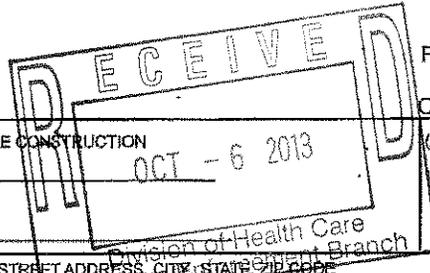


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2013
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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 MAGNOLIA STREET TOMPKINSVILLE, KY 42167
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F 000	INITIAL COMMENTS	F 000	F329	
F 329 SS=E	<p>A standard health survey was conducted on 09/10-12/13. Deficient practice was identified with the highest scope and severity at 'E' level.</p> <p>483.25(f) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility procedures the facility failed to ensure that four of twenty-one residents' drug</p>	<p>On 9/13/2013 physician ordered for resident #1's antipsychotic medication to be discontinued. On 9/24/2013 resident #11's physician ordered for her antipsychotic medication to be reduced in an effort to gradually reduce unnecessary drugs. On 9/23/2013 physician ordered for resident #17s antipsychotic medications to be discontinued. On 9/16/2013 physician ordered for resident #9's antipsychotic medication to be reduced in an effort to gradually reduce any unnecessary drugs. On 9/27/2013 Social Services Director updated residents #9, #11, and #17's care plan with additional resident specific behavioral interventions. Care plan team determined that no behavioral interventions needed to be added to resident #1s care plan.</p> <p>On 9/30/2013 a list of all residents on antipsychotic medications was obtained from the pharmacy. On 9/30/2013 DON and Social Services Director met and discussed all the</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Misty Payne Cook TITLE: Administrator (X6) DATE: 10/6/2013

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 329	<p>Continued From page 1</p> <p>regimen was free from unnecessary drugs. The facility failed to ensure there were adequate indications for the use of antipsychotic medication for Residents #1, #9, #11, and #12.</p> <p>The findings include:</p> <p>A review of the facility's procedure for Psychotropic Medication Reduction (not dated) revealed on a quarterly basis the facility pharmacist reviewed the medical record of residents who received antipsychotic medications. Pharmacy recommendations were then given to the psychiatrist at the psychiatrist's next monthly visit. If the psychiatrist did not see the resident, the pharmacy recommendations were sent to the physician. In addition, the care plan team met quarterly to review antipsychotic medications utilizing the Psychiatric Monitoring Tool and made recommendations to residents' physicians for reduction in medication.</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 07/26/11 with diagnoses including Senile Dementia with Disturbances in Behavior, Depression, Anxiety, Chronic Kidney Disease, and Chronic Ischemic Heart Disease. A review of the most recent Minimum Data Set (MDS) significant change in condition assessment dated 07/17/13 revealed the facility had assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6. The MDS also revealed the resident had not exhibited any behavioral symptoms during the assessment period. A review of the physician's orders for Resident #1 revealed an order dated 06/07/13 for the resident to receive 0.5 milligrams (mg) of Risperdal (antipsychotic) every night for</p>	F 329	<p>residents on antipsychotic medications. The residents who had not had a trial reduction were discussed. Physicians were asked for trial reductions for medication on all residents except those residents with a diagnosis of schizophrenia or psychotic mood disorder unrelated to dementia. DON and Social Service Director documented justification in the nurse's notes and in the social notes for those residents where a trial reduction was contraindicated. By 10/4/2013 all gradual drug reduction requests were approved by the resident's primary physician, orders were written and the resident's drug regiments were changed. Between 9/27/2013- 10/4/2013 Social Services reviewed and updated behavioral intervention on those residents with gradual dose reductions. On 9/30/2013 DON reviewed all "Consultant Pharmacist Communication to Physician Forms" to determine which resident forms had been marked I agree by the physician. DON or her appointee contacted the physicians that marked</p>		

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F 329	<p>Continued From page 2</p> <p>Dementia with Disturbance of Behavior. A review of a "Consultant Pharmacist Communication to Physician" form dated 08/21/13 revealed the pharmacist (RPh) had documented a notification to Resident #1's physician of the Food and Drug Administration's (FDA's) warning that, "Elderly patients with dementia related psychosis treated with an antipsychotic are at an increased risk of death and are not approved for the treatment of dementia related psychosis." The RPh documented that she was requesting the physician to re-evaluate the risks versus the benefits of continuing the Risperdal or to consider tapering the medication off. The communication sheet revealed Resident #1's physician had reviewed the RPh's recommendation on 08/22/13 and documented she had disagreed because the resident was having increased behaviors. A review a behavior report completed by facility staff revealed no behaviors had been documented by staff from 06/01/13 through 09/11/13. A review of Social Service Progress Notes for Resident #1 dated 08/23/13 at 1:00 PM, revealed the Social Worker had documented the resident had had no behavioral problems observed during the observation period.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #1 on 09/12/13 at 3:55 PM, and SRNA #2 on 09/12/13 at 4:00 PM, revealed Resident #1 required total assistance with all care needs. The SRNAs stated they had never observed Resident #1 have any behaviors in which he/she could have harmed himself/herself or any other resident.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 09/12/13 at 4:05 PM, revealed Resident #1 "at times" would talk to a deceased</p>	F 329	<p>I agree on the "Consultant Pharmacist Communication to Physician Forms" for clarification on the specific dose reduction that he or she desired and orders were written to reduce medications.</p> <p>On 10/11/2013 DON or her appointee will educate all nursing staff, Social Services Staff and activities staff regarding behavioral interventions that must be attempted, documented and deemed unsuccessful prior to using drug therapy. Examples of behavioral interventions will be discussed and a list of interventions will be given to the staff members and will be made accessible in the care plan books. On 10/11/2013 The DON or her appointee will explain to all nursing staff members that resident specific interventions are on the resident's care plan and personal care record. On 10/11/2013 DON will educate nurses about the importance of not asking the physician for drug therapy unless the</p>		

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F 329	<p>Continued From page 3</p> <p>sibling, but had never exhibited any behavior which could have caused harm to himself/herself or to any other resident.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 09/12/13 at 3:50 PM, revealed she was aware that Resident #1 had "talked" to a deceased relative "a couple months ago"; however, according to RN #1, Resident #1 had not exhibited any behavior which could have caused himself/herself or any other resident any harm.</p> <p>An interview conducted with Resident #1's physician on 09/12/13 at 5:30 PM, revealed she was also the facility's Medical Director. The Medical Director stated Resident #1 had exhibited agitated behaviors while in the hospital in July but was doing "a lot better now" and, "It was probably time to begin tapering off the dosage of the Risperdal." The Medical Director revealed she was aware of the FDA warning regarding Risperdal and treatment of dementia-related behaviors. According to the Medical Director, she attended all Quality Assurance meetings which were held quarterly, reviewed all facility policies, and was responsible for relaying issues to the residents' physicians. The Medical Director stated the facility was trying to become "more aggressive" in decreasing antipsychotic medications and trying to keep behaviors under control.</p> <p>2. A review of the medical record for Resident #11 revealed the facility admitted the resident on 03/30/12. Resident #11's diagnoses included Senile Dementia; Depressive Disorder; Anxiety; and Alzheimer's Dementia with Behaviors. A review of the Annual Minimum Data Set</p>	F 329	<p>resident is exhibiting certain behaviors that are harmful to himself or herself or are harmful to others. On 10/11/2013 DON will reeducate nurses that gradual dose reduction must be attempted to determine the continuous need for the drug therapy unless it is deemed contraindicated by the physician. On 9/21/2013 DON in conjunction with our medical director sent a letter to our attending physicians regarding the necessity to attempt gradual dose reductions when a resident is on any antipsychotic drugs and are not exhibiting certain behaviors that are of harm to themselves or others. On 9/30/2013 Social Services Director sent a letter to the psychiatrist regarding the necessity to attempt gradual dose reductions when a resident is on any antipsychotic drugs and is not exhibiting certain behaviors that are of harm to themselves or others. Weekly Administrator, DON, and Social Services (Drug Reduction Team) will meet and discuss those</p>		

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F 329	<p>Continued From page 4</p> <p>Assessment dated 02/27/13 revealed the facility had assessed the resident to have short and long-term memory problems. The annual assessment and the most recent Quarterly Minimum Data Set Assessment, dated 08/15/13 revealed the resident was "sometimes" able to make him/herself understood and "sometimes" had the ability to understand others. The annual and quarterly assessments also revealed Resident #11 had exhibited physical behaviors one to three days during the previous seven-day assessment timeframe of each assessment. According to the quarterly assessment, Resident #11 had rejected care one to three days during the assessment timeframe. In addition, a review of a "Behavior Detail Report" for the seven days (08/08-15/13) prior to the quarterly assessment revealed Resident #1 had exhibited physical behavior toward others on three separate occasions. On 08/09/13 at 2:15 PM, the resident "hit," "kicked," and "shoved" staff; however, staff documented the resident's behaviors had no impact on the resident or staff. On 08/09/13 at 3:15 PM, the resident "hit" staff. Documentation revealed the behavior had no impact on the resident or staff. Also, on 08/13/13 at 1:00 PM, Resident #11 "hit" staff and documentation at that time also revealed the resident's behavior had no impact on the resident or staff.</p> <p>Observation of a skin assessment of Resident #11 was conducted on 09/11/13 at 2:25 PM. The resident was observed to curse and resist staff attempts to remove an adult incontinence brief.</p> <p>A review of the most recent physician's orders for Resident #11, signed/dated 07/19/13 revealed the physician had prescribed 20 mg of Geodon (antipsychotic) to be administered to the resident</p>	F 329	<p>residents with new antipsychotic drug therapy orders and those residents with an increase in their drug therapy dosage. Drug Reduction Team will determine if the drug therapy is warranted. Weekly the Drug Reduction Team will meet and discuss behaviors charted, Pharmacy Recommendations, Psych Recommendations, and care plan team drug reduction requests on all residents on antipsychotic medications. Social Services will track pharmacy recommendations, psych recommendations, and care plan team reduction requests to ensure that the physician has responded to all recommendations. Social Services will report to the Drug Reduction Team concerning any pharmacy recommendation, psych recommendation, and care plan team request that the physician has failed to respond too. Each week Social Services will report to the Drug Reduction Team anytime a physician denies a drug reduction request from the</p>		

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F 329	<p>Continued From page 5</p> <p>at bedtime. The original order date of the Geodon was 11/30/12. A review of a "Psychotropic Medication Monitoring Tool" dated 08/15/13 revealed Resident #11 received the antipsychotic medication (Geodon) due to "Dementia."</p> <p>A review of a "Consultant Pharmacist Communication to Physician" document for Resident #11, dated 08/21/13 revealed, "This elderly resident is currently on antipsychotic therapy for a dementia-related diagnosis." The pharmacist noted a FDA boxed warning that revealed, "Elderly patients with dementia-related psychosis treated with an antipsychotic are at an increased risk of death compared to placebo." The pharmacist's documentation also noted "these agents" are not approved for the treatment of dementia-related psychosis. Continued review of the document revealed the pharmacist requested the physician to "please re-evaluate the risks vs [versus] benefits of continuing antipsychotic therapy in this resident. Consider tapering off the current medication and adding an alternative from a different class of agents if behaviors are still unmanageable without medication therapy." The resident's physician acknowledged by signature dated 08/29/13 that "I agree" in the "physician response to recommendation/findings." However, a review of the Medication Administration Record on 09/11/13 for Resident #11 revealed the resident continued to receive the antipsychotic, Geodon, on a daily basis.</p> <p>Interview with Registered Nurse #2 revealed when the pharmacist makes a recommendation, the pharmacist faxes the recommendation to the physician. According to RN #2, when the</p>	F 329	<p>pharmacy, psychiatrist, and/or care plan team. DON or her appointee will consult with the physician when he or she fails to respond to the drug reduction request or if he or she denies the gradual dose reduction. When a gradual dose reduction is contraindicated the Drug Reduction Team will ensure that behavioral interventions have been attempted without success and documentation of behaviors is documented proving that the resident is at harm to themselves or others.</p> <p>The Drug Reduction team will track the frequency of gradual dose reductions to ensure that the facility complies with regulations. Results of the Drug Reduction Team's tracking will be reported in the quarterly QA meeting.</p> <p>Completion Date</p>	10/21/2013	

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F 329	<p>Continued From page 6</p> <p>physician comes to the facility, he/she indicates by signing the recommendation form whether he/she agrees or disagrees with the pharmacist's recommendation. RN #2 stated if the physician agrees with the recommendation, the physician would write an order related to the recommendation; or, if the order is given verbally to the nurse, the nurse would write a verbal order. RN #2 also stated if the physician acknowledged agreement for a dose reduction and failed to document the specific dose, the nurse would contact the physician for clarification. RN #2 confirmed after review of the physician's orders and the pharmacist's recommendations made on 08/21/13 for Resident #11, the physician had acknowledged agreement with the pharmacist's recommendation for a dose reduction of the Geodon; however, the dose of the Geodon (antipsychotic) had not been reduced.</p> <p>3. A review of Resident #17's medical record revealed the facility admitted the resident on 04/04/13 with diagnoses that included Aphasia, Respiratory Failure, Depression, Non-Alzheimer Dementia, and Anxiety.</p> <p>Observation of Resident #17 on 09/12/13 at 2:15 PM and 2:25 PM revealed the resident was lying in bed. The resident did not exhibit any behaviors during these observations.</p> <p>Interviews with Certified Medication Technician (CMT) #1 on 09/12/13 at 2:15 PM and Licensed Practical Nurse (LPN) #2 on 09/12/13 at 2:25 PM revealed Resident #17 did not exhibit behaviors.</p> <p>A review of a "Psychiatric Initial Evaluation" dated 05/01/13 revealed staff reported the resident "has sundowners and is very restless at night." The</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>evaluation stated the resident had a history of depression and was receiving Seroquel (antipsychotic medication that was initiated on 04/05/13) 25 milligrams (mg) at bedtime and Geodon (antipsychotic medication that was initiated on 04/20/13) 20 mg at bedtime. Psychiatry Services recommended that Seroquel be discontinued; however, staff documented that the physician was notified and the physician did not want to change the resident's medications because the resident's family did not want any changes.</p> <p>A review of a "Psychotropic Medication Monitoring Tool" dated 07/08/13 revealed the resident continued to receive Seroquel and Geodon medications. According to the monitoring tool, the medications were effective because the resident had decreased restlessness at night. The documentation revealed the resident was receiving two medications to treat the same symptoms or condition and Seroquel should be discontinued. However, there was no evidence Seroquel was discontinued at that time.</p> <p>A review of a "Psychiatric Follow-Up Evaluation" dated 08/08/13 revealed, "Staff reported patient hasn't had any recent mood or behavior problems noted," and the resident continued to receive Geodon and Seroquel medication. According to the psychiatric follow-up, Geodon or Seroquel should have been discontinued because Resident #17 was receiving "two atypical antipsychotics."</p> <p>A review of Resident #17's physician's orders revealed Seroquel medication was discontinued on 08/12/13, and on 08/14/13 a physician's order was written to add diagnoses of Vascular Dementia, Delusional Disorder, Depressive</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>Disorder, and Anxiety Disorder to the resident's medical record "to support use of Geodon."</p> <p>A review of Resident #17's "Behavioral Detail Report" for 07/01/13 through 09/12/13 revealed Resident #17 had two behaviors. On 07/18/13 at 3:22 PM, staff documented the resident refused "to be checked for both rounds." On 07/23/13 at 2:55 PM, staff documented Resident #17 "hit us while trying to change [him/her]." Staff documented the behavior did not impact the resident or others. The resident did not have any documented behavior after 07/23/13.</p> <p>A review of a "Psychotropic Medication Monitoring Tool" dated 08/21/13 revealed the resident was without behaviors but continued to receive Geodon. The interdisciplinary team chose not to request a reduction attempt and would try a reduction attempt with the next assessment due to a recent decrease in antipsychotic medication.</p> <p>A review of a "Consultant Pharmacist Communication to Physician" dated 08/21/13 revealed the facility pharmacist documented the resident was receiving Geodon medication. "This elderly resident is currently on antipsychotic therapy for a dementia-related diagnosis. Please be aware that there is a FDA boxed warning that states 'Elderly patients with dementia-related psychosis treated with an antipsychotic are at increased risk of death compared to placebo.' Most deaths appear to be cardiovascular or infectious in nature. Therefore, these agents are not approved for the treatment of dementia-related psychosis." The pharmacist further documented, "Please re-evaluate the risks vs [versus] benefits of continuing antipsychotic therapy in this resident. Consider tapering off the</p>	F 329		

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F 329	<p>Continued From page 9</p> <p>current medication and adding an alternative from a different class of agents if behaviors are still unmanageable without medication therapy."</p> <p>Further review of the pharmacist's communication to Resident #17's physician revealed the physician agreed with the pharmacist and signed the communication form on 08/29/13. However, physician's orders were not written regarding the antipsychotic medication.</p> <p>4. A review of Resident #9's medical record revealed the facility admitted the resident on 09/25/09, and the resident had diagnoses that included Alzheimer's disease, Depression, Anxiety, and Psychosis.</p> <p>A review of the annual Minimum Data Set (MDS) completed by the facility on 07/03/13 revealed Resident #9 exhibited verbal behavioral symptoms directed toward others that did not affect the resident or others. According to the assessment, Resident #9 did not exhibit physical behavioral symptoms or any other behavioral symptoms. However, according to the assessment, Resident #9 had received antipsychotic medications during the last seven days of the assessment.</p> <p>A review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 06/27/13 revealed Resident #9 was receiving Geodon (antipsychotic medication). Further review of the CAA for the resident revealed the resident had a long history of behavioral issues such as crying, yelling, restlessness, and agitation with staff. According to the CAA, the behavioral episodes had decreased with the medication regimen and the</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET TOMPKINSVILLE, KY 42167		
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F 329	<p>Continued From page 10 resident was "stable and doing well."</p> <p>Observations of Resident #9 on 09/11/13 at 10:55 AM and 2:50 PM revealed the resident moaned when staff provided personal care.</p> <p>Interviews with SRNA #3 on 09/10/13 at 6:45 PM and on 09/11/13 at 10:55 AM revealed Resident #9's behavior consisted of yelling during bathing. The SRNA stated the resident "did better" if the resident received medications before the bath.</p> <p>An interview with LPN #3 on 09/11/13 at 10:55 AM revealed Resident #9 yelled during bathing and sometimes yelled when he/she was eating or taking medications. The LPN stated the resident received Geodon and Trazodone (antidepressant) medications that helped decrease the behavior.</p> <p>An interview with SRNA #5 on 09/12/13 at 2:15 PM revealed the resident yelled/moaned during bathing. The SRNA stated she believed the reason for the behavior was because the resident was in pain.</p> <p>A review of Resident #9's Behavior Report completed by the facility revealed the resident had nine episodes of either resisting care or screaming at staff from 06/14/13 through 09/11/13 at 2:10 PM. Further review revealed the resident hit a staff member on 09/05/13; however, the behavior had no impact on the resident or others.</p> <p>A review of a Psychiatric Follow-Up Evaluation dated 07/10/13 revealed the resident had a diagnosis of Alzheimer's Dementia, late onset with disturbance of mood and behavior; Delusions; Depressive Disorder, Psychosis, and</p>	F 329			

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F 329	<p>Continued From page 11</p> <p>Anxiety and was receiving Geodon 20 mg every 12 hours since 08/01/13.</p> <p>A review of the Psychotropic Monitoring Tool dated 06/27/13 revealed the resident received Geodon for Alzheimer's Dementia with psychosis and for "restlessness" and "yelling out." The monitoring tool revealed the resident's behavioral episodes had decreased; however, facility staff did not request a reduction attempt because the resident's behaviors continued.</p> <p>A review of a "Consultant Pharmacist Communication to Physician" dated 08/21/13, revealed Resident #9 continued to receive Geodon 20 mg every 12 hours. The pharmacist documented that the resident was receiving antipsychotic therapy for a dementia-related diagnosis and that there was a FDA boxed warning that states, "Elderly patients with dementia-related psychosis treated with an antipsychotic are at increased risk of death compared to placebo." According to the pharmacist communication to Resident #9's physician, "Most deaths appear to be cardiovascular or infectious in nature. Therefore, these agents are not approved for the treatment of dementia-related psychosis." The pharmacist further documented that the physician should re-evaluate the risks versus benefits of continuing antipsychotic therapy in Resident #9 and to consider tapering off the current medication and adding an alternative from a different class of agents if behaviors were still unmanageable without medication therapy.</p> <p>An interview with the Consultant Pharmacist on 09/12/13 at 4:50 PM revealed she sent the warning dated 08/21/13 to Residents #1, #9, #11,</p>	F 329			

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F 329	<p>Continued From page 12</p> <p>and #17's physicians to ensure they were aware of the warning of using antipsychotic medications with residents who had dementia. The pharmacist stated the residents were not due for a reduction attempt (usually attempts a gradual dose reduction every six months if the resident has been on the medication less than one year and annually if the resident has been on the medication for more than one year), but wanted to be sure the physicians were aware of the warning because they should consider a plan in the future to reduce the antipsychotic medication and "get rid of them." According to the pharmacist, the physician signed the recommendation and the pharmacist "assumed" that by signing the document the physician was stating he/she understood there was a warning and would look at reducing this resident's medications at a later date.</p> <p>An interview with the physician for Residents #9, #11, and #17 on 09/12/13 at 5:20 PM revealed antipsychotic medications were initiated for these residents due to behaviors of fighting, falling, and/or grabbing other people; however, they were doing much better compared to three months ago. The physician stated when residents were stable and the medications seem to be working, he did not want to change their medication.</p> <p>An interview with the facility Administrator and Director of Nursing (DON) on 09/12/13 at 10:00 AM revealed the facility had been working on reducing antipsychotic drug use in the facility and on 07/30/13 changed the program and began meeting weekly to review the medical record and discuss the residents who were receiving antipsychotic medications. According to the Administrator, she believed that if a resident had</p>	F 329			

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F 329	Continued From page 13 a diagnosis of Psychosis, Hallucinations, or Delusions, it was acceptable for the resident to receive antipsychotic medication. In addition, the DON stated the facility had a new consultant pharmacist effective 08/01/13. The DON asked the pharmacist to review the medical record for the residents who received antipsychotic medications. The DON stated the pharmacist found that there was no documentation that the physicians were aware of the risks of the residents receiving antipsychotic medications and as a result sent out the "Consultant Pharmacist Communication to Physician" to physicians on 08/21/13. The DON stated they planned to request antipsychotic medication reductions for Residents #1, #9, #11, and #17 during future quarterly care plan meetings.	F 329	On 9/11/2013 Dietary Manager moved white plastic containers used for dirty dish clothes from dry food storage area to the dishwashing room.  On 9/17/2013 Dietician completed a Sanitation Check of the Kitchen ensuring that the facility's food is stored, prepared, distributed, and served under sanitary conditions. Concerns noted by Dietician were fixed immediately.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to store food under sanitary conditions. Observation during the initial tour of the kitchen on 09/10/13, at 3:00 PM, revealed two plastic	F 371	On 9/27/2013 Dietary Manager educated dietary staff members on where the dirty dish clothes should be stored, about the Dry Food Storage Policy, and about the items audited on the sanitation check.  Weekly Dietary Manager will perform a Sanitation Check. Dietary Manager will fix and address any concerns she finds on the sanitation checklist immediately. Monthly Dietician will assist Dietary Manager in doing a Sanitation Check. A copy of the completed		

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F 371	<p>Continued From page 14</p> <p>containers with lids that contained soiled dishcloths stored in the dry food storage room. In addition, a soiled dishcloth with a pink substance on it was observed on the floor beside the plastic containers.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Food and Non-Food Storage," dated 2006, revealed dry foods would be stored in well-lit storage areas and would be protected from splashes and other contamination during storage.</p> <p>Observation of the dry food storage room on 09/10/13, at 3:00 PM, revealed a white plastic container with a lid and a clear plastic container with a lid both containing soiled dishcloths. The plastic containers were observed to have dried brown debris on the outside of the containers. A soiled dishcloth with a pink substance on it was observed on the floor beside the plastic containers.</p> <p>An interview conducted with the Dietary Manager on 09/12/13, at 2:20 PM, revealed she had not considered storing soiled dishcloths in the same area as dry foods a concern. However, after consideration, the Dietary Manager stated she could see how this practice could be a concern.</p> <p>An interview conducted with the Registered Dietitian (RD) on 09/12/13, at 2:30 PM, revealed she completed a monthly sanitation check as part of the Quality Assurance program, and had not identified any issues regarding sanitation during her sanitation checks. The RD stated the plastic containers with the soiled dishcloths were covered and she had not considered storage of</p>	F 371	<p>sanitation checklist will be given to the administrator. Dietary Manager will report results of sanitation inspections at the Quarterly QA meeting.</p> <p>Completed</p>	10/11/2013	

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F 371	Continued From page 15 the containers in the dry food storage room as a concern. However, the RD stated the soiled dishcloth on the floor was a concern.	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/10/2013
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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET TOMPKINSVILLE, SOUTH CAROLINA 29157
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type 111(000)  SMOKE COMPARTMENTS: 6  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 09/10/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "F" level.	K000	K144 Load test was completed by Evapar on 10/2/2013.  No other concerns with the generator were identified  On 9/27/2013 Maintenance Director revised his preventative maintenance schedule to include a yearly load test instead of every three years.  Each year Maintenance Director will give Administrator a copy of the load test. Annually, the Maintenance Director will report the results of the load test in the 4th quarter quality assurance meeting.  Completion Date	10/11/2013
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Misty Paige Cook* TITLE: *Administrator* (X6) DATE: *10/6/2013*

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

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K 144	Continued From page 1 accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 104 beds with a census of 103 on the day of the survey.  The findings include:  During the Life Safety Code survey on 09/10/13, at 3:30 PM, an interview and record review with the Director of Maintenance (DOM) revealed the diesel-fueled generator operated at approximately 15 percent of the load capacity rating when tested on a monthly basis. Diesel-powered generators are required to run at not less than 30 percent capacity or the generator must be properly loaded on an annual basis. This type of testing helps ensure the generator operates as intended in an emergency situation. Documentation revealed the generator was last load tested on 03/22/11.  The DOM stated the generator was load tested every three years and he was not aware of the proper testing requirements for the generator.	K 144			

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K 144	<p>Continued From page 2</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p>	K 144		