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MAY 1 2009
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 03/16/09 and completed on 03/19/09, the sample included 4 residents for complete review, 9 residents for focused review and 2 closed records for review.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	1. For resident #14 this is no longer applicable, but a policy revision will be completed. 2. All residents who experience a significant deterioration have the potential to be affected. 3. The current policy for Notification of Next of Kin is being reviewed and revised. The revised policy will include notification of Physician and next of kin. Nursing will be in serviced regarding policy changes on 5/13/2009. (See attachment A) 4. Completion date: ~~6/10/09~~ 05/27/09 5. The Director of Nursing (DON) or designee will be responsible to monitor. The DON or designee will monitor to assure notification of Physician and next of kin has been completed on any significant deterioration. The DON or designee will monitor weekly times one month. Monthly times three months and quarterly times one year. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee.	Telephone call per administration/DON BH 05/04/09 14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4-30-09

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician and family for 1 of 2 closed record residents (Resident #14) who experienced a significant physical deterioration. Failure to contact the physician and family did not provide the opportunity for prescribing treatment and implementing ongoing monitoring of the effectiveness of the treatment and may have resulted in the resident's untimely death. Findings include: The medical record for Resident #14, reviewed on 03/19/09, identified the facility admitted the resident on 12/10/08. Resident #14's current medical diagnoses included, in part, congestive heart failure, COPD (chronic obstructive pulmonary disease), pulmonary fibrosis, diabetes mellitus, anxiety and depression. The 5 day Minimum Data Set (MDS) assessment, dated 12/17/08, identified no long or short term memory problems. Resident #14's current care plan identified, "Problem: Alteration in health maintenance related to pulmonary fibrosis, COPD, CHF, oxygen dependant . . . Intervention: . . . MD [medical doctor] consults as needed . . ." Review of Resident #14's Nurse's Notes revealed the following: * 12/18/08 at 8:00 a.m., "Foley catheter patent, draining dark amber urine. [name] PA [Physician's Assistant] was notified of that . . . order for UA [urine analysis] [after] antibiotics done . . ." * 12/18/08 at HS [bedtime], "Alert - but delusional - Tells staff she is delusional - Req [request] to go	F 157		

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F 157	Continued From page 2 to ER [emergency room]. Informed this nurse would review meds [medications] et [and] call [name of clinic] - agreeable - States she sees people in bed - talks to people in her BR [bathroom] - wants to call her parents . . ." * 12/19/08 at 5:15 [a.m. or p.m. not identified], "moans loudly - SOB [short of breath] O2 [oxygen] off 'help me I'm sick' - 'everywhere' sitting [on] edge of bed - Assist to recliner [with] 2 - weak poor wgt [weight] bearing - legs [up] - call lite in reach - reminded to use call lite instead of calling out." * An event report dated 12/19/08 at 8:45 [a.m. or p.m. not identified],"CNA's [Certified nursing assistants] ambulating resident to BR (2 CNA et gait belt) resident's knees buckled et CNAs lowered her to floor." Review of the event report revealed neither the physician or family were notified. * 12/19/08 at 11:00 [a.m. or p.m. not identified], "Cath [catheter] patent urine dark red." * 12/20/08 at 2:00 [a.m. or p.m. not identified], PRN [as needed] Xanax et Percocet given @ [at] 1:30 p.m. - very anxious - c/o [complains of] pain (L) [left] side, feet, legs . . ." * 12/20/08 at 2:10 [a.m. or p.m. not identified], "Panting resp. [respirations]. Encouraged to breathe in thru nose et out thru mouth 'I am' foley drng [draining] red urine . . ." * 12/20/08 at 8:00 a.m., ". . . Refuses to eat for breakfast, states 'I am not going to eat, I have no intention of eating' Foley catheter remains patent - urine slightly brown . . . Received last dose Ceftin [antibiotic] @ 8AM. Very confused. Blood sugar 147 @ 7AM - insulin held per order . . ." * 12/20/08 at 3:30 p.m., "Very anxious and upset. Wants her window open . . . Zanax [sic] 0.25mg [milligrams] given per PRN order for anxiety per [resident's name] request along [with] 650mg	F 157		

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F 157	Continued From page 3 Tylenol given for discomfort." * 12/20/08 at 11:20 [a.m. or p.m. not identified], "calls out - very short of breath . . .urine blood tinged - legs over edge of bed - 'I need to get up.' - Repeats - Encouraged to relax . . . transferred to recliner . . . Eyes wide et glossy . . . Reg [regular] Ativan et Tylenol - for leg, back discomfort - Percocet [two] given . . ." * 12/21/08 at 7:00 a.m., ". . . BS [blood sugar] 304 this AM . . . Clear brownish urine . . ." * 12/21/08 at 10:00 a.m., "CNAS [certified nursing assistants] during cares 'Res. [Resident] eyes rolled back into head.' reports CNA. 'Res. body was shaking.' Res. very lethargic opens eyes when spoken to slurs words then shuts eyes again. Very pale O2 sats [oxygen saturation] 91% 3LNC [91 percent at 3 liters per nasal canula]. Res. sitting up in chair currently. States shes @ [at] [facility name and room number]. Then closes eyes again, lethargic. Will cont. [continue] to monitor." * 12/21/08 at 8:00 p.m., ". . . Xanax given for [increased] anxiety @ HS [bedtime] cares. . . ." * 12/22/08 at 4:00 a.m., "Resident very restless/agitated. c/o [complaints of] pain all over. Repositioned, H2O [water] given along [with] PRN's [as needed]. Will attempt to get UA." * 12/22/08 at 5:45 a.m., "Little relief obtained from PRN's. Remains restless et [and] agitated. Sats 88 - 89% [with] O2 at 4LNC. Is sitting [up] in recliner now. SOB [short of breath] [with] any exertion." * 12/22/08 at 6:15 a.m., "Res. expired in her sleep . . . sleeping in her recliner [at] time of death. Daughters called [and] [no] answer from both. Son [name of son] called [and] OK'd release . . ." * 12/22/08 at 6:45 a.m., ". . . called to notify [doctor's name]."	F 157		

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F 157	Continued From page 4 The nurses notes identified facility staff notified the PA the morning of 12/18/09 and failed to notify the PA or physician again until Resident #14's death. During an interview on 03/19/09 at 1:15 p.m., an administrative staff member (#2) stated she would expect the facility to notify Resident #14's physician and family of the decline in her condition.	F 157		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, facility staff allowed 1 of 1 sampled resident (Resident #11), identified by the facility staff with short and long term memory problems and noninterviewable, to continue self administer medications. Failure to discontinue this practice placed the resident at risk for harm. Findings include: - The initial tour of the facility occurred 03/16/09 at 10:45 a.m. Observation revealed 2 white pills in a medication cup on the bedside stand positioned next to Resident #11. When asked about the pills, Resident #11 stated, "they're for gas." - Observation on 03/18/09 at 8:45 a.m. showed 4 medication cups on the bedside stand positioned	F 176	1. For Resident #11 medications will not be left @ bedside. 2. All residents who Self Administer Medication with Assistance (SAMA) have the potential to be affected. 3. The current procedure for SAMA is being reviewed. Nursing staff will be in serviced regarding SAMA procedure on 5-13-09. (See attachment 8) Telephone call per Administration/DON 05/04/09 BT 6-10-09 4. Completion date: 05/27/09 14 5. The Director of Nursing (DON) or designee will be responsible to monitor. The DON or designee will monitor to assure SAMA	

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F 176	Continued From page 5 next to Resident #11. The cups contained the following: cup one - 1 small blue pill; cup two - 1 small white pill; cup three - 1 large white pill; cup four - 2 large white pills. Observation also showed a medication cup next to Resident #11's tissue box contained 2 large white pills. Review of Resident #11's March Medication Administration record (MAR) on 03/18/09 at 9:15 a.m. showed SAMA (Self Administration of Medication with Assistance) written in red ink on the first page of the MAR to alert nursing staff of Resident #11's ability to self administer her medications. The medical record for Resident #11, reviewed on March 18-19, 2009, identified the facility admitted this resident on 09/04/07. Resident #11's current medical diagnoses included, in part, transient ischemic attack, chronic back pain, hypertension, hypothyroid, glaucoma, mild macular degeneration, anxiety, and depression. Review of Resident #11's current medications included, in part, Diovan, Imdur, Labetalol, Lasix, Oxycodone, Extra Strength Tylenol, Levoxyl, Plavix, Cymbalta, Lorazepam, Meclizine, Senokot, multivitamin, Tums, GasX, Omeprazole, and Metamucil. Resident #11's care plan revealed SAMA discontinued on 03/05/09. Review of Resident #11's current Minimum Data Set (MDS), dated 03/03/09, identified both long and short term memory problems and moderately independent in daily decision making. During an interview the morning of 03/18/09,a nursing administrative staff member (#1) stated during Resident #11's family care conference on	F 176	**Policy and Procedures are followed. The DON or designee will monitor weekly times one month. Monthly times one quarter and quarterly times one year. If concerns are identified immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA committee.**	

PRINTED: 04/21/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 176	Continued From page 6 03/05/09, the family and Resident #11 agreed to discontinue SAMA. Administrative nursing staff member (#1) acknowledged discontinuation of SAMA and this was transferred to Resident #11's MAR, but nursing staff failed to follow procedure.	F 176	1. Resident # 11 bruises will be monitored until resolved. 2. All residents who have skin conditions such as bruising have the potential to be affected. 3. The policy for Occurrence/Accident has been revised to include follow up assessment and documentation of skin conditions. Nursing staff will be in serviced regarding revised policy and procedure on: 5/13/09 (See attachment C) 4. Completion date: ~~6-10-09~~ 05/27/09 5. The Quality Assurance Coordinator (QA) or designee will be responsible to monitor. The QA coordinator or designee will monitor to assure that the follow up assessment and documentation has been implemented. The QA coordinator or designee will monitor this weekly times one month. Monthly times one quarter and quarterly times one year. If concerns are identified, immediate corrective action will be implemented. The QA coordinator will submit a report of the monitoring results to the QA committee.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accurately assess and document the skin condition for 1 of 2 sampled residents (Resident #11) who acquired bruises after falls. Failure of facility to assess and regularly document skin conditions, such as bruising, has the potential for an injury or bruise of an unknown origin to go unmonitored by facility staff and later, the possibility of being investigated as possible abuse. Findings include: An undated facility policy titled, "Policy and Procedure for Occurrence/Incidents," stated, " . . . Nurse will assess for injuries . . . Chart in nurses notes the initial assessment then 24 - 48 & [and] 72 hour post occurrence . . ." Observation on 03/17/09 at 9:10 a.m., showed Resident #11 had her left hand on her left hip/thigh area and stated, "It hurts" as she walked from the bathroom to her recliner. A Certified Nursing Assistant (CNA) (#4) questioned Resident #11 about her comment and Resident #11 stated, "you want to see it?" This resident	F 281	Telephone call per Administrator/DON BN 05/04/09	

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F 281	Continued From page 7 proceeded to pull her trousers down and observation revealed a purple bruise from the left hip down the left thigh to just above the left knee. Resident #11 stated, "I fell." CNA (#4) stated to CNA (#3), "I didn't know she fell. Did you know she fell?" The medical record for Resident #11, reviewed on March 18-19, 2009, identified the facility admitted this resident 09/04/07. Resident #11's current medical diagnoses included, in part, transient ischemic attack, chronic back pain, glaucoma, mild macular degeneration, anxiety, and depression. Review of Resident #11's nurses notes identified the following: * An event report, dated 02/16/09 at 9:15 p.m., stated, "Residents legs gave out walking to B.R. [bathroom] Found sitting on buttocks of floor. . . . approx. [approximately] 2 cm [centimeter] diameter abrasion R [right] elbow . . ." * A nurses note, dated 02/17/09 at 7:30 a.m., stated, "[up] in easy chair - warm pack to [up] shoulders. Light blue bruising noted rt. [right] elbow. New drsg [dressing] to skin abrasion, [no] active bleeding. Limited ROM [range of motion] pt. [patient] flinches out [with] movement. told writer 'I'm so dizzy med. [medication] not working - is there anything different.' Assured I would bring to Dr. attention R/T [related to] fall et concern over dizziness." * A nurses note, dated 02/17/09 at 11:40 a.m., stated, "Return fax from Dr. [name] [with] NNO [no new orders]. [no] x-rays or change med. Vertigo." * A nurses note, dated 02/24/09 at 9:00 a.m., stated, "During bath today, it was noted that [resident name] has an ecchymotic area on Rt	F 281		

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F 281	Continued From page 8 [right] hip area. [resident name] had fallen to her Rt side approximately one week ago. We explained that this is probably a deep bruise from that fall and deep bruises do not show right away . . . No discomfort noted. Reassurance given." Review of the Nurses Weekly Summary for Resident #11, dated 03/01/09, stated, ". . . Skin Condition: has bruises that are fading from fall 02/16/09 . . ." Review of Resident #11's care plan failed to address bruising related to falls. The medical record failed to show any further assessment or documentation of Resident #11's bruises such as location, size or color. Review of Resident #11's current Minimum Data Set (MDS), dated 03/03/09, identified both long and short term memory problems, limited assistance with bathing, horrible or excruciating hip/joint pain less than daily, and a fall in the past 30 days. Section M4. of the MDS, Other skin problems or lesions present, failed to identify the large bruise on Resident #11's right hip area. During an interview on 03/19/09 at 2:45 p.m. regarding Resident #11's bruises, administrative nursing staff member (#2) stated the facility is expected to complete an event report which includes the initial event report, 24 hour follow up, 48 hour follow up, and 72 hour follow up. She expected nursing staff to follow up with any significant skin conditions after 72 hours in the nurses notes. Administrative nursing staff member (#2) stated she had no knowledge of Resident #11's bruise or it's size.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309	Continued From page 9 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of facility policy, and review of professional literature, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being for 1 of 2 sampled residents (Resident #11) who sustained a head injury following a fall. Failure of facility staff to assess Resident #11's neurological status after a fall, limited the staff's ability to identify changes in the resident's level of consciousness and confusion and placed the resident at risk for complications. Findings include: Professional Standard of Practice for Assessment of known or suspected head injuries: Lippincott Manual of Nursing Practice (6th edition, 1991): The standard of nursing practice dictates that following a head injury, the resident should be monitored for signs of increased intracranial pressure-altered level of consciousness, observed for cerebrospinal fluid leakage, assess for contusions about the eyes and ears and assessed for neurological changes - pupils, reflexes, and motor ability. A thorough assessment including neurological status checks will be done and documented for 72 hours	F 309	1. Resident #11 will have neurological checks completed with any injury to head following a fall. 2. All residents who have falls with noted head injuries have the potential to be affected. 3. The current Policy and Procedure is being revised and staff will be in serviced regarding the revised Policy and Procedure on 5/13/09. (see attachment D & E) 4. Completion date: 5. The Quality Assurance Coordinator (QA) or designee will be responsible to monitor. The QA coordinator will monitor to assure the neurological checks are being completed and documented as implemented. The QA coordinator or designee will monitor weekly times one month. Monthly times one quarter and quarterly times one year. If concerns are identified immediate corrective action will be implemented. QA coordinator or designee will submit a report of the monitoring results to the QA committee. Telephone call per Administration 10:00 BN 05/19/09 ~~6-10-09~~ 05/24/09 14	

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F 309	Continued From page 10	F 309		

following the incident. The recommended nursing standard for neurological assessments are: every fifteen minutes for the first hour, then every thirty minutes for the second hour, then every hour for the next four hours, then every two hours for the first 24 hours, and then every shift for the second and third day. These assessments should be continued if the person is not stable or is showing evidence of a change in status.

An undated facility policy titled, "NEURO CHECKS," reviewed on 03/18/09, stated, "Policy: To be performed by an RN or LPN orientated and trained in the procedure Purpose: To assess the neurological function of the patient . . . Procedure: 1. Review Dr's order for neuro check. 2. Obtain vital signs as ordered and record. 3. Assess patient's level of consciousness. 4. Assess patient's motor response. 5. Check pupil response to light."

An undated facility policy titled, "Policy and Procedure for Occurrence/Incidents," reviewed on 03/18/09, stated, "Policy: All staff to follow protocol for resident occurrences. Procedure: . . . 4. Nurse will assess for injuries. a. Notify physician if injury occurs. b. Nurse and staff will follow physician orders . . . Chart in nurses notes the initial assessment then 24 - 48 & 72 hour post occurrence . . ."

Review of Resident #11's nurses notes identified the following:
* An event report, dated 03/10/09 at 3:30 a.m., stated, "Describe scene: Found on floor in front of toilet [with] back against N. [north] wall . . . Describe injury if any: Bump on L [left] lateral head behind ear . . . Objective statement made by resident: 'I slipped." The report showed vital signs

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	355046	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

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F 309	Continued From page 11 completed, pupils checked - "Perl" (pupils equal and reactive to light), and physician and family notified of the fall. * The 24 hour assessment, dated 03/11/09 at 3:30 a.m., identified no new injuries and PERL. An objective statement by Resident #11 stated, "just so tired." * The 48 hour assessment, dated 03/12/09 at 3:30 a.m., identified a bruise on Resident #11's left thigh and a small bump to the left side of her head. An area on the assessment for documentation of neuro checks stated, [no] complaints this evening." * The 72 hour assessment, dated 03/13/09 at 3:30 a.m., identified no new injuries and no neuro checks. The event report identified notification of Resident #11's physician, but failed to state if the physician gave any orders related to neuro checks. Review of Resident #11's standing orders revealed no order for neuro checks. During as interview on 03/19/09 at 3:15 p.m., an administrative nursing staff member (#2) stated facility staff are expected to complete the initial, 24, 48 and 72 hour assessments and follow physician orders regarding neuro checks. This nursing staff member further stated neuro checks are left to the nurse's discretion if the initial check in negative.	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 12 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, staff and resident interview, the facility failed to ensure residents who receive hypnotic drugs received gradual dose reductions, unless contraindicated, for 1 of 2 sampled residents (Resident #9) and 1 closed record (Resident #15) who received hypnotic medication. Failure to conduct gradual dose reductions has the potential for residents to receive unnecessary medications. Findings include: The Centers for Medicare & Medicaid has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or	F 329	1. For resident #9 Tapering of hypnotic dosage will be initiated per Federal Guidelines. Resident #15 is no longer applicable. 2. All residents who are on a scheduled hypnotic have the potential to be affected. 3. The current policy for hypnotic use is being revised. Nursing Staff will be in serviced regarding the revised policy and procedure on 5/13/09. (See attachment F & G) 4. Completion date: 5. The MDS coordinator or designee will be responsible to monitor. The MDS coordinator or designee will monitor to assure all residents on hypnotics will have a dosage reduction with sleep log quarterly. The assessment information will be in the RAP review regarding the effectiveness of the medication. The MDS coordinator or designee will monitor quarterly times one year. If concerns are identified, immediate corrective action will be implemented. The MDS coordinator will submit a report of the monitoring results to the QA committee. Telephone call pd Administrator/DON BH 05/04/09 ~~6-10-09~~ 05/27/09 14	

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F 329	Continued From page 13 to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization or decline. For hypnotic medication for as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. The Nursing 2009 Drug Handbook, 29th Edition, pp. 777-778 identified Restoril as a sedative-hypnotic and stated, "Use cautiously in patients with chronic pulmonary insufficiency, impaired hepatic or renal function . . . Restoril peaks within 1-2 hours and the duration is unknown." Resident #9's medical record, reviewed March 16-19, 2009, identified the facility admitted the resident on 10/03/07. The resident's current diagnoses included osteoarthritis, peripheral neuropathy, atrial fibrillation, chronic renal failure, congestive heart failure, pain and insomnia. The current Minimum Data Set (MDS), dated 01/01/09, identified sleep/cycle issues, no mood or behavior symptoms, an unsteady gait, and no long or short term memory problems. Current medications for Resident #9 include Restoril 15 milligrams (mg) orally every H.S., with an order date of 10/11/07.	F 329		

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F 329	Continued From page 14 Resident #9's current Comprehensive Care Plan, dated 04/03/08, stated, "Alteration in mood r/t [related to] insomnia. HX [history] of chronic insomnia prior to admission. Approach - quiet and darkened environment as able at night, offer backrub at H.S. [hour of sleep]. Sedative/hypnotic per order, monitor for side effects, monitor for changes in sleeping patterns, encourage resident to verbally report." The pharmacy review for Resident #9, dated 01/10/08, stated, "Has resident had a dose reduction trial of Restoril?" The documented reply was "yes failed." A physician progress note, dated 09/17/08, stated, "In reviewing patient's chart he does have Restoril at nite which is needed for his sleep. Nothing else has been affected so we will continue that." The Mood Resident Assessment Protocol Summary (RAPS), dated 10/02/08, stated , "He continues to receive hypnotic medication which has already been addressed." The RAP lacked assessment information regarding the effectiveness of the medication. During interview at 3:50 p.m. on 03/17/09, Resident #9 stated when he was first admitted to the facility (10/03/07) he was in a double room with a room mate and he likes the private room he currently resides in. He also stated he took a sleeping pill at home "once in a while." During interview on the afternoon of 03/19 09, an administrative nurse (#1) stated the physician discontinued Resident #9's Restoril on 10/10/07	F 329		

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F 329	Continued From page 15 and restarted it on 10/11/07. Review of Nurse's Notes failed to indicate other non-medical interventions were attempted prior to restarting the Restoril. No further attempts to taper Resident #9's Restoril occurred since the first week after admission in October 2007 (17 months ago). - Resident #15's closed medical record, reviewed on 03/19/2009, identified the facility admitted the resident on 01/10/08. Resident # 15's diagnoses included congestive heart failure, asthma, chronic obstructive pulmonary disease (COPD), diabetes osteoarthritis, peripheral neuropathy. MDSs completed on 04/19/08, 07/10/08, 01/08/09 and 02/06/09 failed to identify insomnia issues. Admission orders for Resident #15 included Restoril 15 mg every H.S. as needed, which was discontinued on 02/14/08 and reordered 02/16/08 to be administered every H.S. Resident #15's Comprehensive Care Plan, dated 01/23/08, stated, "Alteration in mood insomnia - Approaches . . .meds per order sedative/hypnotic prn [as needed], monitor for side effects." Revision of the care plan occurred on 04/10/2008 and stated "Alteration in mood r/t depression and insomnia . . sedative hypnotic medication per orders, monitor for side effects." A physician progress note, dated 04/15/08, stated, "She is on Restoril for insomnia. She had had other medication as an outpatient that have not worked. The Restoril has worked very nicely for her. Typically it is not my practice to prescribe benzos for sleep in the elderly but the fact that it has worked well versus the other things we will	F 329		

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F 329	Continued From page 16 continue it as is." An additional physician progress note, dated 11/11/08, stated, "She is having a bit of difficulty with sleeping; Restoril works excellently for her so that is why we are using it and will continue to use it . . ." The Resident Assessment Protocol (RAP), dated 10/09/08, stated, "She also continues to receive rx [prescription] restoril 15 mg q [every] H.S. for diagnoses of insomnia." The RAP lacked assessment information regarding the effectiveness of the medication. No attempts to taper Resident #15's Restoril occurred since she began receiving it every H.S. on 02/16/08. The resident remained in the facility until 03/04/09.	F 329		