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 _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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; (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	F 758		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 758	Continued From page 1 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. 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.	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.	

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F 758	Continued From page 2 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". 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,	F 758	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 designee to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance.	

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F 758	Continued From page 3 "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 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	F 758		

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F 758	Continued From page 4	F 758		

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 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

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F 758	Continued From page 5 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		