STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHELBYVILLE MANOR	1111 WEST NORTH 12TH STREET SHELBYVILLE, IL 62565

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)
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to asses and document the warranted use of an anti-anxiety medication for one (R1) of three residents reviewed for medication administration in the sample of six. Findings include: The Physician order [REDACTED]. This same POS includes an order dated [DATE] for [MEDICATION NAME] (anti-anxiety) liquid 2 mg per 1 milliliter (ml), give 0.5 ml (1 mg) every 2 hours as needed by mouth, or 1 ml (2 mg) every 2 hours as needed by mouth for anxiety/air hunger. R1's Medication Administration Record (MAR) dated [DATE] documents V3, Licensed Practical Nurse on 2:00 to 10:30 pm shift administering [MEDICATION NAME] 1 mg/0.5 ml liquid by mouth to R1 at 3:16 pm and 6:57 pm. V3 documents on the MAR that the above medication was given for as follows: family request, no outward indicators of pain, discomfort or restlessness noted. Nursing Notes dated [DATE] at 3:16 pm, V3 documents: Family requesting that ([MEDICATION NAME]) be given at this time due to resident (R1) being restless. Upon entering room resident (R1) is resting quietly with eyes closed and easy respirations. Will arouse easily to verbal and tactile stimuli. No outward indicators of pain discomfort or restlessness noted. PRN (as needed) [MEDICATION NAME] ([MEDICATION NAME]) 0.5 ml given (by mouth). Resident required much encouragement to swallow but was able to do so. R1's MAR dated [DATE] documents V4, Licensed Practical Nurse on 6:00 am to 2:30 pm shift giving [MEDICATION NAME] 1mg/0.5 ml to R1 at 7:53 am, 10:41 am and 1:41 pm. V3 documents on the MAR for 7:53 am comfort measures, 10:41 am comfort measures and 1:41 pm comfort measures. There is no documented assessment in the Nursing Notes of R1 needing or exhibiting signs and symptoms of anxiety or air hunger. R1's MAR dated [DATE] documents V5, Registered Nurse from 2:00 pm to 10:30 pm shift administering and signing the MAR, giving [MEDICATION NAME] 2 mg or 1 ml liquid by mouth to R1 at 4:36 pm and 6:46 pm. There is no documented assessment in the Nursing Notes for R1's need of the medication. However, V5 documents on the MAR for the 4:36 pm dose as follows: family request, no outward indicators of pain, discomfort or restlessness noted. V5 also documents on the MAR for the 6:46 pm dose as follows: family request. Nursing Notes dated [DATE] document (R1) expired at 1908 (7:08 pm) with family at bedside. On [DATE] at 12:10 pm, V4 stated the family was demanding that an order be gotten for [MEDICATION NAME] for R1, so V11, Nurse Practitioner was called and the order was received. V3 stated that V4 had documented on the MAR on [DATE] that [MEDICATION NAME] had been documented as given for comfort measures. However, V4 stated the [MEDICATION NAME] had been given because the family was demanding it. V4 stated I documented incorrectly and should have documented the real reason R1 received the [MEDICATION NAME] ([MEDICATION NAME]). On [DATE] at 10:30 am, V5 stated the family kept pushing for the [MEDICATION NAME] even though (R1) was resting quietly. (R1) did not appear to be actively dying. V5 confirms an assessment for the need of [MEDICATION NAME] was not done. On [DATE] at 1:25 pm, V3 stated V3 gave the [MEDICATION NAME] even though R1 was resting quietly and was not having problems with breathing. V3 stated R1's family was at the desk demanding that [MEDICATION NAME] be given. V3 stated so I gave it to (R1). V3 stated I gave it because I thought I had to, the family was demanding it. I didn't know that I could have called the physician about the family's demands. On [DATE] at 2:27 pm V10, Primary Care Physician of R1 and facility Medical Director stated the expectation when a medication is ordered as needed (PRN), that the assessment of the resident for which the medication is prescribed indicates the need for that medication. V11 stated the facility Nurses should have called me and told me that the family was demanding the [MEDICATION NAME] when R1 did not need it. On [DATE] at 2:45 pm, V2 Director of Nursing stated expectations for nurses would be that they would have notified V2 of R1's family demands and education about the medication of [MEDICATION NAME] would have been given to the family and documented. The facility policy titled Medication Administration dated February 2004 directs the staff on the following: Documentation of administration of PRN meds shall contain the following information: PRN medications must state when and why the medication is used. a. Date and time of administration. b. Reason for administration of medications. c. Results of administration (as best as can be determined, e.g., effective, resident had bowel movement, went to sleep, et,) d. Documentation shall be done either on reverse side of the MAR in appropriate area or in nurses charting notes. All PRN orders shall contain dose, frequency of use, and indication for use.

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.