

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Sanfield Rehab & Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 95 Main Street Hartland, ME 04943	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>37015</p> <p>Based on record reviews and interviews, the facility failed to ensure that as needed (PRN) psychotropic medication orders were limited to 14 days, for 1 of 5 residents reviewed for unnecessary medications (Resident #21).</p> <p>Findings:</p> <p>1. On 9/17/24, during a review of Resident #21's physician orders, a surveyor noted an order dated 2/21/24 for Seroquel (an antipsychotic medication, also known as quetiapine [generic form]) 12.5 milligrams (mg) by mouth twice daily and 25 mg daily as needed (PRN) for Parkinson's Disease with dyskinesia. The surveyor noted no 14-day limit (or stop date) for the PRN order, leaving it in effect until 3/5/24. Without a stop date, the order remained in the queue of the resident's electronic physician orders, and available for the staff to administer for an additional 15 days, when it was discontinued on 3/21/24.</p> <p>On 3/26/24, the provider renewed Resident #21's order for Seroquel 25 mg by mouth daily as needed for agitation. The order did not include a stop date and was in effect until 4/8/24. The order remained in queue and was available for staff to administer for an additional 40 days until it was renewed again on 5/18/24. During this time, the resident received PRN dosing on 4/9/24 and 4/24/24.</p> <p>On 6/5/24, the consultant pharmacist provided the following recommendation to the physician, Resident #21 has a PRN order for an antipsychotic, which as been in place for greater than 14 days without a stop date. Please discontinue PRN quetiapine. If this PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated prior to issuing a new PRN order.</p> <p>On 6/5/24, the physician declined the recommendations and stated Patient is on hospice. Has Parkinson's Disease with hallucinations. PRN med needed. Continue 14 days and re-assess. The nurse practitioner visited the resident on 6/18/24. A review of Physician's orders for June, 2024, did not reveal a renewal of the PRN order for Seroquel after 6/18/24.</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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/19/24 the consultant pharmacist provided the following recommendation to the physician, CMS (Centers for Medicare and Medicaid Services) requires PRN antipsychotics be limited to 14 days. The order in (the electronic medical record) is dated 5/18/24. This needs to be discontinued and reassessed if the patient requires. If so, then reordered with a 14-days stop date. (Resident #21) has a PRN order for an antipsychotic which has been in place for greater than 14 days without a stop date: quetiapine. Please discontinue PRN quetiapine. If this PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated prior to issuing a new PRN order.</p> <p>On 8/7/24, the physician declined the recommendations and stated continue for another 14 days. On hospice with hallucinations. During this time, the order remained in queue and was available for staff to administer until the physician changed it to scheduled dosing on 8/22/24.</p> <p>2. Resident #21's physician orders included an order dated 4/23/24 for Lorazepam (an antianxiety medication) 0.5 mg orally every 6 hours as needed. The order did not include a stop date, except as noted on a provider progress note, dated 6/18/24, which indicated the order was in effect until 5/23/24.</p> <p>On 6/5/24, the consultant pharmacist provided the following recommendation to the physician, Resident #21 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg, one table by mouth every 4 hours as needed. Please discontinue PRN lorazepam, tapering as necessary. CMS requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order.</p> <p>On 6/5/24, the physician declined the recommendation and stated Patient is on hospice. Has Parkinson's Disease with hallucinations that can increase anxiety. The order was not renewed at that time, nor at the provider visit on 6/18/24.</p> <p>A review of Resident #21's medication administration records indicated staff administered a PRN dose of Lorazepam on 6/29/24 without a valid physician's order.</p> <p>On 7/19/24, the consultant pharmacist provided the following recommendation to the physician, This order needs a stop date added to it. CMS requires a stop date on the PRN (such as 60 days, etc.,) or it is limited to 14 days. Hospice is not exempt.</p> <p>On 8/7/24, the physician declined the recommendation and stated Continue for 14 days, then re-evaluate. On hospice. The order remained in effect until the medication was scheduled by the physician on 8/22/24.</p> <p>On 9/17/24, in an interview with the Administrator, a surveyor discussed that original PRN orders for Lorazepam and Seroquel had been written without stop dates but had remained available in the electronic orders after expiration, allowing administration without a valid order being in effect. The consultant pharmacist had notified the physician on two occasions that the orders needed to be discontinued or renewed with a rationale for continued use. It was not until 8/22/24, that the physician changed the PRN dosing to scheduled dosing.</p>		