

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445457	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/10/2024
NAME OF PROVIDER OR SUPPLIER  Monroe Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  465 Isbill Rd Madisonville, TN 37354	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30647</p> <p>Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to prevent abuse for 3 residents, (Residents #3, #4, and #5) of 7 residents reviewed for abuse or neglect. The facility failures resulted when the facility failed to protect Residents #3, #4, and #5 from abuse by Resident #2, who was involved in 3 separate altercations between 1/16/2024 and 1/20/2024 in which he slapped Resident #4 on 1/16/2024, slapped Resident #3 on 1/19/2024, and grabbed Resident #5's arm on 1/20/2024.</p> <p>The Findings Include:</p> <p>Review of the facility policy titled, Abuse, Neglect, and Exploitation, implemented 9/18/2023, revealed .Abuse .the willful infliction of injury .Physical abuse includes but is not limited to hitting, slapping, punching, biting, and kicking .The facility will make efforts to ensure all residents are protected from physical abuse .</p> <p>Review of the medial record revealed Resident #2 was admitted to the facility 2/8/2022 with diagnoses including Unspecified Dementia with Behaviors, Type 2 Diabetes, Hypertension, Congestive Heart Failure, Arteriosclerotic Vascular Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, and Stage 3 Chronic Kidney Disease.</p> <p>Review of the Care Plan for Resident #2 dated 1/16/2024, revealed the resident had impaired cognition, elopement risk, and verbal behaviors. The care plan included new interventions for physical behaviors directed toward others.</p> <p>Review of the re-admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Resident #2 had impaired thought processes, mobility limitations, and required assistance of one or two persons for activities of daily living.</p> <p>Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Cerebral Atherosclerosis, Age Related Debility, Unspecified Dementia with Behaviors, Anxiety Disorder, and Hypertension.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #4 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Resident #4 required assistance of one or two persons for ADLs. Resident #4 had no history of behaviors towards self or others.</p> <p>Review of the facility investigation documentation dated 1/16/2024 at 5:50 PM, revealed Resident #2 and Resident #4 were seated in the lobby. Resident #2 slapped Resident #4 on the right cheek as the two interacted without provocation. Staff immediately separated the residents, notified the facility Director of Nursing (DON), the Administrator, and the Hospice Providers for both residents of the incident. Neither resident recalled the incident within 5 minutes of its occurrence and denied an altercation had happened at all. Resident #4 did not sustain injuries in the incident. Resident #4 had no injuries or recall of the incident. Resident #2's family declined recommended medication adjustments made by the hospice provider. No changes were recommended by hospice for Resident #4. Resident #2 was placed on increased supervision with every 15- minute checks for 3 days. Resident #4 was followed by the facility social worker for 3 days with no evidence any recall of the incident, psychosocial harm or decline in condition.</p> <p>Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia with Psychosis, Malnutrition, Congestive Heart Failure, Generalized Anxiety Disorder, Impulse Disorder, and Stage 3 Chronic Kidney Disease.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 had severe cognitive impairment and the BIMS assessment was unable to be obtained due to impaired thought processes. The MDS revealed Resident #3 had mobility impairments, and required 2 persons assistance for ADLs.</p> <p>Review of the care plan for Resident #3 showed the resident was care planned for verbal and physical behaviors directed toward others and was resistant to personal care.</p> <p>Review of the facility investigation documentation dated 1/19/2024 at 3:30 PM, revealed Resident #2 was seated in a wheelchair in the lobby near Resident #3 who was seated in a gerichair (A specialty chair for persons with impaired trunk control or mobility). Resident #2 slapped Resident #3 on the left side of the face. Staff separated the residents. Resident #2 was placed on 1 to 1 supervision until the resident was transferred by Emergency Medical Services (EMS) to a local emergency department (ED) for psychiatric evaluation. Resident #3 was taken to her room where she was examined by the nurse and no injuries were noted. Resident #3 had no recall of the incident shortly after it occurred. Resident #2 had no recall of the altercation by the time EMS arrived to the facility. The Hospice Provider for both residents were notified of the altercation. The hospice nurse evaluated Resident #3, determined no changes in the treatment plan were warranted, and notified the hospice physician of the altercation for both residents. The Resident #2 was examined at the hospital, was diagnosed with a urinary tract infection, and was discharged back to the facility on 1 to 1 supervision for monitoring on 1/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/5/2024 at 1:15 PM, the Maintenance Director stated he witnessed the incident between Resident #2 and Resident #3. The Maintenance Director reported he separated the residents and reported the situation to the nursing staff and the DON immediately. The Maintenance Director stated Resident #2 and Resident #3 were seated in wheelchairs in the front lobby where Resident #2 tried to take a piece of paper from Resident #3 who was reading the paper. Resident #3 pulled the paper back from Resident #2's grasp, at which time Resident #2 lightly slapped Resident #3 on the cheek before he could intercede. The Maintenance Director reported both residents were severely confused at baseline, and neither resident recalled the incident 5 minutes or less after it occurred. The Maintenance Director stated he witnessed the altercation as .a very light tap . on Resident #3's cheek and no injuries were noted to either resident.</p> <p>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Adult Failure to Thrive, Type 2 Diabetes, Iron Deficiency Anemia, Unspecified Dementia without Behaviors, Atrial Fibrillation, Metabolic Encephalopathy and Long-Term Anticoagulant Use.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Resident #5 had limited ability to comprehend speech or express needs, mobility limitations and required assistance of one or two persons for ADLs. Resident #5 had no history of behaviors directed at self or others.</p> <p>Review of the facility investigation documentation dated 1/20/2024 at 11:25 AM, revealed Resident #5 while being rolled in a wheelchair by a staff member passed Resident #2 in the hallway who was also being rolled by a staff member in the opposite direction. (Resident #2 was on 1 to 1 supervision due to behaviors at the time). As the residents were rolled in their wheelchairs by staff past each other, Resident #2 reached out and grabbed Resident #5's right hand and arm. Resident #5 became briefly agitated and pulled away. The Certified Nurse Aides (CNA A and CNA B) quickly separated the residents and continued in opposite directions to their respective rooms. Nursing staff immediately responded, assessed Resident #5 for any injuries and none were noted. The Nurse Practitioner (NP) for both residents were notified of the incident, ordered precautionary mobile X rays of Resident #5's arm, which were performed the same day and were negative. Resident #2 was transferred by EMS back to the local hospital for psychiatric evaluation and was admitted to the hospital for acute psychiatric care.</p> <p>Review of the nursing notes dated from 1/20/2024 to 1/27/2024, revealed Resident #5 had no recall of the altercation a few hours after the incident occurred and experienced no negative outcomes or injuries from the incident.</p> <p>During interview on 6/6/2024 at 11:15 AM, the DON stated Resident #2 had several prior stays at the facility prior to 2022 and no prior history of physical aggression directed at others had been observed before 1/16/2024. The DON stated Resident #2 had severe cognitive impairment and occasionally had verbal behaviors but had never shown physical aggression towards other residents. The DON further stated Resident #2 was occasionally resistant to ADL care related his cognition and diagnosis of Dementia. The DON confirmed Resident #2's aggression towards Resident #4 appeared unprovoked, and Resident #2 had slapped Resident #4. Continued interview revealed the DON confirmed on 1/19/2024, Resident #2 was the aggressor and had slapped Resident #3 during the altercation. The DON stated Resident #2 was aggressive towards Resident #5 and Resident #2 grabbed Resident #5 on the arm and hand. The DON confirmed the facility failed to prevent abuse of Residents #3, #4, and #5 by Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2024 at 2:52 PM, CNA A stated she had been providing 1 to 1 care for monitoring with Resident #2 on 1/20/2024 and the resident had become agitated after lunch. CNA A stated after Resident #2 finished the lunch meal, she took Resident #2 to his room for a less noisy environment and to provide ADLs assistance. CNA #2 reported as she rolled Resident #2 in his wheelchair down the hall, in the opposite direction, past Resident #5 , who was being transported by CNA B in a wheelchair, Resident #2 without warning, abruptly reached out and grabbed Resident #5 by the right hand and arm. CNA A stated Resident #5's arm was resting on the wheelchair arm at the time of the incident. CNA A stated Resident #5 pulled away forcefully, which exacerbated Resident #2's agitation. CNA A stated she and CNA B immediately separated the residents and continued along their ways to their respective rooms as nursing staff responded from the nursing station. Nursing staff examined Resident #5 and no injuries were noted. The nursing staff notified the NP and X-rays were obtained for Resident #5's hand and arm. CNA A confirmed Resident #2 was the aggressor in the altercation and reported shortly afterwards, EMS personnel arrived and took him to the hospital.</p>		