharge Summary, revealed the physician believed the Acute Kidney Injury was likely due to dehydration. Interview (Post Survey) with Registered Nurse (RN)/MDS Coordinator, on 03/14/16 at 2:09 PM, revealed she cared for Resident #1 on 01/22/16. She stated she would expect a physician to be notified if a resident continues with elevated temperatures over the course of several days, especially a resident that is receiving antibiotic therapy. She stated, she was unaware that Resident #1 had ongoing elevated temperatures when she cared for Resident #1 on 01/22/16 and in hindsight she should have looked back at the previous week of nurses notes which would have shown Resident #1 had an ongoing temperature over the course of several days. Interview (Post Survey) with Licensed Practical Nurse (LPN) #2, on 03/14/16 at 2:27 PM, revealed she cared for Resident #1 on 01/24/16 and did not recall Resident #1's condition being acute or in need of a physician's notification at that time. She stated she was unaware that Resident #1 had an ongoing temperature over the course of several days when she took care of him/her on 01/24/16 and that if she would have been aware she would have notified the physician. Interview with LPN #1 who has cared for Resident #1, on 03/02/16 at 10:42 AM, revealed she would have expected licensed staff to notify the physician anytime a resident's acute clinical condition was not improving and anytime a resident had an ongoing elevated temperature. Interview with LPN #3 who worked on another unit, on 03/04/16 at 9:47 AM, revealed she expected all licensed staff to ensure a physician was notified if a resident continued to show elevated temperatures after starting antibiotic therapy. She also stated a physician should be notified if a resident had continually had low fluid intake accompanied by an elevated temperature. Interview with the LPN/House Supervisor, on 03/02/16 at 08:35 AM, revealed she expected licensed staff to be sure to notify the physician when a resident had a continued elevated temperature after being on antibiotic therapy. Interview with Assistant Director of Nursing (ADON), on 03/03/16 at 10:30 AM, revealed she expected all licensed staff to ensure the physician was made aware of any resident who continued to have elevated temperatures accompanied with low fluid intake as this could potentially cause dehydration. Interview with the Director of Nursing (DON), on 03/03/16 at 10:35 AM, revealed she would have expected licensed staff to inform the physician when a resident had continued elevated temperatures, and any other acute condition that was not improving or resolving. Interview with Resident #1's APRN, on 03/03/16 at 4:35 PM, revealed she would expect the facility to notify herself or the physician for any resident who had continued to have increased temperatures after starting an antibiotic and also for any resident that had continued to have low fluids consumption accompanied by ongoing elevated temperatures. Interview with the Administrator, on 03/04/16 at 10:23 AM, revealed she expected licensed staff to notify the physician if an acute illness or sickness that the resident was being treated and monitored for was not improving. She stated an ongoing

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.

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F 0157 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) temperature accompanied with low fluid intake would have warranted physician notification for guidance from the physician for possible altered treatment.
F 0280 **Level of harm** - Actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy, review of emergency room Documentation of Transfer form, and review of the hospital History and Physical and Discharge Summary, it was determined the facility failed to revise the plan of care for one (1) of three (3) sampled residents (Resident #1) when the resident's status changed. Resident #1 was identified as having a cough, rash, elevated temperature on 01/20/16, and was started on antibiotic therapy. In addition, the resident had an episode of emesis, an ongoing temperature over the next five (5) days. However, the facility failed to revise the resident's plan of care to address the antibiotic use and the increased risk of dehydration. Resident #1 was hosptalized on [DATE] for nine (9) days with [DIAGNOSES REDACTED]. The findings include: Review of the facility's policy and procedure titled Care Plans - Comprehensive, revised October 2010, revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Further review of this policy, revealed each resident's comprehensive Care Plan should incorporate identified problem areas and risk factors associated with identified problems. The care plan should build on the resident's strengths reflect the resident's expressed wishes regarding care and treatment goals. In addition, the care plan should have timetables and objectives in measurable outcomes, identify the professional services that are responsible for each element of care, aid in preventing or reducing declines in the resident's functional status and/or functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitated program, and reflect currently recognized standards of practice for problem areas and conditions. The policy further revealed assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Record review revealed the facility readmitted Resident #1 on 12/09/12 with diagnoses, which included Dementia, Anxiety, Dysphagia, Muscle Weakness, Abnormal Posture, and Cognitive Communication Deficit. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 11/29/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5) which indicated the resident was not interviewable. Review of a Nurse's Note, dated 01/20/16 at 4:50 PM, revealed Resident #1 was noted to have a decline in alertness, a rash to the trunk and an elevated temperature on 01/20/16; the resident was placed on an antibiotic. Further review of the Nurse's Notes, revealed Resident #1 had a temperature of 100.9 degrees Fahrenheit (F) on 01/22/16 at 2:19 AM; 99.6 degrees F on 01/22/16 at 5:48 AM and at 3:57 PM; and 99.4 degrees F on 01/24/16 at 2:25 PM. In addition, review of Resident #1's Consumption Records revealed Resident #1 did not consume any food or fluid intake at breakfast, lunch or dinner on 01/23/16 and only 120 Cubic Centimeters (cc) of fluid on 01/24/16. However, review of Resident #1's current Interdisciplinary Care Plans, dated 08/27/15, 08/29/15, 10/07/15, and 10/09/15, revealed there were no revisions to the care plan to address Resident #1's use of an antibiotic, his/her ongoing temperature and decreased intake, which placed the resident at an increased risk of dehydration. Review of a Nurse's Note, dated 01/25/16 at 2:00 PM, revealed Resident #1 was sent to the emergency room (ER) and was hospitalized for [REDACTED]. Review of the Discharge Summary revealed the resident was discharged back to the facility on [DATE]. However, further review of Resident #1's current interdisciplinary care plans dated 08/27/15, 08/29/15, 10/07/15, 10/09/15, revealed there were no revisions made to the care plans to address the resident's identified risk for dehydration. Interview with the Assistant Director of Nursing (ADON), on 03/03/16 at 10:30 AM, revealed she would have expected Resident #1's care plans to have been updated to reflect his/her changes in his/her clinical condition. Interview (Post Survey) with Registered Nurse (RN)/MDS Coordinator, on 03/14/16 at 2:09 PM, revealed the nursing leadership updates care plans with resident condition changes, treatment changes and anything pertinent to the resident's overall care. She stated nursing management brings the previous twenty-four (24) hours worth of nursing notes and physician's orders [REDACTED]. She further stated, there was a great deal of orders and nurses notes to look through daily that some stuff could possibly get missed and not care planned. Interview (Post Survey) with the facility Wound Care Nurse, on 03/14/16 at 3:05 PM, revealed the floor nurses are not responsible for updating the care plans. She stated the nursing management team updates the care plans during the morning department head meeting. She revealed the nursing management team brings all of the nursing notes and physicians orders for all residents that have been created in the previous twenty-four (24) hours to be reviewed, followed up on and care planned, if indicated. She further stated if something was not care planned it may have been missed in the process or it may have been something that the team did not think was pertinent. Interview with the Director of Nursing (DON), on 03/03/16 at 10:35 AM, revealed she expected care plans to be updated on an ongoing basis with any clinical condition changes or with any new high-risk conditions that arise for residents. She further stated Resident #1's care plans should have been updated with his/her condition changes and identified problems that arose from his/her acute medical conditions that led to a hospitalization . The DON stated all nurses were able to and responsible for updating care plans with new orders, treatments, and changes that were pertinent to the resident. She further stated all Physicians' Orders written during the course of the day were taken to the Department Head morning meeting the following day and the team was to assure anything that was pertinent had been care planned and/or followed up on. Interview with the Administrator, on 03/04/16 at 10:23 AM, revealed she expected the facility to follow the care plan policy and procedure.
F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, review of emergency room Laboratory Report and hospital Discharge Summary, it was determined the facility failed to ensure each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of three (3) sampled residents (Resident #1). Resident #1 was identified as having a cough, rash, elevated temperature on 01/20/16, and was started on antibiotic therapy. The resident had an episode of emesis and an ongoing temperature over the next five (5) days; however, the facility failed to conduct ongoing assessments to identify if the resident was showing signs and symptoms of dehydration; if the resident was receiving adequate fluids; if the resident's temperature was controlled with the use of Tylenol; and, if the antibiotic was effective. On 01/25/16, Resident #1 was identified to be unresponsive, was lethargic, respirations were shallow, and skin turgor was poor. Resident #1 was hosptalized on [DATE] for nine (9) days with [DIAGNOSES REDACTED]. The findings include: Review of the facility's policy and procedure titled, Acute Condition Changes - Clinical Protocol, last revised October 2010, revealed the nursing staff will help the physician identify any complications and or problems that occurred during a recent hospital stay, which may indicate the risk of additional acute problems. Further review of the policy and procedure, revealed the nursing staff will monitor and document the resident's progress and responses to treatment. Interview with the Director of Nursing (DON), on 03/03/16 at 10:35 AM, revealed the facility had no policy and procedure for assessing and monitoring residents related to antibiotic therapy or dehydration and was unable to provide any policy and procedure related to these areas. Record review revealed the facility readmitted Resident #1 on 12/09/12 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 11/29/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5) which indicated the resident was not interviewable.

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Review of the Nutritional at Risk Plan of Care, dated 10/09/15, revealed interventions for staff to monitor for signs and symptoms of dehydration to include dry tenting skin, dry mucous membranes and decreased urinary output. However, the care plan did not address the amount of assessed fluid needs and the resident's normal intakes. Review of the physician's orders [REDACTED]. Review of a Nurse's Note, dated 01/17/16 at 1:43 PM, revealed Resident #1's family came in to visit and reported Resident #1 had vomited on himself/herself. Further review of the Nurse's Notes revealed there was no documented evidence of ongoing assessments due to the resident's change in condition until 01/20/16 at 4:50 PM (three {3}days later), when it was noted Resident #1 had a cough, a rash to his/her trunk of body, was not as alert, and had an elevated temperature of 100.6 degrees Fahrenheit (F) (resident normal: 97.3 degrees F). The physician was notified and the resident was placed on an antibiotic. Further review of the Nurse's Notes revealed there was no documentation of another assessment of Resident #1 until 01/21/16 at 3:31 AM. The Nurse's Note stated Resident #1 had two (2) vomiting episodes at the beginning of the shift and the resident was medicated with an as needed (PRN) nausea medication with no further episodes noted. Review of a Nurse's Note, dated 01/22/16 at 2:19 AM, revealed Resident #1 had an elevated temperature of 100.9 degrees F and PRN Tylenol was given. Further review of the Nurse's Notes, revealed on 01/22/16 at 3:57 PM, Resident #1 had a temperature of 99.6 degrees F and received PRN Tylenol at approximately 2:00 PM. However, review of the Nursing Notes, dated 01/20/16 through 01/22/16, and review of the January 2016 Medication Administration Record (MAR) revealed there was no documented evidence Resident #1 was assessed after the administration of the Tylenol to determine if the medication was effective. Review of Resident #1's Consumption Records, revealed there was no documentation that Resident #1 had consumed any food or fluid intake at breakfast, lunch or dinner on 01/23/16 and only consumed 120 cc of fluid on 01/24/16. However, further review of the Nursing Notes, dated 01/23/16 and 01/24/16, revealed there was no documented evidence the resident was assessed for signs and symptoms of dehydration to include dry tenting skin, dry mucous membranes and decreased urinary output. Review of a Nurse's Note, dated 01/25/16 at 2:00 PM, revealed at 12:30 PM Resident #1 was noted to be unresponsive, lethargic, respirations were shallow, and skin turgor was poor. The Advanced Practice Registered Nurse (APRN) was notified and Resident #1 was sent to the emergency room (ER) to be evaluated. Review of the emergency room (ER) laboratory results, dated 01/25/16 at 1:22 PM, revealed Resident #1 had elevated levels of Hemoglobin 16.8 (normal range 12.2 - 16.20), Hematocrit 53.0 (normal range 37.0 - 47.0) , Blood Urea Nitrogen (BUN) 111 (normal range 7 - 18), Chloride 126 (normal range 98 -107) and Sodium 159 (normal range (136 - 145) which indicated the resident was dehydrated. Review of Resident #1's Discharge Summary, dated 02/03/16, revealed Resident #1 was treated for [REDACTED]. Further review of the Discharge Summary, revealed the physician documented the Acute Kidney Injury was likely due to dehydration, Resident #1 was given Intravenous (IV) fluids, Resident #1's mentation improved with improving Kidney Injury and his/her Urinary Tract Infection [MEDICAL CONDITION] and he/she was back to baseline by day of discharge. Interview with emergency room Registered Nurse (RN) #1 on 03/02/16 at 3:30 PM, revealed Resident #1 was received in the ER with extremely dry and crusted lips, tongue and oral mucosa which was an indicator Resident #1 was dehydrated. He further stated Resident #1 had blood-work at the hospital and his/her laboratory values were also an indicator Resident #1 was dehydrated. RN #1 also stated, Resident #1 had to receive intravenous (IV) fluid replacement because he/she was dehydrated. Interview with the ER Physician, on 03/03/16 at 9:25 AM, revealed he was the attending physician in theER on [DATE] and he was very concerned about Resident #1 due to his/her level of dehydration. He stated Resident #1 had blood-work done which reflected elevated laboratory levels of hemoglobin, hematocrit, blood urea nitrogen (BUN), chloride and sodium that were indicative of true dehydration/fluid volume deficit and not due to a medical condition such as a renal impairment or disease process. He further stated he was very concerned with how dry and crusted Resident #1's lips and mouth were. The ER Physician stated Resident #1 had a dried mucus like crust covering his/her gums in his/her oral cavity which was also indicative of true dehydration and lack of fluid intake over a period of several days. He stated Resident #1's level of dehydration would have come from several days of minimal fluid intake and this was negligent due to this particular resident's cognitive and physical impairments, as he/she was dependent upon others to provide fluids as he/she would be unable to do so by himself/herself without assistance. Interview (Post Survey) with the MDS Coordinator, on 03/14/16 at 2:09 PM, revealed she cared for Resident #1 on 01/22/16. She stated she was on call that day and worked the unit Resident #1 resides on. She revealed she would have been expected to document on the MAR if she administered any type of PRN medication and she would have been expected to chart the follow up results of the PRN medication on the PRN flow sheet and in the nurses notes. Review of Nurse's Note, dated 01/22/16 at 3:57 PM, and January 2015 MAR, revealed the MDS Coordinator documented Resident #1 had a temperature of 99.6 degrees F and was given Tylenol at approximately 2:00 PM. However, further review of Resident #1's Nursing Notes, dated 01/22/16 and January 2016 MAR revealed there was no documented evidence an assessment was completed to determine if the Tylenol was effective. Continued interview with MDS Coordinator, revealed she must have forgot to do the follow up charting on the PRN Tylenol, but should have done so. She also stated she had done an assessment on Resident #1 for dehydration signs and symptoms due to the elevated temperature but had forgot to add that to her nurse's note entry. She further stated she would have notified the physician if the assessment showed any signs and symptoms of dehydration. Interview with Licensed Practical Nurse (LPN) #2, on 03/01/16 at 11:25 AM, revealed she would have expected licensed staff to document on the MAR any medications given and to follow up on the medication given to see if it was effective. Further interview (Post Survey) with LPN #2, on 03/14/16 at 2:27 PM, revealed she cared for Resident #1 on 01/24/16. LPN #2 stated she remembered assessing Resident #1 for signs and symptoms of dehydration but must have forgot to chart it in the nurse's notes, but she always assesses a resident for signs and symptoms of dehydration if they have an elevated temperature. She also stated she would have notified Resident #1's doctor if she found Resident #1 to have had any signs and symptoms of dehydration. Interview with LPN #1, on 03/02/16 at 10:42 AM, revealed she would have expected licensed staff to document on the MAR any medications given and to follow up on the medication to see if it was effective. She further stated licensed staff was expected to assess and document every shift when a resident is on an antibiotic. LPN #1 stated the assessment should include assessing for adverse side effects of the antibiotic and for the reason the antibiotic therapy was initiated to determine if it was effective. Interview with LPN #3, on 03/04/16 at 9:47 AM, revealed she expected all licensed staff to document on the MAR anytime medications were given and to follow up on the PRN medication given to see if effective. She stated licensed staff should assess and document every shift when a resident was on an antibiotic. LPN #3 stated the assessment should include assessing for adverse side effects of the antibiotic and the resident's acute illness or acute change in condition. Interview with the LPN/House Supervisor, on 03/02/16 at 08:35 AM, revealed she expected licensed staff to always document any PRN medication given on the MAR and to follow up on any PRN medication for the results of the medication given. She further stated she expected licensed staff to assess for signs and symptoms of dehydration for any resident that had an elevated temperatures and poor fluid intake. Interview with Assistant Director of Nursing (ADON), on 03/03/16 at 10:30 AM, revealed she expected all licensed staff to document on the MAR anytime medications were given and to follow up on the PRN medications given. She also stated following up on PRN medication would be important to see if the medication was effective in treating the resident's condition. The ADON stated she expected licensed staff to assess the resident and document every shift when a resident was on an antibiotic and had an acute illness. Interview with the DON, on 03/03/16 at 10:35 AM, revealed she expected licensed staff to ensure documentation on the MAR if the medication was given and to also follow up on the medication to see if it was effective. She stated she expected licensed staff to do ongoing assessments when a resident has any kind of acute illness or recent decline in baseline conditions. The DON also stated she would have expected licensed staff to assess for and document any signs and symptoms of dehydration with any resident who had poor fluid intake and an ongoing elevated temperature. Interview with Resident #1's APRN on 03/03/16 at 4:35 PM, revealed she would have expected the nursing staff to have followed up on any medication that was given for elevated temperatures to see if the medication was effective and if the elevated temperature was relieved or resolved. She stated a prolonged temperature increase would contribute to the risk of dehydration and warrant an increase in fluid consumption. She further stated that was why it was very important to follow up on elevated temperatures.

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) Interview with the Administrator on 03/04/16 at 10:23 AM, revealed she expected licensed staff to assess residents thoroughly and ongoing during any type of acute illness or sickness in which they were being treated or monitored. She further stated she would expect all licensed nurses to document any PRN medication given on the MAR and to follow up on the PRN medication for results as to whether the medication was effective or not effective.
F 0327 **Level of harm** - Actual harm **Residents Affected** - Few	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility policy, review of emergency room Laboratory Report and Documentation of Transfer Form, and Hospital Discharge Summary, it was determined the facility failed to have an effective system in place to ensure one (1) of three (3) sampled residents (Resident #1) was provided with sufficient fluid intake to maintain proper hydration and health. Resident #1 began having episodes of vomiting on 01/17/16 and an elevated temperature on 01/20/16. The resident was placed on antibiotics on 01/20/16; however, the resident continued to have a temperature and had another episode of vomiting on 01/21/16. The facility failed to ensure the amount of fluid the resident consumed was documented consistently on his/her consumption records to be able to determine if the resident's intake was decreasing; and, they failed to have an effective system in place to ensure the resident's fluid intake was monitored. In addition, the facility failed to provide ongoing assessments to determine if the resident had signs and symptoms of dehydration; and, failed to notify the physician of the resident's ongoing temperature and decreased fluids while on the antibiotic. On 01/25/16, Resident #1 was assessed to be unresponsive, lethargic, respirations shallow, and having poor skin turgor. Resident #1 was sent to the emergency room and was hosptalized on [DATE] for nine (9) days with [DIAGNOSES REDACTED]. The findings include: Review of the facility's policy titled, 'Hydration-Clinical Protocol' last revised October 2010, revealed the physician and staff will identify individuals with a significant risk for subsequent fluid and electrolyte; for example, those with prolonged vomiting, diarrhea, or fever or who are not eating or drinking well. Record review revealed the facility readmitted Resident #1 on 12/09/12 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 11/29/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5) which indicated the resident was not interviewable. In addition, the facility assessed the resident as requiring extensive assistance of one (1) staff for eating. Review of Resident #1's Nutritional Data Set and Progress Note (assessment), completed by the Registered Dietician (RD), dated 10/09/15, revealed the facility assessed Resident #1's daily fluid needs to be 1600 Cubic Centimeters (cc) -1920 cc daily. However, further review revealed the section to be completed for past fluid intake to determine if the resident was at risk for dehydration was blank. There was no documented evidence the Dietician assessed the resident's past fluid intake to determine if the resident was at risk for dehydration. Interview (Post Survey) with RD, on 03/11/16 at 8:24 AM, revealed she was not the Dietician when the Nutritional Data Set and Progress Note was completed on 10/09/15. However, she stated the Nutritional Data Set and Progress Note was an assessment completed by the RD when a resident was admitted to the facility, with any significant change in weight gain or weight loss, annually and any time a resident was admitted to the hospital and gone over twenty-four (24 hrs). The RD stated it was very important for the Nutritional Data Set to be completed in its entirety in order to get an accurate overall picture of the resident being assessed. She further stated the portion of the assessment related to the resident's current fluid intake, should be completed as this would give important information in regards to the facility's need to attempt other possible interventions to improve a resident's fluid intake if that particular resident had not been consuming an adequate amount. Review of the Nutritional at Risk Plan of Care, dated 10/09/15, revealed an intervention for staff to monitor for signs and symptoms of dehydration to include dry tenting skin, dry mucous membranes and decreased urinary output. However, the care plan did not address the amount of assessed fluid needs and the resident's normal intakes. Review of Resident #1's December 2015 and January 2016 Consumption Logs revealed there were to many undocumented spaces (blanks) to determine how much fluid the resident consumed daily on a consistent basis to determine if the resident was meeting his/her fluid needs. Further review revealed the amount of fluid the resident consumed was only documented for five (5) out of eighteen (18) meals from 01/17/16 through 01/22/16. Review of a Nurse's Note, dated 01/17/16 at 1:43 PM, revealed Resident #1's family came in to visit and reported Resident #1 had vomited on himself/herself. Further review of the Nurse's Notes revealed there was no documented evidence the resident's condition was assessed again until 01/20/16 at 4:50 PM (three {3}days later), when it was noted Resident #1 had a cough, a rash to trunk of body, was not as alert, and had an elevated temperature of 100.6 degrees Fahrenheit (F) (normal for resident 97.3 degrees F). The resident was administered Tylenol for the increased temperature. Review of Resident #1's physician's orders [REDACTED]. Further review of the Nurse's Notes revealed there was no further documentation of Resident #1's condition until 01/21/16 at 3:31 AM. The Nurse's Note revealed Resident #1 had two (2) vomiting episodes at the beginning of the shift and the resident was medicated with an as needed (PRN) nausea medication with no further emesis noted. On 01/22/16 at 2:19 AM, Resident #1 had an elevated temperature of 100.9 degrees F and PRN Tylenol was given. A Nurse's Note, dated 01/22/16 at 5:48 AM, revealed Resident #1 had a temperature of 99.7 degrees F. Further review of the Nurse's Notes, revealed on 01/22/16 at 3:57 PM, Resident #1 had a Temperature of 99.6 degrees F and received PRN Tylenol at approximately 2:00 PM. Record review revealed there was no evidence the resident was assessed for signs and symptoms of dehydration related to the resident's emesis and ongoing temperature. Review of a Nurse's Note, dated 01/23/16 at 2:51 PM, revealed Resident #1 was fed by staff and only ate a few bites but drank well; and, the resident's daughter was made aware of the resident not eating well this shift. Review of Resident #1's Consumption Records for 01/23/16, revealed there was no documented evidence of food or fluid intake at breakfast, lunch or dinner. Further review revealed Resident #1 had a temperature of 99.4 degrees F on 01/24/16 at 2:25 PM and review of the Consumption Record revealed the facility documented the resident consumed 120 cc of fluid that day. However, review of the Nursing Notes for 01/23/16 and 01/24/16 revealed there was no documented evidence the facility assessed Resident #1 for any signs and symptoms of dehydration to include dry tenting skin, dry mucous membranes and decreased urinary output related to the resident's decreased fluid intake and continued temperature. Review of a Nurse's Note, dated 01/25/16 at 2:00 PM, revealed Resident #1 was noted to be unresponsive, lethargic, respirations shallow and had skin turgor poor. The Advanced Practice Registered Nurse (APRN) was notified of Resident #1's condition and an order was received to send Resident #1 to the emergency room (ER) for evaluation. Review of physician's orders [REDACTED].#1 was to be sent to the emergency room for evaluation due to being unresponsive with shallow respirations. Interview with Licensed Practical Nurse (LPN) #1, on 03/02/16 at 10:42 AM, revealed she sent Resident #1 to theER on [DATE] for an evaluation. LPN #1 stated she could tell Resident #1 was not acting like his/her normal self and was very sluggish with shallow respirations. She stated she called the physician's office and spoke with the Advanced Practice Registered Nurse (APRN) and explained Resident #1's deteriorating condition and the APRN ordered to send Resident #1 to the ER for an evaluation. LPN #1 stated she called and followed up on Resident #1 later after he/she had been sent to the ER. She stated the ER staff informed her Resident #1 was being admitted to the hospital with [REDACTED]. LPN #1 further stated she would have expected staff to attempt to encourage and increase fluids for a resident who had an elevated temperature and had poor fluid consumption. The LPN stated she was not aware of the facility's policy to monitor fluid and hydration status. Review of the emergency room (ER) laboratory results, dated 01/25/16 at 1:22 PM, revealed Resident #1 had elevated levels of Hemoglobin 16.8 (normal range 12.2 - 16.20), Hematocrit 53.0 (normal range 37.0 - 47.0) , Blood Urea Nitrogen (BUN) 111 (normal range 7 - 18), Chloride 126 (normal range 98 -107) and Sodium 159 (normal range (136 - 145) which indicated the resident was dehydrated. Review of the ER documentation of transfer, dated 01/25/16 at 3:00 PM, revealed Resident #1 was being transferred to the hospital from the ER due to [DIAGNOSES REDACTED]. Review of Hospitalist Progress Notes, dated 01/26/16 through 02/02/16, revealed Resident #1 was receiving intravenous fluids (IV) to treat dehydration. Review of Resident #1's Discharge Summary, dated 02/03/16, revealed Resident #1 was treated for [REDACTED]. Further review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185331	A. BUILDING _____ B. WING _____	03/04/2016

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0327 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Discharge Summary, revealed the physician documented he believed the Acute Kidney Injury was likely due to dehydration. Interview with emergency room Registered Nurse (RN) #1, on 03/02/16 at 3:30 PM, revealed he was the ER Nurse when Resident #1 arrived at theER on [DATE]. He stated Resident #1 was received in the ER with extremely dry and crusted lips, tongue and oral mucosa which was an indicator Resident #1 was dehydrated. He further stated Resident #1 had blood-work done and his/her laboratory values were also an indicator Resident #1 had dehydration. The emergency room RN stated, Resident #1 received intravenous (IV) fluid replacement because he/she was dehydrated. Interview with ER Physician, on 03/03/16 at 9:25 AM, revealed he was the attending physician in theER on [DATE] when Resident #1 was sent to the ER for an evaluation. He stated he was very concerned about Resident #1 due to the resident's level of dehydration. He stated Resident #1 had blood-work done and had elevated laboratory levels of hemoglobin, hematocrit, blood urea nitrogen (BUN), chloride and sodium that were indicative of true dehydration/fluid volume deficit and not due to a medical condition such as a renal impairment or disease process. He further stated he was very concerned with how dry and crusted Resident #1's lips and mouth. He stated Resident #1 had a dried mucus like crust covering his/her gums in his/her oral cavity which was also indicative of true dehydration and lack of fluid intake over a period of several days. He stated Resident #1's level of dehydration would have had to result from several days of minimal fluid intake and he felt the facility was negligent because the resident was dependent on others to provide fluids as he/she was not able to provide his/herself fluids due to his/her cognitive and physical impairments. Interview with Resident #1's Power of Attorney (POA)/Daughter on 03/01/16 at 6:30 PM, revealed she felt like the facility was not adequately feeding or providing fluids for Resident #1. She stated she often came to the facility and staff would report Resident #1 did not eat or drink much or had refused food and fluids. The Daughter stated Resident #1 needed ample time to consume fluids and food and he/she was slow at consuming food and fluids and due to this, staff did not take the time to ensure Resident #1 had ample consumption of food and fluids. She also stated Resident #1 had to have extra encouragement and cueing to consume adequately. Interview with Certified Nursing Assistant (CNA) #1 on 03/01/16 at 11:17 AM, revealed CNA #1 stated Resident #1 was on thickened liquids and did not drink well at times. CNA #1 stated she could recall Resident #1 being sent out to the hospital on [DATE] due to being sick, non-responsive, and not eating or drinking much. CNA #1 stated she remembered hearing that Resident #1 was admitted to the hospital with [REDACTED].#1 had to be fed all meals by a nurse now to be sure he/she received adequate fluids and nutrition. Interview with CNA #2, on 03/01/16 at 11:22 AM, revealed Resident #1 did not drink fluids well and staff have to keep encouraging him/her to take drinks throughout the day. CNA #2 stated she remembered hearing that Resident #1 was admitted to the hospital because he/she had been dehydrated. She stated Resident #1 was to be fed all meals by licensed staff now since returning from the hospital. CNA #2 stated this was to ensure Resident #1 was getting adequate fluids and food. Interview with LPN #2, on 03/01/16 at 11:25 AM, revealed she remembered Resident #1 was sent to theER on [DATE] because he/she had become kind of unresponsive with shallow respirations and was not acting normal in regards to responding to physical and verbal stimuli. LPN #2 stated due to Resident #1's overall deterioration he/she was sent to the ER for evaluation and was admitted with Dehydration and a Urinary Tract Infection. LPN #2 further stated Resident #1 was now to be fed by licensed staff for all meals because the resident did not eat or drink well and that's part of what led him/her to being admitted to the hospital with [REDACTED].#2 further stated she would have expected staff to attempt to encourage and increase fluids for a resident who had an elevated temperature and poor fluids consumption. She stated she was not familiar with how the facility ensures a resident consumes their assessed daily fluid needs on a daily basis. Interview with facility's Registered Dietician (RD) on 03/02/16 at 4:15 PM, revealed a resident's assessed daily fluid needs were very important and the assessed fluid needs were determined by taking into consideration the resident's overall medical condition and disease processes. She further stated, it would be important to attempt to meet the resident's assessed need. Interview with Resident #1's APRN, on 03/03/16 at 4:35 PM, revealed she would have expected the nursing staff to have notified herself or the physician due to Resident #1 having an ongoing elevated temperature after the antibiotic therapy was started and due to ongoing poor fluid intake by Resident #1. She further stated it was important to attempt to increase fluids in anyone who has an elevated temperature because this increased the need for more fluids. Interview with the Director of Nursing (DON), on 03/03/16 at 10:35 AM, revealed she would have expected her licensed nurses to have notified the physician or APRN due to Resident #1 having continued elevated temperatures and poor fluid intake over the course of several days. She stated she would also have expected staff to have attempted to encourage Resident #1 to increase his/her consumption of fluids due to the continued elevated temperature and poor fluid intake. The DON stated she was unsure what systems the facility had in place to ensure the resident's actual assessed fluids needs were being met. She also stated, the charge nurses on the floor were to be looking at consumption records at the end of their shifts and looking for any alert in regards to a resident refusing meals or having decreased fluid intake from the resident's usual consumption and if this is noted she would expect the nurse to take action at that time. The DON stated she was unsure what system was in place to ensure the charge nurses were checking resident consumption of fluid and nutrition at the end of their shifts.