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	255293	A. BUILDING _____ B. WING _____	10/11/2019

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SHELBY HEALTH AND REHABILITATION CENTER	1108 CHURCH STREET SHELBY, MS 38774

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with a complaint, MS #15712, from 10/7/2019 to 10/11/2019. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated MS #15712 for Unnecessary Medications and cited F758 related to the complaint. The SA also cited F640 and F641, during the recertification survey. The facility held a license for 60 beds, with a census of 52.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		11/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/01/2019

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 640	Continued From page 1 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to transmit a Minimum Data Set (MDS) assessment within a timely manner for one (1) entry, Resident #205, and two (2) discharge MDS assessments for Resident #6 and #1; for three (3) of 22 residents reviewed. Findings include: On 10/9/19 at 11:25 AM, an interview with the	F 640	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State law. F640: 1. Resident #205's Entry Tracking was	

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F 640	Continued From page 2 Assistant Director of Nursing (ADON) revealed the facility does not have a policy and procedure for the timing of the Minimum Data Set (MDS), the facility uses the Resident Assessment Instrument (RAI) manual for guidance. The RAI - required Assessment Summary revealed a Discharge Assessment - return not anticipated should be completed by the 14th day after the Discharge Date. Review of a statement on facility letterhead, signed by the Administrator, and dated 10/10/19, revealed: All MDS assessments are completed by the direction of the RAI manual. Resident #1 Review of Resident #1's Discharge MDS, with an ARD of 6/12/19, revealed the MDS had not been completed and submitted. Review of the MDS history for Resident #1, revealed a Discharge MDS with a date of 6/12/19, with a status of export ready on 10/9/19. During an interview on 10/09/19 at 10:24 AM, Registered Nurse (RN) #1 confirmed the discharge MDS for Resident #1 had not been completed on 6/12/19. RN #1 revealed she was not the MDS nurse at that time and did not know why the MDS was not completed. RN #1 revealed a Discharge MDS should be completed by the 14th day after the ARD date. On 10/09/19 at 11:25 AM, an interview with the ADON confirmed the Discharge MDS for Resident #1, with an ARD of 6/12/19, was not completed and was 105 days late. Resident #6 Review of Resident #6's medical record revealed	F 640	submitted 2 days late (in the past), so therefore it cannot be corrected now. The Minimum Data Set (MDS) Nurse was in-serviced on 10/31/2019 by the Registered Nurse Consultant on timeliness, accuracy, and completion of MDS assessments based on the Resident Assessment Instrument (RAI) guidelines. Resident #1's Discharge MDS assessment was completed on 10/9/2019 and transmitted on 10/16/2019 by the MDS Nurse. Resident #6's Discharge MDS assessment was completed and transmitted on 10/31/2019 by the MDS Nurse. 2. On 10/31/19, the MDS Nurse completed a 100% audit of the Tracking/Discharge roster to determine any other resident with the potential for this same issue for timeliness and accuracy of discharge assessments and transmissions to ensure they were completed within the Resident Assessment Instrument (RAI) Manual guidelines. There was one assessment that was not in compliance. That MDS was completed and submitted 10/31/2019 by the MDS nurse. 3. On 10/31/19, the MDS nurse was in-serviced on timeliness of Entry and discharge MDS submission per the RAI guidelines by the Registered Nurse Consultant. 4. Starting 10/31/19, the MDS nurse will audit assessments weekly to ensure	

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F 640	Continued From page 3 the resident expired in the facility on 9/24/2019, and the Discharge Assessment has not been opened or completed as of 10/10/2019. Interview with RN #1 on 10/10/19 at 4:43 PM, revealed that she is new in the position, and is scheduled to go to the MDS training later in the month. RN #1 stated the assessment should have been completed within seven (7) days of the resident's discharge. Resident #205 Record review revealed Resident #205 was sent to the hospital on 9/17/2019. Resident #205 was admitted to Geri-Psych unit and was readmitted to the facility 10/1/2019. The MDS Entry tracking was completed 10/9/2019, instead of 10/7/19. Interview with RN #1 on 10/11/19 at 9:43 AM, revealed the assessments were not completed timely. She stated that Admissions and Discharges are discussed in the stand up meeting daily.	F 640	timely transmissions. Results of these audits will be brought to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for four (4) of 22 MDS assessments reviewed as evidenced by inaccurate coding for:	F 641	F641: 1. The following Minimum Data Set (MDS) assessments were corrected by the MDS Nurse:	11/8/19

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F 641	Continued From page 4 one (1) resident discharged to home (Resident #56), two (2) residents with a gastrostomy tube (Resident #51 and Resident #35), one (1) resident with Insulin injections (Resident #51), two (2)residents with pressure ulcers (Resident #51 and Resident #35), and two (2) residents without an anticoagulant ordered (Resident #51 and Resident #35). Findings include: Review of a statement on facility letterhead, signed by the Administrator, and dated 10/10/19, revealed: All MDS assessments are completed by the direction of the Resident Assessment Instrument (RAI) manual. Resident #56 Record review of Resident #56's Discharge MDS, with an Assessment Reference Date (ARD) of 9/6/19, revealed "Acute Hospital" was chosen as the Discharge Status. Record review of Resident #56's Physician's Orders, dated 9/6/19, revealed: Discharge home with Home Health, with front wheel walker, standard wheelchair, and a bedside commode. During an interview on 10/10/19 at 4:43 PM, Registered Nurse (RN) #1/MDS Nurse/Care Plan Coordinator, confirmed she did enter the wrong information about the discharge status of Resident #56 on the MDS, with an ARD of 9/6/19. She stated, "I was under the impression that she was discharged to another facility, a hospital". RN #1 stated she was in orientation at the time and input information into the MDS according to what the Director of Nursing (DON) told her. She stated, "I've never done MDS". She stated she is	F 641	Residents #35 - corrected on 10/12/19 and transmitted 10/31/19. Resident #51 - corrected and transmitted 10/31/19. Resident #56 - corrected and transmitted 9/13/19. Resident #43 - corrected and transmitted 10/31/19. 2. On 10/31/19 and 11/1/19, the MDS Nurse and the Registered Nurse Consultant completed a 100% audit of MDS assessments to determine anyone else with the potential for this same issue for the past 6 months for discharge location, gastrostomy tubes, insulin injections, pressure ulcers, and anticoagulants. Four assessments needed to be corrected to be in compliance. They were corrected and submitted 11/1/2019. 3. On 10/31/19, the MDS nurse, was in-serviced on accuracy of the MDS and coding per the Resident Assessment Instrument (RAI) guidelines by the Registered Nurse Consultant. 4. Starting 11/1/19, MDS nurse will audit each MDS prior to completion. Starting 11/1/19, the Director of Nursing (DON) or the Nursing Home Administrator (NHA) nurse will randomly audit five MDS assessments weekly to review accuracy of the MDS assessments. If accuracy issues are discovered, the MDS will be corrected by the MDS nurse. Results of these audits will be brought by the DON/NHA to the Quality Assurance	

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F 641	Continued From page 5 scheduled to go to the State MDS training this month. Resident # 51 Review of Resident #51's MDS, with ARD of 9/18/2019, was inaccurately coded with the following: Section K0510B was not coded for a gastrostomy tube, K0710A and B were not coded for the amount of nutrition received via gastrostomy tube, M0100A and B was not coded for pressure ulcer, M0210 was coded "0" for number of stage 2 pressure ulcers, N0300 was coded "0" for injections received, N0350A was blank for insulin injections, N0410E was coded "7" for days of anticoagulant therapy. Review of the physician's orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), Weekly Skin Assessments, and Care Plan, for Resident #51, all initiated on 9/6/19, revealed the resident had a gastrostomy tube and received medications and enteral feedings via this route, resident had a stage 2 pressure ulcer, resident received seven (7) days of insulin injections, and there was not an anticoagulant ordered or received during the seven (7) day look back period. Resident #35 Review of Resident #35's MDS with an ARD of 8/25/2019, revealed Section N0410E was coded "7" for days receiving an Anticoagulant. Record review of the August 2019 MAR and Physician's Orders revealed an anticoagulant was not ordered or received by Resident #35. Resident #43 Review of Resident #43's Annual MDS, with an ARD of 9/5/2019, revealed section K0510B was	F 641	Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance.	

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F 641	Continued From page 6 not coded for a gastrostomy tube, K0710A was not coded for fluid intake, and M0300B was not coded for pressure ulcers. Review of the September 2019 physician's orders, MAR, TAR, care plan, and weekly skin assessments, revealed Resident #43 had a gastrostomy tube, received flushes per tube every shift, and had two (2) facility acquired Stage 2 pressure ulcers. Interview with RN #2, on 10/8/19 at 10:24 AM, revealed Resident #43 had two (2) Stage 2 pressure ulcers that are being treated on a daily basis. Interview with RN #1 on 10/10/19 at 4:43 PM, revealed she was in orientation at the time and input information into the MDS according to what the Director of Nursing told her. She stated, "I've never done MDS". She stated she is scheduled to go to the State MDS training this month. She stated she is still in training and was completing the MDS, with guidance from the previous Director of Nursing. She confirmed the MDS assessments for Residents #56, #43, #35, and #51 were coded in error.	F 641		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		11/8/19

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F 758	Continued From page 7 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 8 This REQUIREMENT is not met as evidenced by: CI MS #15712 Based on record review, staff interview, family interview, and facility policy review, the facility failed to ensure that an order for an as needed (PRN) antipsychotic medication (Haldol), was limited to a duration of 14 days, without physician reassessment; and an antipsychotic medication (Seroquel) was not decreased per MD order for one (1) of six (6) residents reviewed for receiving antipsychotic medications, Resident #206. Findings include: Review of the facility's Psychopharmacologic Drugs policy, dated Nov 2017, revealed, "Unnecessary Drugs, 1. Each resident's drug regimen must be free from unnecessary drugs...2. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication." Review of Resident #206's January 2019 Physician's Orders, revealed an order, dated 12/11/19, for Haloperidol (Haldol-an antipsychotic medication) Lactate Solution-Inject five (5) milligrams (mg) intramuscularly as needed for psychosis daily. Give one (1) milliliter (ml). Review the Pharmacy Consultation Report, dated 12/25/18, revealed a recommendation regarding Resident # 206's PRN Haldol order, related there was no stop date. The Medical Doctor declined the recommendation on 1/7/19, with the rationale: "still agitated-working on changing meds".	F 758	F758: 1. Resident #206 was discharged from the center on 2/12/2019. 2. On 10/29/2019, the Director of Nursing (DON) audited as needed (PRN) orders for antipsychotic medications to determine anyone else who may have the potential for this same issue to ensure they were limited to a duration of 14 days unless there was physician evaluation. Medications were audited to ensure the physician orders have been followed. There were no other issues noted during this audit. 3. On 10/29/2019, nurses were in-serviced to ensure order setup in the electronic health record followed the physician order for antipsychotic medications as well as PRN antipsychotic orders were limited to 14 days unless physician evaluation was completed. This in-service was completed by the DON and the Staff Developer. All nurses will receive this education no later than 11/8/2019. 4. Starting 11/1/2019, the DON or Assistant Director of Nursing (ADON) will audit physician orders weekly to ensure antipsychotic medications are handled within the specifications of the regulations and physician orders for psychotropic medications are being followed. Results of these audits will be brought by the DON or	

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F 758	Continued From page 9 Review of the Pharmacy Consultation Report, dated 1/28/19, revealed Resident #206 continued to have a PRN order for Haldol 1 ml (5 mg) PRN psychosis, which had been in place for greater than 14 days. Order started on 12/11/18. The Physician declined the request with a response: Recommend Pharmacist meet me every 14 days to examine patient. On 10/10/19, at 3:55 PM, RN #2 stated it was the facility policy that PRN antipsychotic drugs are limited to 14 days and cannot be renewed unless the physician examines the resident. She stated, "We can't write a stop date without an order and he won't write it". Record review of the Medication Record for February 2019 revealed the resident did not receive an injection of Haldol from 2/1/19 - 2/12/19. In a phone interview, on 10/09/19 at 4:47 PM, Resident #206's daughter, not the Responsible Party (RP), stated she was not happy with the care her father received at the facility, that he was admitted for rehab and was never able to participate in therapy due to, in her opinion, being over medicated and always "out of it" when she visited. She stated that the facility gave him Seroquel to make him sleep and he could hardly wake up. The Daughter stated Resident #206 was sent to the local hospital several times and the Emergency Room (ER) doctors always said he was over medicated. Review of Resident #206's Physician's Orders revealed Quetiapine Fumerate (Seroquel-an antipsychotic medication) 25 mg one (1) by	F 758	designee to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance.	

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mouth (po) two (2) times a day (bid), was started on 1/16/19.

Review of Progress Notes for Resident #206, dated 2/6/19, at 10:10 AM, revealed family was in the facility demanding that the resident be sent to the hospital, due to the resident was asleep during her visitation hours. The resident was transported to the hospital via ambulance, where he was evaluated for Altered Mental Status. Upon return to the facility at 6:09 PM, a new order was noted by Registered Nurse #3 (RN). Resident #206's Physician Orders, dated 2/6/19, revealed an order: Cut the Seroquel down to one (1) pill at night, do not give a dose tonight or tomorrow morning, start it on 2/7/19 at hour of sleep (HS).

Review of the February 2019 Medication Administration Record (MAR) revealed the Seroquel order was not updated on the MAR to reflect the 2/6/19 order for giving one (1) pill daily. The MAR continued documentation to give Seroquel (Quetiapine Fumarate Tablet) 25 mg by mouth two (2) times a day for psychosis, Order Date- 01/16/2019. The medication had a discontinue date of 02/12/2019. The Seroquel was documented as not given on 2/6/19 at 6:00 PM, with the reason code "07 sleeping". The medication was documented as given at 10:00 AM, on 2/7/19, and not given on 2/7/19 at 6:00 PM, with the reason code "07 sleeping". The medication was given twice a day on 2/8/19 - 2/10/19, with only one (1) dose given on 2/11/19, at 10:00 AM.

During an interview on 10/9/19 at 6:20 PM, RN #3 reviewed the order written on 2/6/19, and stated that he could not recall the order, but thought it meant that the Seroquel should not be given on

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(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 758	Continued From page 11 the night of 2/6/19, and the morning of 2/7/19. RN #3 stated the Seroquel should have been restarted on the evening of 2/7/19, and only given one (1) pill at night thereafter. He stated that the resident would get really drowsy because of the medicine, and could not tolerate it. He stated he only worked the 3/11 shift and would not know what the resident got on the day shift. In an interview, on 10/10/19 at 3:50 PM, RN #2 stated that RN #3 entered the order on 2/6/19, in a way that would not enable it to flow to the MAR, therefore it was never changed on the MAR and confirmed the Seroquel was not changed and should have been cut down to one (1) pill at night. She revealed that Resident #206's behavior was up all night and slept during the day. She stated that his sleep pattern was off. She stated that Resident #206 continued to get the same dose prior to going to the hospital, so she didn't think it would have been an adverse effect for him, because he wasn't getting more than he was used to getting.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255293	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/09/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/22/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255293	A. BUILDING _____ B. WING _____	10/09/2019

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 10/09/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/22/2019

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