

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

PRINTED: 10/01/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/25/2008
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 NORTH LONG AVENUE TAYLOR, AR 71861		
(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 329} SS=E	<p>483.25(I) 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 and interview, the facility failed to ensure a dose reduction was attempted or there was clinical justification for the continued use of a proton pump inhibitor for 1 (Resident #9) of 3 (Resident #2, 3 and 9) case mix residents who received a proton pump inhibitor. The facility failed to ensure a gradual dose reduction was attempted for 2 (Resident #7 and # 8) of 4 (Resident #3, 4, 7 and 8) case mix residents who received</p>	{F 329}			
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 329}	Continued From page 1 antidepressant medications. These failed practices had the potential to affect 19 residents who received a proton pump inhibitor and 26 residents who received an antidepressant medication as documented on a list received from the ADON (Assistant Director of Nursing) on 9/24/08. The findings are: 1. Resident #9 had diagnoses of Multiple Sclerosis and Gastroesophageal Reflux Disease. The Quarterly Minimum Data Set (MDS) dated 8/17/08 documented the resident had modified independence in cognitive skills for daily decision making and was totally dependent on staff for all activities of daily living. a. A physician order dated 11/30/07 documented, "Prilosec OCT (over the counter) 20 mg. (milligrams) tab (tablet) one PO (by mouth) daily." b. A pharmacy consult report to the physician dated 4/8/08 documented, "May we discontinue the Prilosec 20 mg. TR (time release) capsule and start Pepcid 10 mg. 2 tabs (20 mg.) BID (twice a day)." The consult documented, "Continue current orders" and was signed by the physician on 4/12/08. c. A pharmacy consult report to the physician dated 7/21/08 documented, "May we discontinue the Prilosec 20 mg." The consult documented, "Continue current orders" and was signed by the physician on 7/24/08. d. A physician order dated 9/3/08 documented, "1. D/C (discontinue) Prilosec 20 mg 2. Pepcid 10 mg ii (2) tabs PO BID (twice a day)." e. On 9/23/08, the RN (Registered Nurse)	{F 329}			

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{F 329}	Continued From page 2 consultant stated, "We got [physician] to change from Prilosec to Pepcid. We thought that would be all right..." f. As of 9/24/08 there was no documentation in the clinical record to indicate a dose reduction was attempted, justification as to why an attempt would be contraindicated or why there was an increase in dosage of the proton pump inhibitor from 20 mg to 40 mg a day. 2. Resident #8 had diagnoses of Congestive Heart Failure and Depression. The Quarterly MDS dated 6/13/08 documented the resident was independent in cognitive skills for daily decision making, had no indicators of depression, anxiety or sad mood and received an antidepressant in the last 7 days. a. A physician order dated 12/10/07 documented, "Paxil 20 mg tab 1 PO daily and Remeron (Mirtazepine) 7.5 mg. one tab PO @ (at) HS (bedtime)." b. A pharmacist's consult to the physician dated 5/8/08 documented, "May we decrease to Paxil 10 mg. PO QD after current supply?" The physician's response to the consult dated 5/11/08 documented, "No changes are to be made at this time." c. The care plan updated 6/13/08 documented, "Problem Identity Date: 9/27/07 at risk for falls or injury related to psychotropic drug use: Medication, as ordered, document signs of side effects, effectiveness, reasons for taking and progress and review medication dosage with appropriate health care professionals to determine possible dose reduction trial..."	{F 329}			

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{F 329}	Continued From page 3 d. As of 9/23/08, there was no documentation in the clinical record to indicate a dose reduction was attempted since the initiation of the medication on 12/10/07. e. A Geriatric Depression Scale dated 9/10/08 documented the resident scored a "2" which a score greater than 5 would equal probable depression. f. On 9/23/08 at 4:30 p.m., the Assistant Director of Nursing (ADON), the Nurse Consultant and Licensed Practical Nurse (LPN) #2 were asked why this resident had not had a gradual dose reduction trial for the antidepressants. The Nurse Consultant stated, "We didn't get that one reduced, the pharmacist hadn't said anything..." 3. Resident #7 has diagnoses of Depression with Anxiety and Anxiety State. The MDS dated 7/27/08 documented the resident had short term memory problems, modified independence in cognitive skills for daily decision making, no mood or behavior problems and had received an antidepressant for the last 7 days. a. A physician order dated 7/24/06 documented, "Zoloft (Sertraline) 50 mg tab 1 PO Q (every) AM (morning)." b. The pharmacist's consult to physician dated 3/12/08 documented, "May we decrease to Zoloft 25 mg QAM after current supply?" The physician faxed a reply to the facility on 3/16/08 and documented, "Continue present management." c. A Geriatric Depression Scale dated 7/25/08 documented a score of 4. A score greater than 5	{F 329}			

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{F 329}	Continued From page 4 equals probable depression. d. On 9/23/08 at 4:30 p.m., the ADON stated, "I'll look for documentation of behaviors to justify the use of Zoloft... No, It doesn't; look like there had been any reduction." e. As of 9/24/08 there was no documentation in the clinical record to indicate a dose reduction was attempted since the initiation of the medication on 7/24/06. f. On 9/24/08 at 9:15 a.m., the ADON stated, "I can not find any documentation of behaviors in the nurses notes." g. On 9/24/08 at 9:20 a.m., RN #1 stated, "We do not use any behavior sheets, our company does not use them. Our policy is to document in the nurses notes."	{F 329}			