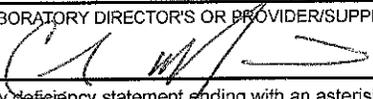


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  485286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/24/2014
NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE T SPARKS AVENUE JAMESTOWN, KY 42629	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 000  F 428 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 07/22-24/14. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the pharmacist reported drug irregularities to the resident's attending physician and the Director of Nurses (DON) for four (4) of twenty-three (23) sampled residents (Residents #1, #4, #18, and #23). Record review revealed Residents #1, #4, #18, and #23 had physician's orders for antidepressant medications to be administered routinely; however, there was no evidence the consultant pharmacist reviewed these medications for consideration for possible dosage reduction.</p> <p>The findings include:</p> <p>Review of the facility's policy for Reduction of the</p>	F 000  F 428	<p>Fair Oaks Health Systems Plan of Action Standard Survey 7/24/2014</p> <p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>F428</p> <p>The pharmacist shall report any irregularities to the attending physician, and the director of nursing, and these reports shall be acted upon.</p> <p><b>Criteria #1:</b> The drug regimen for residents # 1, 4, 18, and 20 were reviewed by the facility pharmacist on August 12, 2014 with the following recommendations made:</p> <p>Resident #1 - The facility pharmacist met with the interdisciplinary team to review Resident #1's antidepressant medications for consideration for possible dosage reduction. A Comprehensive Assessment for Gradual Dose Reduction/Tapering in Nursing Facilities was completed for Resident #1 and recommended to taper/discontinue the Celexa for Resident #1. See Attachment 1.</p> <p>Resident #4 - The facility pharmacist met with the interdisciplinary team to review</p>

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



TITLE

Administrator

(X6) DATE

8.15.14

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 428	<p>Continued From page 1</p> <p>Use of Antipsychotic, Psychopharmacologic, and Hypnotic Drugs (revision date April 2007), revealed gradual dose reduction/tapering would be evaluated and/or attempted twice in two separate quarters with at least one month between attempts for antipsychotics or psychopharmacologicals within the first year of initiation of these medications.</p> <p>1. Review of the medical record revealed the facility admitted Resident #1 on 12/31/08 with diagnoses that included Senile Dementia and Depression Disorder. Review of the July 2014 physician's orders revealed Celexa (antidepressant) 20 milligrams (mg) was prescribed to be administered daily. According to review of the physician's orders, the physician had initially prescribed the antidepressant medication, Celexa, on 01/03/14.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated 01/18/14 revealed the facility assessed Resident #1 to have no indicators of delirium and a depression score of 0, which indicated the resident had minimal depression.</p> <p>Review of the monthly pharmacy medication reviews dated 01/14/14 through 07/24/14 revealed no evidence the pharmacist had recommended a dosage reduction attempt for the use of Celexa which had been administered routinely to the resident since 01/03/14.</p> <p>2. Review of the medical record for Resident #4 revealed the facility admitted the resident on 03/28/11 with diagnoses that included Organic Mental Disorder and Depression.</p>	F 428	<p>Resident #4's antidepressant medications for consideration for possible dosage reduction. A Comprehensive Assessment for Gradual Dose Reduction/Tapering in Nursing Facilities was completed for Resident #4 and recommended to decrease the Effexor. See Attachment 1.</p> <p>Resident #18 - The facility pharmacist met with the interdisciplinary team to review Resident #18's antidepressant medications for consideration for possible dosage reduction. A Comprehensive Assessment for Gradual Dose Reduction/Tapering in Nursing Facilities was completed for Resident #18 and recommended to decrease the Celexa. See Attachment 1.</p> <p>Resident #20 - The facility pharmacist met with the interdisciplinary team to review Resident #20's antidepressant medications for consideration for possible dosage reduction. A Comprehensive Assessment for Gradual Dose Reduction/Tapering in Nursing Facilities was completed for Resident #20 and recommended to decrease the Celexa. See Attachment 1.</p> <p><b>Criteria #2:</b> A drug regimen review was completed on all current residents receiving Antidepressant medications by the facility pharmacist by August 15, 2014 to determine if there were any irregularities needing to be reported to the attending Physician and Director of Nursing.</p>	

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F 428	<p>Continued From page 2</p> <p>Review of the Consultant Pharmacist Report revealed the resident's physician had previously prescribed Lexapro (antidepressant) for the resident, and on 06/14/13, the pharmacist recommended to the resident's physician to change the resident's Lexapro to 75 mg of Effexor (antidepressant) on a daily basis, at bedtime.</p> <p>Documentation revealed on 07/26/13, the physician acknowledged the pharmacist's recommendation and prescribed the recommended dosage of 75 mg of Effexor to be administered at the resident's bedtime.</p> <p>Review of the annual comprehensive assessment dated 01/07/14 and the quarterly comprehensive assessment dated 06/10/14, revealed the facility assessed Resident #4 to have a score of 0 for Depression, which was noted to be minimal. In addition, the facility assessed Resident #4 to have no mood or behaviors.</p> <p>Further review of the Consultant Pharmacist Reports revealed from 06/14/13, the date the pharmacist made recommendations to change the resident's Lexapro to Effexor, through 07/22/14, there was no evidence the pharmacist had recommended a gradual dosage reduction attempt for the use of the Effexor, a timeframe of one year.</p> <p>3. Review of the medical record for Resident #18 revealed the facility admitted the resident on 12/19/11 with diagnoses that included Alzheimer's, Senile Dementia, Depressive disorder, and Unspecific psychosis.</p> <p>Review of the physician's orders revealed at the</p>	F 428	<p><b>Criteria #3:</b> The facility pharmacist received in-service education on the regulatory requirements of F tag 428 as provided by Nurse Consultant on August 12, 2014.</p> <p><b>Criteria #4:</b> The CQI indicator for monitoring of pharmacy services, including, but not limited to Antidepressant medication Gradual Dosage Reduction requests, shall be utilized monthly X 3, quarterly X 2 and then every 6 months thereafter under the supervision of the Director of Nursing and Medical Director. See Attachment 2.</p> <p><b>Criteria #5:</b> August 15, 2014</p>	8/15/2014

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F 428	<p>Continued From page 3</p> <p>time of admission on 12/19/11, Resident #18's physician prescribed 30 mg of Celexa, by mouth, once a day.</p> <p>Review of the quarterly comprehensive assessment dated 06/03/14, revealed the facility assessed Resident #18 as "0" for behaviors, "0" for the frequency of Mood and Behaviors, and "00" (minimal) for depression.</p> <p>Further review of the medical record revealed from 08/28/13 to 06/12/14, the consultant pharmacist had conducted a monthly medication regimen review for Resident #18; however, there was no evidence the pharmacist had identified the use of the anti-depressant medications for Resident #18 during this timeframe and no evidence the pharmacist had recommended a dosage reduction attempt for this medication that was administered on a routine basis to the resident.</p> <p>Review of physician's orders dated July 2014 revealed the physician continued to prescribe 30 milligrams of Celexa for Resident #18 at bedtime.</p> <p>4. Review of the medical record revealed the facility admitted Resident #20 on 03/07/08 with diagnoses including Psychosis, Anxiety Disorder, Depressive Disorder, Senile Dementia, and Insomnia.</p> <p>Review of the quarterly MDS assessment for Resident #20 dated 05/13/14 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. In addition, the resident was assessed to exhibit no episodes of delirium or behaviors</p>	F 428		

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F 428	<p>Continued From page 4 during the assessment period.</p> <p>Review of the July 2014 (dated 06/20/14) physician's orders revealed the physician prescribed 20 mg of Celexa to be administered routinely for Resident #20 every morning. Further review of the physician's orders revealed the physician had initially prescribed the medication on 09/14/11.</p> <p>Review of the Consultant Pharmacist's reviews from August 2013 to July 2014 revealed the Pharmacist had conducted a monthly medication regimen review for Resident #20; however, there was no evidence the Pharmacist (RPh) had considered a gradual dose reduction of the antidepressant medication, Celexa, during this time period.</p> <p>Interview with the facility pharmacist on 07/23/14, at 11:00 AM, revealed the pharmacist was responsible to conduct the monthly medication regimen reviews for all residents at the facility. The pharmacist stated he had not considered recommendation for gradual dose reduction or tapering for the use of antidepressants for residents in the facility who routinely received antidepressant medications.</p>	F 428			