

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

PRINTED: 08/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 N MAGNOLIA STREET, PO BOX 387 TOMPKINSVILLE, VA 22167 Division of Health Care Southern Enforcement Branch	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F246	
F 246 SS=D	<p>A standard health survey was conducted 07/24-26/12. Deficient practice was identified with the highest scope and severity at "E" level. 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policy/procedure it was determined the facility failed to make reasonable accommodations for call light usage for one of twenty sampled residents (Resident #3). The resident was severely visually impaired and the resident's call light was observed out of the resident's reach on 07/24/12 and 07/25/12.</p> <p>The findings include:</p> <p>The facility had no specific policy/procedure related to call lights; however, the facility's Standards of Care for staff to follow stated the resident's call light must be within reach.</p> <p>Review of the medical record of Resident #3 revealed the facility admitted the resident on 07/01/09, with diagnoses that included chest pain, anxiety, hypertension, Alzheimer's disease,</p>	F 246	<p>On 7/25/2012 Resident #3s call light was placed in reach. A wireless pendant from the facility's call light system vendor was purchased and was attached to the resident's clothing on 8/13/2012. On 8/13/2012 the administrator informed the resident of the location of the pendant and on how to use the pendant to call for assistance. The Administrator educated nursing staff member on how to operate the call pendant on 8/10/2012.</p> <p>On 7/25/2012 call lights were checked by the charge nurses to ensure they were in reach of all residents. All other call lights were in reach of the residents. On 8/15/2012 the Interdisciplinary Team identified other residents with special needs. It was determined that the call lights in use are appropriate for our other residents.</p> <p>On 8/10/2012 the DON reeducated nursing staff members on the importance of making sure residents' call lights are within reach at all times. On 8/13/2012 the Administrator educated nursing staff members on how to use the call</p>	

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

TITLE

(X6) DATE

*Mitzzy Cook*

*Administrator*

*8/17/2012*

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 246	Continued From page 1 non-psychotic brain syndrome, and blindness. Review of the significant change assessment for Resident #3 dated 10/17/11, revealed the resident had severely impaired vision and required the assistance of one staff member for bed mobility, transfers, and ambulation.  Observations of Resident #3 on 07/24/12, at 12:55 PM, 1:25 PM, 2:05 PM, 3:22 PM, 4:15 PM, 5:05 PM, and 6:15 PM, revealed the resident's call light was looped around a hook on the wall approximately four feet above the resident's bed and out of the resident's reach. Observations of Resident #3 on 07/25/12, at 8:20 AM, 9:17 AM, 10:32 AM, and 11:39 AM, revealed the resident's call light was placed at the foot of the resident's bed out of the resident's reach.  Interview on 07/24/12, at 6:15 PM, with Certified Nursing Assistant (CNA) #10, revealed she was responsible for the care of Resident #3 on 07/24/12. According to CNA #10, the resident's call light should be within reach at all times. The CNA was unaware the call light was on the wall out of the resident's reach.	F 246	pendant purchased for Resident #3. On 8/13/2012 the Administrator placed call pendant on Resident #3. On 8/13/2012 Resident#3s care plan and personal care record were updated to include the pendant. Nursing staff members were told to communicate any issues with call light placement.  Each shift Resident #3s charge nurses will ensure and document on the MAR that call pendant is attached to the resident's clothing. Weekly the DON will review resident #3s MAR to ensure that nurses are checking for call light pendant placement. At least weekly the Administrative Staff will check all resident rooms to ensure that call lights are in reach. Administrative Staff will address concerns immediately with the Nurse in Charge and report findings to the DON on Friday of each week. DON and Administrator will report findings to the Quality Assurance Committee on a Quarterly Basis.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		8/31/2012	

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F 279	Continued From page 2.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a care plan was developed for one of twenty sampled residents (Resident #15) that included measurable objectives and timetables to meet the resident's needs. Resident #15 was admitted to the facility with a diagnosis of End Stage Renal Disease that required dialysis treatment. The facility failed to develop a plan of care for Resident #15 that addressed the risk factors, potential complications, and/or specific dialysis related care needs.  The findings include:  Review of the facility's policy/procedure Assessment/Care Planning, dated as revised 06/06/11, revealed once the Minimum Data Set (MDS) and Care Area Assessment (CAA) was completed a Care Plan would be developed to guide staff to provide optimal/individualized care for each resident.	F 279	F279  On 7/27/2012 a copy of the care plan from the dialysis center was received. On 7/27/2012 the MDS coordinator reviewed the care plan from the dialysis center and updated the facility's care plan and personal care record to correlate with the medical care provided at the dialysis center. On 8/3/2012 the facility's dietician contacted the dietician at the dialysis center to discuss the nutrition needs of resident #15. On 8/10/2012 the dietician reviewed and updated the nutrition care plan for resident #15. The resident's care plan now addresses the special nutritional and fluid volume needs, care of the access site, monitoring of vital signs, weights, and instructions regarding giving medications in an effort to prevent dialysis treatment from removing medication from the resident's system.  No other residents at the facility are receiving dialysis treatments.  A Dialysis Communication Record which includes comments from the facility's nurse, medications given at the dialysis center during and after treatment, pre and post treatment	

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F 279	Continued From page 3  Review of the medical record of Resident #15 revealed the facility admitted the resident on 05/16/12, with diagnoses that included cardiovascular disease, diabetes mellitus, hypertension, dysphasia, and chronic kidney disease. Review of the comprehensive assessment for Resident #15 dated 05/23/12, revealed the resident was severely cognitively impaired and required extensive assistance of two staff members for activities of daily living. Additionally, the resident was assessed to require outpatient hemodialysis treatments three times a week.  Review of the Comprehensive Care Plan for Resident #15, dated 05/28/12, revealed the resident required dialysis three times a week and staff was to observe the shunt for signs/symptoms of infection or edema. The care plan did not address the special nutritional and fluid volume needs, care of the access site, monitoring of vital signs, weights, or instructions related to timeframes for administering the resident's medications in an effort to prevent dialysis treatments from removing medication from the resident's system. There was no evidence the care plan incorporated dialysis center protocols for continuity of care. There was no evidence in the care plan of coordination between the facility and the certified dialysis center. The care plan included a problem area related to a risk for alteration in the resident's nutrition and hydration status and a goal for the resident to lose one to two pounds each month, to reach the weight goal of 196-202 pounds; however, a review of the orders for treatment at the dialysis center revealed the resident had a	F 279	weight, pre and post treatment vital signs, access problems, special instructions, and a request of a copy of all labs done by the dialysis center was devised. On 8/10/2012 the DON informed Nurses that the Dialysis Communication Record should be sent with Resident #15 each time Resident #15 goes to the dialysis center for treatment. The DON informed Nurses to read, act upon, and file the Dialysis Communication Record in the Medical Chart when the resident returns from the Dialysis Center. The MDS Coordinator or the MDS nurse in her absence and the Dietician will review The Dialysis Communication Records at least weekly. Care plans will be updated accordingly.  The MDS Coordinator or the MDS nurse in her absence will review the Dialysis Communication Process for compliance at least weekly for four weeks and then monthly thereafter to ensure that appropriate revisions have been made to Resident #15s plan of care. QA Findings will be reported to the Director of Nursing, Administrator and Dietary Manager weekly and the Quality Assurance Committee quarterly.	9/3/2012	

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F 279	Continued From page 4 physician-ordered target weight (weight at which the resident would have no excess fluid) of 180 pounds. The care plan also listed interventions that included a regular, no-added-salt diet and a nutritional treat at lunch.  Observations of Resident #15 on 07/26/12, at 9:01 AM, revealed the resident was in bed being fed by staff. The resident was non-responsive to questions  Interview on 07/26/12, at 10:40 AM, with Certified Nursing Assistant (CNA) #5 revealed she would follow the resident's care plan to provide care and treatment to the resident. According to CNA #5, if needs were not on the care plan she would not know what to do for the resident.  Interview on 07/26/12, at 10:20 AM, with CNA #9 revealed the CNA had not cared for Resident #15 prior to 07/26/12. CNA #9 stated she followed the care plans for the residents. CNA #9 stated she was responsible for the care of Resident #15 on 07/26/12, but would not know what the resident's care needs were if they were not on the care plan.  Interview with the Registered Dietitian (RD) on 07/26/12, at 9:57 AM, revealed the RD had not contacted the dialysis center related to the nutritional needs for Resident #15 and had developed the nutritional plan of care without consultation with the dialysis center.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in	F 282	F282  On 7/24/2012 the alert mate was placed on Resident #2 by the Charge Nurse. On 7/30/2012 members of the Falls Committee reassessed the	

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F 282	<p>Continued From page 5</p> <p>accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide services in accordance with the written plan of care for one of twenty sampled residents (Resident #2). The facility failed to ensure Resident #2 had personal alarms in place in accordance with the resident's plan of care.</p> <p>The findings include:</p> <p>A review of the facility policy, Assessment Care Planning Policy and Procedure (dated 06/06/11), revealed care plans included a plan to promote a more independent state or maintained a resident at the current functioning level. The policy further revealed the care plan was developed to guide staff to provide optimal/individualized care for each resident.</p> <p>A review of Resident #2's Comprehensive Care Plan dated 04/25/12, revealed two alarm mats were to be in place at all times and placed in an area the resident could not reach. According to the care plan, the cords to the alarm mats were to be short so the alarms activate quickly.</p> <p>Observations of Resident #2 on 07/24/12, at 12:40 PM, 1:45 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, and 6:00 PM, revealed the resident was in bed with a personal alarm affixed to the bed frame. However, the cord and clip for the alarm</p>	F 282	<p>resident's needs and discontinued the use of two alarms. On 8/2/2012 the ADON put a new clip on Resident #2s alert mate, to keep the alarm attached to the resident.</p> <p>On 8/2/2012 the Director of Nursing compiled a list of alarms used. On 8/2/2012 the Director of Nursing checked all alarms to assure alarms were on residents correctly and in proper working order.</p> <p>On 8/10/2012 Resident's MARs were updated to reflect residents with alarms and alert nurses to check to see if they are in place and working properly with each med pass. The ADON will keep an up to date list of residents with alarms. The ADON will ensure that any new alarms are added to the resident's MAR and any discontinued alarms are taken off of the resident's MAR. On 8/10/2012 the Director of Nursing reeducated nursing staff members on the importance of ensuring that alarms are placed properly and in working order. On 8/10/2012 the Director of Nursing educated Nurses on the importance of checking for alarm compliance, taking care of any problems found,</p>	

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F 282	Continued From page 6 were lying on the floor instead of attached to the resident.  Interviews with Certified Nursing Assistant (CNA) #5 and CNA #6 on 07/26/12, at 8:50 AM, with CNA #7 on 07/26/12, at 9:00 AM, with CNA #8 on 07/26/12, at 9:05 AM, and with RN #2 on 07/26/12, at 9:10 AM, revealed the personal alarms were to be attached to the resident at all times for Resident #2. The staff did not know why the alarms were not in place for Resident #2 on 07/24/12.  Interview with the Director of Nursing (DON) on 07/26/12, at 9:15 AM, revealed the supervisors check all alarms in the building one time weekly as a part of the quality assurance program. The DON stated the nurses were to check alarms for placement and functioning when they entered resident rooms and provided care. The DON further stated that CNAs were to put the alarms in place for Resident #2 after all care was provided. According to the DON, the alarms should be checked every time a staff member entered Resident #2's room. The DON did not know why the personal alarms were not attached to Resident #2 as required by the resident's Plan of Care.	F 282	and documenting findings on the MAR.  On a weekly basis the ADON will check alarms to ensure proper placement and that they are in working order. The ADON will also review MARs to ensure that the Nurses on each wing are checking for proper placement and working order on each med pass. Findings will be given to the DON and the Administrator weekly. Quarterly the findings will be reported to the Quality Assurance Committee.	9/3/2012
F 371 SS=D	483.35(j) 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	F 371	F371  On 7/24/2012 Cornmeal, Pinto Beans, and Nonfat Dry Milk in opened containers were thrown away and replaced with new product. On 7/26/2012 the soiled exterior of the milk cooler was cleaned by the head cook. No residents were negatively affected by the deficient practice.	

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F 371	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy/procedure, observation, interview, and record review, it was determined the facility failed to store food under sanitary conditions. Observations revealed dry foods stored in containers that were partially open and the dry food was exposed to air/possible contaminants and a milk cooler was in need of cleaning.  The findings include:  1. A review of the facility's dietary policy/procedure for Food and Non-Food storage (dated 2006) revealed plastic containers with tight-fitting lids were to be used to store dry food items.  Observation in the kitchen at 9:50 AM (CDT) on 07/24/12, revealed there were five plastic storage containers used to store dry food items located in the dry storage room. Observation further revealed three of the five storage containers did not have the lids tightly secured. The storage containers contained commmeal, pinto beans, and nonfat dry milk. The lids were loose and partially open, exposing the dry food items to the air/potential contaminants.  Interview at 10:00 AM on 07/24/12, with the Dietary Manager (DM) revealed kitchen staff was supposed to close the lids tightly after removing food from the storage containers.	F 371	On 8/13/2012 Dietary Manager replaced old dry food storage bins with new storage bins that are tilted and have sliding doors on top of the bins. The Dietary Manager updated the cleaning schedule for the milk cooler to include the Head Cook cleaning the exterior of the milk cooler after washing each meals pots and pans. On 8/10/2012 the Dietary Manager reeducated the dietary staff on the dry food storage policy, showed the staff the new storage bins and educated the dietary staff on the new cleaning schedule for the milk cooler.  For two weeks the head cooks will be checking the dry food storage bins every two hours to ensure that the bins are closed. For four weeks the dietary manager or her assistant in her absence will be checking the dry food storage bins for proper storage and the exterior wall of the milk cooler for cleanliness at least five times per week. After four weeks of compliance, the dietary manager or the assistant in her absence will check the dry food storage bins for proper storage and the milk cooler for cleanliness on a weekly basis.	

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F 371	Continued From page 8  2. A review of the facility's dietary policy/procedure (dated 2006) revealed employees were to follow routine cleaning schedules that indicated the frequency for cleaning equipment and the kitchen area.  A review of the Recommended Cleaning Frequency schedule dated 2006 revealed the refrigerator (milk cooler) was scheduled to be cleaned weekly.  Observation at 10:00 AM on 07/24/12, and at 1:30 PM on 07/26/12, of the exterior of a milk cooler located by the preparation sink revealed the exterior of the milk cooler was soiled with food particles and soap residue and was in need of cleaning.  Interview with the Dietary Manager on 07/25/12, at 10:05 AM, revealed the milk cooler should be cleaned weekly. The Dietary Manager agreed the milk cooler did not appear to have been cleaned in the past week.	F 371	Findings will be reported to the administrator on a weekly basis and the Quality Assurance Committee on a quarterly basis.	8/31/2012	
F 441 SS=E	483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441  Residents #1, #2, #9, and #16 did not suffer ill affects from the deficient practice. On 7/30/2012 the DON reeducated RN#1 on proper hand washing during wound care. The DON observed RN#1 providing wound care to assure understanding of proper hand washing to prevent the spread of infection. Before returning to work from her vacation on 8/18/2012 LPN #4 will be educated on proper hand washing during clean procedures. On 8/18/2012 the Director of Nursing will observe LPN#4 performing		

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F 441	<p>Continued From page 9</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to establish and maintain an effective infection control program to prevent the development and transmission of disease and infection for four of twenty sampled residents (Residents #1, #2, #9, and #16) and two unsampled residents. Observation of a wound dressing change for Resident #2 on 07/25/12,</p>	F 441	<p>wound care and care of G-tube to assure understanding of proper hand washing between procedures and after procedures. On 7/30/2012 the DON reeducated LPN #2 on the risk of placing dirty linens on the floor. On 8/1/2012 The DON reeducated C NA #3 on how to properly discard linens. DON observed CN A #3 change a bed and discard linens appropriately. On 7/30/2012 C NA #1 was reeducated on proper hand sanitizing while feeding residents. On 7/30/2012 the DON observed CNA#1 feeding residents to assure proper hand sanitizing.</p> <p>An Infection Control Subcommittee was established that includes nursing, housekeeping, administrative, and dietary staff members. The committee met on 7/31/2012 and will continue to meet monthly to discuss problems identified and discuss ways to prevent the spread of infection. The subcommittee has not found any other residents affected by this deficient practice.</p> <p>On 8/10/2012 the DON reeducated nursing staff members on the proper procedures of hand washing and hand sanitizing during wound care,</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/26/2012
NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 708 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
(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 441	<p>Continued From page 10</p> <p>revealed staff failed to wash/sanitize hands prior to and after every glove removal. Observation of Resident #1 on 07/24/12, revealed staff failed to wash/sanitize hands after glove removal following incontinence care; staff was then observed to provide gastric tube flushing and suctioning without washing/sanitizing hands after glove removal. In addition, observations on 07/26/12, revealed on two separate occasions staff placed dirty linens directly onto the floor in two resident rooms (Residents #9 and #16). One of three staff members observed during meal service on 07/24/12, at 1:42 PM, failed to wash/sanitize their hands between two unsampled residents.</p> <p>The findings include:</p> <p>A review of the facility policy/procedure, Hand Hygiene, dated as effective 08/01/12, revealed staff was required to use an alcohol-based hand rub before and after direct contact with residents, after contact with a resident's intact skin, and after contact with objects in the immediate vicinity of the resident. The facility did not provide a current policy/procedure for hand hygiene. Review of the policy titled Laundry and Linen Services (not dated) revealed linen would be handled, stored, and processed in a manner to control the spread of infection or diseases. The policy stated soiled linen was to be stored in plastic containers. The facility provided a copy taken from the Mosby Textbook for Long Term Care/Nurse Aide Training, 6th Edition/2011, which is used by the facility during training of nurse aides, which directed staff to never put clean or dirty linens on the floor.</p> <p>1. Observation of a wound dressing change for</p>	F 441	<p>between clean and dirty procedures, before and after any procedure and while feeding residents. On 8/10/2012 the DON educated staff members on the risks of lying dirty linens on the floor and on the proper procedure for handling dirty linens. All newly hired staff will be educated during orientation.</p> <p>Each week the Infection Control Nurse will observe at least one Nurse on each shift providing care for a resident. Each week the Infection Control Nurse will observe at least one Nurse Aide on each shift Changing Bed Linens, Providing Care, or Feeding a Resident. Observations will continue until each nurse and nurse aide has been observed at least two times. The Infection Control Nurse will correct any concerns observed immediately. Results will be reported to the DON and Administrator on a weekly basis. All findings will be reported to the Quality Assurance Committee on a quarterly basis.</p>	9/3/2012

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
(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 441	<p>Continued From page 11</p> <p>Resident #2 on 07/25/12, at 4:00 PM, revealed Registered Nurse (RN) #1 failed to wash hands prior to the wound dressing change. RN #1 applied gloves, removed the resident's soiled dressing, and removed/applied new gloves without washing her hands. The RN proceeded to cleanse the wound to the resident's right and left buttocks and applied a clean dressing to the wound. At that time, the RN removed the gloves and proceeded to wash her hands with soap and water.</p> <p>Interview with RN #1 on 07/25/12, at 4:05 PM, revealed hands should be washed before starting a treatment, after every glove removal, and then after the treatment was finished. RN #1 stated she failed to wash her hands before starting the dressing change and had also failed to wash her hands after changing gloves. RN #1 stated she became nervous during the observation and failed to wash her hands appropriately.</p> <p>2. Observation on 07/24/12, at 3:30 PM, revealed Licensed Practical Nurse (LPN) #4 donned gloves and performed a skin assessment for Resident #9. LPN #4 provided incontinence care using disposable wipes after the resident had a bowel movement. LPN #4 removed her gloves and immediately applied clean gloves but failed to wash/sanitize hands after the soiled gloves were removed. Further observation revealed LPN #4 flushed Resident #9's gastrostomy tube (G-tube) and reconnected the tube feeding. LPN #4 was observed to remove and discard the gloves but failed to wash/sanitize her hands after the gloves were removed. Resident #9 began coughing and gestured to the staff to indicate he/she needed suctioned. LPN #4 was observed to don a third</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
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F 441	<p>Continued From page 12</p> <p>pair of gloves to perform oral suctioning for Resident #9. LPN #4 removed and discarded the gloves and exited the resident's room without washing her hands.</p> <p>Interview with LPN #4 on 07/24/12, at 3:30 PM, revealed she was knowledgeable of the requirement to wash/sanitize hands after the removal of gloves. LPN #4 stated cross-contamination could occur if hands were not washed after removing gloves and between tasks as required.</p> <p>Interview on 07/26/12, at 3:00 PM, with the Infection Control Nurse revealed an in-service was conducted on 07/13/12, and staff was instructed to wash hands any time gloves were removed. The Infection Control Nurse concluded that staff should wash hands after the removal of gloves, when entering and exiting a resident's room, and between tasks such as skin assessment, incontinence care, G-tube flushing, and performing oral suctioning.</p> <p>3. Observation on 07/25/12, at 11:10 AM, revealed LPN #2 performed wound care for Resident #1. Following completion of the wound care, Resident #1 required incontinence care due to having a liquid bowel movement that soiled the linens on the resident's bed. LPN #2 was observed to provide incontinence care with disposable wipes. Further observation revealed LPN #2, with the assistance of Certified Medication Aide (CMA) #1, changed the soiled linens. Although LPN #2 and CMA #1 wore gloves and washed hands appropriately, observation revealed LPN #2 laid the soiled linens directly on the floor beside Resident #1's</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
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F 441	<p>Continued From page 13 bed.</p> <p>Interview on 07/25/12, at 2:05 PM, with LPN #2 revealed she was knowledgeable that linens should never be placed on the floor. LPN #2 stated soiled linens should be taken immediately to the soiled linen barrels in the hallway. LPN #2 stated she was focused on the resident's wound treatment and had not anticipated the resident having an incontinence episode. LPN #2 stated she contacted Housekeeping to clean the floor where the soiled linens were placed to prevent the transmission of germs throughout the facility.</p> <p>4. Observation on 07/26/12, at 11:30 AM, revealed CNA #3 had assisted Resident #16 with a partial bath at the resident's bedside. Upon entering Resident #16's room a draw sheet was observed lying on the floor at the foot of the resident's bed. Further observation revealed a wedge cushion enveloped in a pillowcase and a bed pillow covered with a pillowcase was lying on the floor near the sink. CNA #3 was observed to transfer Resident #16 from the bed to a recliner using a mechanical lift. CNA #3 removed all linens from the bed and placed the soiled linens on the floor under the sink. CNA #2 placed clean linens on Resident #16's bed and then obtained the wedge pillow and the bed pillow from the floor and placed the pillows on the resident's bed. Continued observation revealed CNA #2 exited the room, discarded the soiled linens in a dirty linen barrel, and then entered Resident #9's room to assist another CNA with transferring the resident from the bed to a wheelchair. After the transfer, CNA #2 was observed to remove the linens from Resident #9's bed and place the soiled linens on the floor.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
(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)	(X6) COMPLETION DATE	
F 441	Continued From page 14  Interview with CNA #3 conducted on 07/26/12, at 2:50 PM, revealed he was knowledgeable of the requirement to immediately remove soiled linens from resident rooms and place the linens in the soiled linen barrels. CNA #3 stated he realized he should not have placed the pillows that had been on the floor on Resident #16's bed and returned to the resident's room and changed the pillowcases. CNA #3 stated he had hurried to complete the bed changes and had a bad habit of placing dirty linen under the sink until he had completed the necessary tasks in the resident's room. CNA #3 stated as a result of putting soiled linens on the floor, staff/residents could come into contact with bacteria and transmit bacteria throughout the facility.  Interview on 07/26/12, at 3:00 PM, with the Infection Control Nurse revealed linens should never come in direct contact with the floor and should be placed in the dirty laundry barrels stored in the hallway. The Infection Control Nurse provided documentation of an infection control in-service dated 02/10/12, where staff had been instructed that soiled linens and briefs were not to be placed on the floor.  5. Observations of the noon meal on 07/24/12, at 1:07 PM, revealed three staff members feeding three residents each at tables in the dining room. Certified Nursing Assistant (CNA) #1 was observed at 1:42 PM, with three residents at a crescent-shaped table. CNA #1 was feeding the three residents at the table. The CNA was observed to wipe the mouth of one resident with a napkin and proceed to feed another resident without washing/sanitizing her hands between the	F 441			

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167
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F 441	Continued From page 15 two residents.  Interview with CNA #1 revealed she would sanitize her hands using the sanitizer attached to the wall when passing resident trays. CNA #1 stated it was not necessary to wash/sanitize her hands between feeding residents as she was not touching anything. CNA #1 confirmed she did not have sanitizer with her to use if needed.  Interview with CNA #10 on 07/24/12, at 1:59 PM, revealed the CNA was responsible for feeding three residents at her table. CNA #10 stated she was required to use hand sanitizer between residents and carried sanitizer in her pocket.	F 441		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT  If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.  Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.  This REQUIREMENT is not met as evidenced	F 500	F500  On 7/27/2012 the Director of Nursing contacted the dialysis center and received a copy of the resident's current plan of care. On 8/1/2012 the DON notified the dialysis center that going forward we would be sending a Dialysis Communication Sheet with Resident #15 each time that she receives dialysis treatment. The DON asked that the Dialysis Center complete the form and return it to the facility after each treatment.  No other resident in the facility is receiving dialysis.	

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
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F 500	<p>Continued From page 16</p> <p>by:</p> <p>Based on interviews and record reviews it was determined the facility failed to coordinate care with outside resources that provided services to one of twenty sampled residents (Resident #15). Resident #15 required outpatient hemodialysis treatments three times a week due to end stage renal failure. There was no evidence the facility coordinated care with the certified dialysis center.</p> <p>The findings include:</p> <p>Review of the facility's agreements with outside resources revealed an agreement with a certified dialysis center to provide services to the residents in the facility. Further review of the agreement revealed (under Section 2, #B) the parties agreed to cooperate and share in the development and implementation of the resident's plan of care.</p> <p>Review of the medical record of Resident #15 revealed no documented evidence of communication between the dialysis center and the facility.</p> <p>Interview on 07/26/12, at 9:50 AM, with Licensed Practical Nurse (LPN) #3 revealed staff communicated with the dialysis center by telephone if there were any changes in a resident's condition. The LPN stated staff was required to document the telephone conversation in the nursing notes.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 07/26/12, at 11:12 AM, revealed she had been responsible for development of the care plan for Resident #15. LPN #5 acknowledged she had not communicated with the dialysis center for</p>	F 500	<p>A Dialysis Communication Record which includes comments from the facility's nurse, medications given at the dialysis center during and after treatment, pre and post treatment weight, pre and post treatment vital signs, access problems, special instructions, and a request of a copy of all labs done by the dialysis center was devised. On 8/10/2012 the DON informed Nurses that the Dialysis Communication Record should be sent with Resident #15 each time Resident #15 goes to the dialysis center for treatment. On 8/10/2012 the DON informed Nurses to read, act upon and file the Dialysis Communication Record in the Medical Chart when the resident returns from the Dialysis Center. The MDS Coordinator or the MDS nurse in her absence and the Dietician will review the Dialysis Communication Record at least weekly.</p> <p>The MDS Coordinator or the MDS nurse in her absence will review the Dialysis Communication Process for compliance at least weekly for four weeks and then monthly thereafter to ensure that the facility and the dialysis center are completing the</p>		

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
(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 500	Continued From page 17 care needs related to the resident's need for dialysis. LPN #5 was unaware of the specific risks/complications related to hemodialysis treatment.  Interview with the Assistant Director of Nursing (ADON) on 07/26/12, at 10:52 AM, revealed the dialysis center would contact the facility for any problems/concerns identified for the resident. The ADON stated the facility would contact the dialysis center with any change in condition that would prevent the resident from going to dialysis.  Interview with the Director of Nursing (DON) on 07/26/12, at 9:29 AM, revealed staff communicated with the dialysis center by telephone. The DON was unsure whether staff documented the conversation with the dialysis center. The DON reviewed the medical record and confirmed there was no evidence in the record of communication with the dialysis center. According to the DON, the facility had not requested any information from the dialysis center related to laboratory results or treatment records.	F 500	form. QA Findings will be reported to the Director of Nursing and the Administrator weekly and the Quality Assurance Committee quarterly.	9/3/2012	

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER						
STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, MISSISSIPPI 39216						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	STATEMENT OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 07/31/12. 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.			K 000	K050  No resident have been affected by this deficient practice  On 8/10/2012 Administrator instructed the Maintenance Director to do Fire Drills at varying times going forward. Maintenance Director will not consult with administrative staff members on when to do fire drills. Each fire drill within a calendar year will be spaced at least an hour apart.  After performing the fire drill, the Maintenance Director will give the Administrator a copy of the Sign in Sheet. The administrator will track the fire drills to ensure that they are being performed at varying times. Results of the fire drill tracking will be reported to the Quality Assurance Committee on a quarterly basis.	8/31/2012
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.			K 050		

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

TITLE

(X6) DATE

*Marty Cook*

*Administrator*

*8/17/2012*

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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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	<p>Continued From page 1.</p> <p>The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to conduct and document fire drills as outlined by NFPA standards. The facility did not ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness and this failure affected all residents and staff in the facility. The facility has the capacity for 108 beds with a census of 102 residents on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/31/12, at 12:50 PM, with the Director of Maintenance (DOM), a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on all three shifts. From July 2011 to July 2012, four of five first shift fire drills were between the hours of 10:11 AM and 10:50 AM. Three of four second shift fire drills were between the hours of 4:06 PM and 4:37 PM. Four third shift fire drills were between 5:59 AM and 6:35 AM. An interview with the DOM on 07/31/12, at 12:50 PM, revealed he did</p>	K 050		

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:  185168	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  07/31/2012
NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE .706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 050	Continued From page 2 not perform fire drills at varying times because staff did not want to do fire drills at inopportune times.	K 050			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 108 beds with a census of 102 on the day of the survey.  The findings include:  During the Life Safety Code survey on 07/31/12, at 11:40 AM, with the Director of Maintenance (DOM), mismatched temperature rated sprinkler heads were observed in resident room B7. Sprinkler heads must be properly matched to ensure proper operation. During the survey, six resident rooms and four other types of rooms in the A and B Wings of the facility were observed to have mismatched sprinkler heads. Paint was also observed on sprinkler heads throughout the facility. Foreign matter on sprinkler heads decreases their ability to react as intended in a fire situation. An interview with the DOM on 07/31/12, at 11:40 AM, revealed he was not	K 062	K062  No residents were affected by the deficient practice.  On 8/13/2012 the Administrator called Eagle Fire Protection to request a bid to replace mismatched temperature rated sprinkler heads, sprinkler heads that are painted and cannot be cleaned, corroded, damaged, loaded or in the improper orientation. On 8/14/2012 Maintenance Department began cleaning paint off of Sprinkler heads that can be cleaned. On 8/14/2012 representative from Eagle Fire Protection came to the facility and assisted the Maintenance Director and the Administrator in deciding which sprinkler heads needed to be replaced. On 8/17/2012 the Administrator signed a contract for the mismatched temperature rated sprinkler heads, sprinkler heads with corrosion, foreign materials, paint that cannot be cleaned off, and		

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NAME OF PROVIDER OR SUPPLIER  MONROE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167	
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K 062	<p>Continued From page 3 aware of these requirements.</p> <p>At 1:00 PM, a quarterly sprinkler inspection report dated 06/29/12, revealed paint on sprinkler heads, and corroded sprinkler heads needed to be repaired and/or replaced. An interview with the DOM revealed no action had been taken on the sprinkler heads.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Reference: NFPA 13 (1999 edition) 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.</p>	K 062	<p>physical damage be replaced by Eagle Fire Protection. Sprinkler heads are ordered and will be replaced as soon as they are received but no later than 9/30/2012.</p> <p>On a monthly basis the Maintenance Director will audit the sprinkler heads throughout the building for mismatched temperature rated sprinkler heads, sprinkler heads with corrosion, foreign materials, paint, and physical damage. On a quarterly basis Eagle Fire Protection will inspect the sprinkler system for compliance. A copy of the monthly and quarterly audits will be given to the Administrator. Going forward problems with the sprinkler heads will be addressed in a prompt manner.</p>	9/7/2012