STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

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F 000	INITIAL COMMENTS For the standard recertification survey, started on 09/08/15 and completed on 09/10/15, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample include 1 additional resident to verify specific concerns during the survey.	F 000		
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		10/15/15

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

Electronically Signed | 10/01/2015

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Medicare billing notices/records and staff interview, the facility failed to confirm a request for a demand bill for 2 of 2 (Resident #3 and Resident #10) billing records reviewed which required a notice of non-coverage of Medicare services. Failure to confirm a resident and their responsible party requested a demand bill is a violation of resident rights. Findings include: Review of the facility's Medicare billing records occurred on 09/09/15 and showed the following: - Review of the Medicare billing records for Resident #3 showed the resident's responsible party received notification of the non-coverage of Medicare services via telephone on 08/20/15. A nursing staff member (#8) signed for the responsible party and checked the box indicating	F 156	The facility will meet requirements for the notice of rights, rules, services and charges on a consistent basis. A. Certain tasks necessary at the time of admission of a Medicare beneficiary will be reassigned to ensure that the financial elements of payment for services is the responsibility of business office staff and will be completed within the required time frame. Business office staff will verify the Medicare status of the resident and interview resident and/or family to verify if Medicare reimbursement is applicable and if the family wishes to contest an unfavorable determination. For resident #3 staff had mistakenly checked the wrong box under the request for Medicare intermediary review. Resident¿s family had requested that they did not want the bill submitted. This has been corrected and the right box	

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F 156	Continued From page 3 a request for a demand bill. During an interview on the afternoon of 09/09/15, the staff member (#8) stated a demand bill was not submitted as the responsible party did not want a demand bill and that she had accidentally checked the wrong box. - Review of the Medicare billing records for Resident #10 showed the facility left a message for the resident's responsible party of the non-coverage of Medicare services via telephone on 08/21/15. The nursing staff member (#8) signed the notice, but failed to identify, by checking a box, whether the responsible party requested a demand bill or not. During an interview on the afternoon of 09/09/15, the staff member (#8) stated Resident #10's family member called back at a later time and did not want a demand bill, and she (the staff member) forgot to check the box.	F 156	checked. For resident #10, staff had noted that resident¿s family did not want a demand bill, but had forgotten to check the box. This has been corrected and the right box checked. B. Notice of Medicare non-coverage and request for Medicare intermediary review will be the responsibility of business office staff to ensure forms are completed correctly and to look for discrepancies in information. Notice of non-coverage forms will be filed in the resident chart only after verification of accuracy and completeness C. An audit will be conducted and documented by administrator/designee for the next 5 consecutive admissions X 1 month, then will be audited weekly for 3 months. D. Administrator or designee responsible for monitoring results of audit shall discuss outcomes during monthly QA.	
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that enhanced dignity/self-esteem for 1 of 1 sampled residents (Resident #1) who utilized	F 241	The facility will ensure that it promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full	10/15/15

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F 241	Continued From page 4 a commode. Failure to ensure dignity and respect during personal cares does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: - Review of Resident #1's medical record occurred on September 8-10, 2015. Diagnoses included history of falls with fracture, weakness, and fatigue. The significant change Minimum Data Set (MDS), dated 08/14/15, identified severely impaired cognitive skills and extensive assistance of two or more persons required for toileting cares. Observation on 09/09/15 at 10:18 a.m., showed two certified nurse assistants (CNAs) (#3 and #4) providing cares prior to Resident #1's bath. After the CNAs (#3 and #4) transferred Resident #1 onto a commode chair and covered her with a blanket, she stated, "I have to poop." One of the CNAs (#4) replied, "Go ahead and go. We'll clean you up in the bath[ing room]." The two CNAs (#3 and #4) then transported the resident out into the hallway and down the hall to the next room (bathing room) as she was in the process of having a bowel movement (BM) (BM was visible in the bucket below the commode chair.) During an interview on 09/10/15 at 11:15 a.m., two administrative staff members (#1 and #2) confirmed staff should have provided toileting cares prior to transporting the resident to the bathing room.	F 241	recognition of his or her ability by: A. Staff has been educated on giving resident privacy and allowing resident to finish task, wipe resident, empty commode before transporting resident to the shower area. Annual in-service on Resident Rights will also be provided to all staff. B. The facility recognizes that all residents who are cognitively impaired are at risk of being treated in a manner that compromises their dignity and respect. There will be an all staff education and in-service regarding the special care required to protect the resident's right to dignity when resident is unable to do so. In-service has been scheduled for October 6th. C. ADL activities shall be monitored daily X 1 month and weekly X 3 months by DON or designee at intervals to ensure that all cares are carried out in a manner and in an environment that maintains or enhances each resident's dignity and respect. If non compliance is observed, corrective action will be implemented immediately by DON/designee and documented. D. DON or designee responsible for monitoring ADL tasks shall discuss outcomes during daily stand up and monthly QA.	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		10/15/15

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F 280	Continued From page 5 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise care plans for 3 of 9 sampled residents (Resident #2, #4, and #5). Failure to ensure residents' care plans reflect their current needs limits the staff's ability to ensure continuity of care. Findings include: -Review of Resident #4's medical record occurred on all days of survey. The resident's current care plan identified, ". . . Assist required 8/11 [August 11] transfer by standaid [a sit-to-stand mechanical lift] green sling . . ."	F 280	It is the policy of Wedgewood Manor to always include resident, resident's family or resident's legal representative in planning care. It is also the practice of Wedgewood Manor to periodically review and revise resident's care plan by a team of qualified persons after each assessment: A. The system of documentation following any revision of the care plan will be amended to include transfer of information immediately to the CNA care card. Resident #4 care plan has been updated	

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F 280	Continued From page 6 Resident #4's current certified nursing assistant (CNA) care card identified, ". . . Complete all transfers with standing pivot transfer with 2 people assisting resident . . ." Observation on 09/09/15 at 9:59 a.m. showed two CNAs (#3 and #6) transferred Resident #4 into bed with a stand lift. One CNA (#3) stated Resident #4 is usually a pivot transfer, but she received physical therapy that morning and seemed tired. Observation on 09/09/15 at 11:38 a.m. showed two CNAs (#3 and #5) transferred Resident #4 from her bed to the wheelchair using a stand lift. During an interview on the morning of 09/10/15, a supervisory nurse (#2) stated Resident #4's method of transfer should match on the care plan and care card. - Review of Resident #2's medical record occurred on September 8-10, 2015. Diagnoses included dementia with behaviors. The quarterly Minimum Data Set (MDS), dated 07/16/15, identified intact cognitive skills and self performance for transfers, walking in room/corridor, and locomotion on/off the unit. The progress note identified the following: * 06/16/15 at 6:03 p.m., "Wanderguard bracelet did not lock the front door. Resident went outside to the front side walk and was looking at the flowers with the activity manager. Staff came to get nurse - resident willingly went inside and a new bracelet was applied. . . . Resident is confused at intervals - thinking wife was at park place/angry at nurse stating that I told him that	F 280	and CNA care card reflects change with care plan at the nurses' station. Resident #2 care plan has been updated to reflect elopement risk, resident has a roam alert bracelet that is checked every day and facility security system has been changed. Staff will be educated to watch out for signs of agitation and unusual behavior that trigger elopement. Interventions such as gardening activities, coffee, taking resident by the window as he enjoys watching people come and go have been put in place. Behaviors shall be inputted in a daily behavior log. Resident #5 care plan has been updated to include interventions to aid sleep. B. The potential exists for disparity of information between the care plan and the care card for every resident at the time of care planning or changes in condition. In-service has been scheduled for nursing staff on October 6th for more complete use of the electronic health record to eliminate some duplicative documentation as a means to offer consistent reliable information for all caregivers. C. Licensed staff has been assigned to accurately update care plan to reflect change in care card of CNA and comprehensive care plan at the nurses' station. Staff will be educated to watch out for signs of agitation or unusual behaviors that triggers elopement. Behaviors shall be inputted in a daily behavior log. Care plans/care cards will be individually developed to ensure resident needs are	

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F 280	Continued From page 7 [wife] was coming to get him/angry about being in the facility, periods of agitation noted - prn [as needed] Seroquel given with relief." * 07/16/15 at 10:51 p.m., "8:45 p.m.. Found resident outside the facility by the garden. Wanderguard in place to the left wrist. When asking the resident if someone was with him outside - he replied that he pubched [sic] in the code himself. No difficulties with redirection. Resident twenty back inside the building - staff checked on the resident every 1/2 hour. . . ." * 08/16/15 at 9:20 p.m., "Resident's roommate came to nurse's station and told . . . nurse that he thought resident had gone out B-wing door. Roommate stated that resident came into room looking for a flashlight than [sic] left and headed toward door. . . . nurse went out back door while this nurse checked for resident on wings/DR [dining room]/front lobby. . . . nurse found resident . . . outside by door outside by patio furniture. Assisted resident back into building at 9:30 p.m. When asked resident how he got outside, resident stated that he came down from second floor [The facility is all one level] and then went out the door at the end of the long hallway. Confusion noted this evening. Wanderguard in place to left wrist and working. . . ." During an interview on 09/10/15 at 11:15 a.m., two administrative staff members (#1 and #2) confirmed the resident had eloped on three occasions. They reported initiating 1/2 hour checks and changing the facility's alarm system in an effort to prevent further elopements. The resident's care plan failed to identify Resident #2's exit seeking behavior as a concern and failed to reflect the interventions the facility	F 280	met in a consistent manner. D. DON/designee has been assigned to audit documentation for consistency of information between the care plan and CNA care card within 48 hours of care team meeting for 1 month and then 4 care cards weekly for 3 months. DON/designee shall report Outcomes and it will be discussed during daily stand up and monthly QA.	

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F 280	Continued From page 8 had put in place to prevent him from eloping in the future. - Resident #5's medical record, reviewed on all days of survey, identified diagnoses including insomnia. A Quarterly Minimum Data Set (MDS), dated 06/18/15, identified the resident received a hypnotic medication all seven days of the seven day assessment period. Resident #5's current care plan, dated 06/23/15, stated, "Mood/sleep anxious behaviors Ambien hypnotic . . . Medications as ordered, monitor for effectiveness and adverse effects . . . Take time to visit with and listen to concerns Use family as a resource. like [sic] to have familiar objects brought from home." The care plan lacked interventions staff may attempt to aid rest/sleep prior to administering the hypnotic medication.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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 review of facility policy, the facility failed to ensure professional standards of practice regarding medication administration for 1 of 2 supplemental residents (Resident #11) receiving eye drops. Failure to verify medication was administered to the correct resident resulted in Resident #11 receiving another resident's eye drops. Findings include:	F 281	It is the policy of Wedgewood Manor to always ensure that services provided meet professional standards A. Nursing staff will review individual position descriptions, state and federal rule, the ND Nurse practice Act and Nursing Ethics regarding medication administration and facility medication administration policy and procedure. B. All residents receiving medications are at risk of medication errors.	10/15/15

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F 281	Continued From page 9 Review of the facility policy titled "Medication Administration Guidelines" occurred on 09/10/15. This policy, revised March 2002, stated, ". . . After verifying proper resident identification . . . administer the medications. . . . Medications prescribed for 1 resident are not administered to any other resident . . ." Observation of medication administration occurred on 09/08/15 at 5:10 p.m. with a licensed nurse (#7). Resident #11's medication administration record (MAR) identified Cosopt (an eye drop used to treat glaucoma) one drop in the left eye three times daily. The nurse removed eye drops from the medication cart, and the label on the bottle identified Cosopt, one drop in each eye once daily. The nurse stated, "The label is wrong. I'll get it changed." The nurse then administered one drop in Resident #11's left eye. Upon closer inspection, the label identified the eye drops belonged to another resident. During an interview on the morning of 09/10/15, a supervisory nurse (#2) agreed staff should verify resident's identity before administering medications.	F 281	Expectations relating to medication pass will be reviewed with all licensed staff during in-service. C. The system of ordering medications will be reviewed and revised if necessary to ensure correct medications are available. D. Weekly audits X 3 months will be conducted by the DON/designee of each medication cart to ensure all medications ordered for residents are available in sufficient quantity for the next 24 hours. DON or designee will observe medication pass 1 X weekly at different times of the day over the next quarter. Outcomes shall be discussed during monthly QA.	
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		10/15/15

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 08/13/14. Based on observation, record review, and staff interview, the facility failed to provide necessary supervision and assistive devices to prevent accidents for 3 of 5 sampled residents (Resident #1, #4, and #5) observed during staff-assisted transfers. Failure to ensure correct use of a gait belt (Resident #1 and #5) and failure to ensure a consistent and appropriate transfer method (Resident #4) may result in avoidable accidents/injuries. Findings include: -Review of Resident #4's medical record occurred on all days of survey. The resident's current care plan identified, ". . . Assist required 8/11 [August 11] transfer by standaid [a sit-to-stand mechanical lift] green sling . . ." Resident #4's current certified nursing assistant (CNA) care card identified, ". . . Complete all transfers with standing pivot transfer with 2 people assisting resident . . ." Physical therapy orders showed the following: *08/11/15: Please complete transfers with the stand lift *08/26/15: Please discontinue use of stand lift and complete stand pivot transfers with assistance of 2 persons *09/02/15: Staff can use stand lift prn (as needed) for transfers if Resident not comprehending to stand pivot	F 323	The facility will ensure that resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents: A. Resident #4 care plan has been updated and CNA care card reflects change with care plan at the nurses' station. After assessment, resident's care plan was revised to just one mode of transfer. For resident #1, caregivers have been educated to always follow resident's care plan and use a gait belt as required. For resident #5, caregiver has been educated to always follow resident¿s care plan and use a gait belt as required. B. All residents are at risk for accidents, especially those who are physically and/or cognitively impaired and are unfamiliar with the environment. An all staff in-service will be provided describing accident hazards and potential for harm to residents who experience an accident. The in-service will also describe the staff responsibility for maintaining a safe environment that includes supervision of individuals unable to make consistently safe decisions and use of assistive devices as instructed. All staff in-service has been scheduled to be held on October 6th. C. Care givers will be educated and there will be a mandatory in-service described in b. above. Licensed staff has	

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F 323	Continued From page 11 Observation on 09/09/15 at 9:59 a.m. showed two CNAs (#3 and #6) transferred Resident #4 into bed with a stand lift. One CNA (#3) stated Resident #4 is usually a pivot transfer, but she received physical therapy that morning and seemed tired, so they would use the stand lift instead. Observation on 09/09/15 at 11:38 a.m. showed two CNAs (#3 and #5) transferred Resident #4 from her bed to the wheelchair using a stand lift. The CNA identified they would use the stand lift since they used it earlier that morning. Resident #4's care plan conflicted with the CNA's care card and also failed to include prn use of the stand lift. Failure to identify a consistent and appropriate transfer method placed Resident #4 at risk for injury, and enabled unlicensed staff (CNAs) to assess Resident #4 for the most appropriate tranfer method, rather than seeking clarification from licensed staff (nurses). - Review of Resident #1's medical record occurred on September 8-10, 2015. Diagnoses included spinal stenosis, scoliosis, and history of falls with fracture. The significant change Minimum Data Set (MDS), dated 08/14/15, identified severely impaired cognitive skills and extensive assistance of two or more persons required for transfers. Resident #1's current care plan stated, "Long Term Goal: I need assist with my daily cares . . . [Interventions] . . . Transfers: Assist required 08/12 Stand pivot transfer to 'strong' R [right] side with use of gait belt and assistance of 2 persons. . . ."	F 323	been assigned to accurately update care plan to reflect change in care card of CNA and comprehensive care plan at the nurses' station. Care givers will be educated to always follow resident care plan during care and seek clarification from licensed staff (nurses) for most appropriate transfer method. Charge nurse will ensure that care givers have their gait belts at all times. D. There will be weekly audits 1 X weekly for 3 months by DON/designee to ensure that appropriate resident care plan is consistent with actual care provided by caregivers. DON/designee will also audit consistency of information between the care plan and the CNA care card within 48 hours of care team meeting, and then audit 4 care cards weekly X 3 months. Outcomes shall be reported and discussed during monthly QA.	

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	355087	A. BUILDING _____ B. WING _____	09/10/2015

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F 323	Continued From page 12 Observation on 09/09/15 at 10:40 a.m. showed two CNAs (#3 and #4) transferred Resident #1 into her wheelchair. Resident #1's left arm was in a sling. After locking the brakes on the wheelchair, one of the CNAs (#3) cued Resident #1 to place her right arm around her (CNA #3's) neck and encouraged her to stand. The other CNA (#4) guided Resident #1 from behind. The CNAs (#3 and #4) acknowledged the care plan indicates staff should use a gait belt, but stated, "It seems to hurt her arm." The CNAs failed to apply a gait belt prior to transferring Resident #1 from the commode chair to her wheelchair. During an interview on 09/10/15 at 11:15 a.m., two administrative staff members (#1 and #2) confirmed they expect staff to follow Resident #1's care plan. - Review of Resident #5's medical record occurred on all days of survey. The current care plan, dated 06/23/15, stated, "I need assist with my daily cares. . . . Transfers: Assist required: 9/15 Generally (1) assist of 1 with gait belt . . ." Observation on 09/10/15 at 9:22 a.m. showed Resident #5 seated at the edge of her bed. A CNA (#4) assisted the resident to put on her shoes, then provided stand by assistance while the resident transferred herself from the bed to her wheelchair. During an interview on 09/10/15 at 10:00 a.m. a licensed nurse (#8) stated the staff member should have used a gait belt to assist Resident #5 with the transfer.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		10/15/15

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F 329	Continued From page 13 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 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, review of policy, review of professional reference, and staff interview, the facility failed to identify and implement non-pharmacological interventions for 1 of 3 sampled residents (Resident #5) receiving a hypnotic medication. Failure to implement non-pharmacological interventions prior to administering an as needed (PRN) hypnotic may	F 329	It is the policy of Wedgewood Manor to monitor the medication regimen for adverse consequences for each resident and to prevent the use of unnecessary drugs. The use of antipsychotic drug therapy is monitored for applicability to a specific diagnosed and documented clinical reason.	

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F 329	Continued From page 14 have contributed to the resident receiving an unnecessary medication. Findings include: Review of the facility policy "Psychotropic Monitoring" occurred on 09/09/15. The policy, reviewed on 09/24/00, stated, "PROTOCOL: . . . 3. Antianxiety/Hypnotics/Sedatives are to be monitored for effectiveness and continued need for the medication. . . ." Wolters, Kluwer, Nursing 2015 Drug Handbook, Philadelphia, Pennsylvania, page 1481-1482, stated, "Indications & [and] Dosages Short-term management of insomnia . . . For elderly . . . 5 mg P.O. [orally] immediately before bedtime. . . Nursing Considerations . . . Use drug for short-term management of insomnia, usually 7 to 10 days. . . ." Resident #5's medical record, reviewed on all days of survey, identified diagnoses including insomnia. A Quarterly Minimum Data Set (MDS), dated 06/18/15, identified the resident had mild cognitive impairment and received a hypnotic medication all seven days of the seven day assessment period. The record showed, on 11/05/14, the physician initiated Ambien (a hypnotic medication) 5 milligrams (mg) daily at bedtime (HS) for insomnia. A Consultant Pharmacist's Medication Regimen review Report, dated 02/12/15, stated, "Ambien 5 mg HS Due for dose reduction consideration." The physician's response stated, "Try Ambien 5 mg HS PRN [as needed]."	F 329	A. The consultant pharmacist and/ or the visiting psychiatrist will be requested to provide information to nursing staff and medical staff specific to residents receiving antipsychotic drugs including clinical indications and symptoms of adverse consequences. The medication for resident #5 has been discontinued. Resident¿s care plan has been updated to include staff follow resident¿s routine such as pulling blinds; ensuring resident has her hair net on, reducing noise level in order to aid sleep. B. Any resident who receives medications is at risk of receiving unnecessary drugs. Medications will be reviewed to ensure that guidelines for use are clearly indicated. Licensed staff will be in-serviced on PRN use of medication and unnecessary drug protocol. DON or designee will also ensure facility follows psychotropic monitoring and dose reduction policy. Licensed staff will be educated on trying non pharmacological approach before administering PRN hypnotics. C. The consulting pharmacist will continue to review records of each resident and report orders for unnecessary drugs to the physician and DON. Nursing staff will report new orders for anti psychotropic drugs to the DON for review by the consulting pharmacist at the next visit or if adverse consequences are identified. Nursing care plans will identify symptoms of adverse consequences of medications for reporting by any staff	

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F 329	Continued From page 15 Resident #5's current care plan, dated 06/23/15, stated, "Mood/sleep anxious behaviors Ambien hypnotic . . . Medications as ordered, monitor for effectiveness and adverse effects . . . Take time to visit with and listen to concerns Use family as a resource. like [sic] to have familiar objects brought from home." Facility staff failed to implement non-pharmacological interventions to aid rest/sleep prior to administering the hypnotic medication. Review of Resident #5's PRN Medication Administration Records (MARs) for 2015 identified staff administered Ambien at the resident's request, without first attempting non-pharmacological interventions, as follows: * February: 4 of 28 days * March: 9 of 30 days * April: 19 of 30 days * May: 20 of 31 days * June: 20 of 30 days The PRN MAR showed the staff administered no Ambien for Resident #5 from July 4-16. The record lacked evidence Resident #5 had any difficulties sleeping during the 12 day period without the Ambien. Following that period, staff administered Ambien 10 of the remaining 14 days in July, 27 of 31 days in August, and 8 of 8 days in September. The record lacked evidence staff attempted non-pharmacological interventions prior to administering the Ambien. Although the resident had no difficulties sleeping during the 12 day period in July when she did not receive the Ambien, there was no evidence staff contacted the physician regarding a possible dose	F 329	member to the DON. D. The consulting pharmacists monthly visit reports concerning orders for unnecessary drugs will be discussed at monthly QA for 3 months. Evidence of use of unnecessary drugs or adverse consequences of medications will be reported at the monthly QA by the DON/designee for the next 3 months.	

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F 329	Continued From page 16 reduction or discontinuation of the drug. During an interview on 09/10/15, a licensed nurse (#8) stated each night when staff administer the resident's scheduled medications, the resident will ask, "Is there anything to help me sleep?" She stated staff will say "no" and then return later to administer the Ambien. The nurse confirmed staff have not conducted a sleep study for Resident #5 or attempted to encourage the resident to try to sleep without the medication.	F 329		