STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355112	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSIDE VILLAGE	4000 24TH AVE S GRAND FORKS, ND 58201

(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 June 27, 2011 and completed on June 30, 2011 the sample included five (5) residents for complete review, fifteen (15) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy/procedure, the facility failed to assess the use of and continued need for a one piece garment (a type of clothing/jumpsuit with a zipper positioned on the back which residents cannot easily remove) for 2 of 3 sampled residents (Resident #10 and #15) identified by the facility as using a physical restraint. Failure to assess the risks and benefits and determine the continued need for/use of the one piece garment limited Resident #10 and #15's access to their body/trunk and restricted their freedom of movement. Findings include: Review of the facility policy titled "Physical Restraint Policy" occurred on 06/30/11. This	F 221	A trial reduction was completed for Resident #10 and Resident #15 to determine the continued need for the adaptive garment. A revised Adaptive Garment form was completed for other residents currently wearing adaptive garments. Will continue with quarterly restraint assessments per DON The policy on physical restraints was revised to include information on adaptive garments. The adaptive garment assessment form was revised to include semi-annual trial reduction. Information on the requirement for semi-annual trial reduction was shared with nursing department staff during mandatory nursing staff meetings on 7-18-11, 7-20-11 and 7-25-11. Audits will be completed at random to ensure that all residents wearing adaptive garments have a trial reduction completed semi-annually. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services. Audits will be conducted for a year, if the facility continues to have residents with adaptive garments. DON responsible for QA audits.	7-25-11 8/3/11 per DON 7-13-11 1pm CT 7-25-11 8-4-11 via phone 1pm 8/3/11 per Joel Carlson CT DON

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Grant Ryland — TITLE: Administrator — (X6) DATE: 7/22/2011

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 221	Continued From page 1 policy, dated December 2006, stated, "Definition of a Physical Restraint Policy: A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . . . The following guidelines are to be used when considering physical restraints: . . . F. Least restrictive restrain [sic] utilization is reviewed by the RN [registered nurse] Care Coordinator at least quarterly and/or prn [as needed]. An initial physical restraint assessment will be completed prior to initiation of a restraint (expect in emergency situation) . . . I. Examples of devices that could be considered restraints: vest/chest restraints, hand/wrist restraints, waist restraints, lap cushions/trays, full side rails, wheelchair belts, etc . . . ." - Observation on 06/28/11 at 9:40 a.m. showed Resident #10 dressed in a one piece garment. A staff member (#7) unzipped the garment and transferred the resident to the toilet. Observation showed Resident #10 was incapable of removing the one piece garment herself. Review of the medical record on all days of survey identified Resident #10 medical diagnoses included Alzheimer's dementia. The facility originally admitted Resident #10 to their locked dementia unit in 2008 and moved her out of the dementia unit in May 2010. Resident #10's current medical record lacked information pertaining to the date the facility initially implemented use of the her one piece garment. An annual Minimum Data Set (MDS), dated	F 221		

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F 221	Continued From page 2 06/01/11, identified Resident #10 displayed long and short term memory problems; severe impairment in daily decision making; required total assistance of staff with bed mobility and personal hygiene; extensive assistance of staff with transfers, ambulation, dressing, eating, and toileting; and the daily use of a physical restraint (a one piece garment) while in bed during the seven-day look back period. Review of Resident #10's Care Area Assessment (CAA), dated June 2011, stated, ". . . has a history of playing in her BM [bowel movement] at night and getting it all over her clothes, hands, bedding, and wall in her room. She has been wearing a one piece garment at night to prevent this behavior as cognitively she does not recall her toileting needs. No behaviors were noted within the seven-day assessment period. Behavior log remains in place . . . ." Resident #10's "Plan of Care," dated June 2011, included the following intervention, ". . . I need help with dressing my upper and lower body. I am sometimes able to assist with putting my hands and legs into the clothes . . . I need assist with my grooming needs. I wear a one piece garment at night due to inappropriate handling of stool . . . ." Resident #10's "Social Services Reviews," dated 03/09/11 and 06/09/11, identified the resident exhibited no behaviors during the assessment reference periods and continued to wear/utilize an one piece garment at night. Resident #10's "Resident Care Notes," from May 2010 - June 2011 failed to show evidence the facility completed a quarterly assessment	F 221		

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F 221	Continued From page 3 regarding the use of the one piece garment and attempted to engage in a systematic and gradual process toward reducing and/or eliminating her physical restraint (one piece garment). During an interview on 06/29/11 at 9:45 a.m., an administrative nurse (#6) stated she believed the facility trialed Resident #10 without her one piece garment at night and it proved to be unsuccessful. When asked to provide evidence regarding reducing or eliminating Resident #10's one piece garment and the results of this reduction, an administrative nurse (#6) failed to provide any information to confirm the facility attempted a trial reduction of her physical restraint. Review of Resident #10's medical record identified no evidence of planned implemented less restrictive approaches prior to use, and following use of the one piece garment, and no plan for minimizing/reducing the use of the one piece garment. - Review of Resident #15's medical record occurred on June 29-30, 2011 and identified a medical diagnosis of bipolar disorder. A significant change Minimum Data Set (MDS), dated 04/25/11, and a quarterly MDS, dated 06/13/11, identified Resident #15 displayed long and short term memory problems; modified impairment in daily decision making; required total assistance of staff with toileting; extensive assistance of staff with bed mobility, transfers, dressing, and personal hygiene; and the daily use of a physical restraint (a one piece garment) while in bed during the seven-day look back period.	F 221		

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F 221	Continued From page 4 Resident #15's "Plan of Care," dated May 2011, included the following intervention, ". . . I wear one piece garments at bedtime due to inappropriate digging in my BM . . ." Resident #15's "Resident Care Notes," dated 02/19/11, showed the resident exhibited a behavior of "digging in her brief," smearing BM on her legs, and consuming this fecal matter. Resident #15's medical record lacked evidence the resident exhibited this behavior during the March-June 2011 assessment period. During an interview on the morning of 06/30/11 at 9:45 a.m., an administrative nurse (#6) stated she believed the facility trialed Resident #15 without her one piece garment at night and it proved to be unsuccessful "sometime earlier this year." Review of Resident #15's medical record identified one episode (in February 2011) of the resident's "inappropriate handling of stool." The facility failed to attempt quarterly restraint reductions for Resident #10 and Resident #15's one piece garment. Failure to attempt to reduce or eliminate this physical restraint limited both residents' access to their bodies and diminished their sense of dignity.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

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F 225	Continued From page 5 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, the facility failed to investigate injuries of unknown origin for 3 of 5 sampled residents (Resident #4, #8, and #18) identified with bruises. Failure to investigate	F 225	Complete skin assessments with follow-up investigations were completed for Residents #4, #8, and #18. The policy on resident injuries was revised to include a more comprehensive investigation of injuries to determine if a potential neglect or abuse investigation is warranted. The injury investigation form was revised to assist nursing staff in identifying potential causes of injuries which are not witnessed or are unable to be explained by the resident. Information on injury investigation as well as the revised injury investigation form was shared with nursing department staff during mandatory nursing staff meetings on 7-18-11, 7-20-11 and 7-25-11. Random audits will be completed on residents with injuries to ensure that an injury investigation was completed. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services. Audits will be completed for 6 months with Res. found with injuries. DON in charge of audits. Will review all injuries of unknown origins ff of 24° report sheet for 6 months. per Jodi Carlson, DON 8/3/11 1pm CT phone call	7-22-11 7-18-11 7-25-11 8-4-11

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F 225	Continued From page 6	F 225		

bruises and report these immediately to the administrator and to other officials in accordance with State law, does not allow the facility to determine causative factors of the injury and has the potential to place residents at risk for potential mistreatment, neglect, or abuse.

Findings include:

Review of the facility procedure titled "Injury of Unknown Origin Protocol," occurred on 06/28/11. This procedure, dated October 2008, stated, "Purpose: To resolve an injury of unknown origin without complication (bruise, laceration, skin tear, abrasion) . . . Treatment: 1. All injuries of unknown origin will have an injury of unknown origin report completed. . . ."

Review of the facility procedure titled "Injury of Unknown Origin," occurred on 06/28/11. This procedure, dated October 2008, stated, "Purpose: It is the policy . . . to report all injuries of unknown origin by completing an Injury of Unknown Origin report. This report is used to investigate all injuries to determine if the injury is a result of mistreatment, neglect, or abuse of a resident. Definition: Injury of unknown origin is any bruise, abrasion, skin tear, laceration, etc. that occurs and is not witnessed by any individual. Procedure: . . . C. The report shall be completed by a licensed nurse that is on duty at the time the injury is discovered. D. The nurse shall immediately notify the Administrator, Director of Nursing Services or the designee on call for the facility if the injury . . . is potential abuse or neglect. . . . G. Upon notification of the injury the RN [registered nurse] care coordinator will do a follow up investigation to identify possible causes

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F 225	Continued From page 7 of the injury; the investigation will include (but not limited to) staff interview, resident interview if appropriate, medication review, activity level including ADL [activities of daily living] assistance need, behavior and participation with cares, etc. . . ." - Review of the medical record, on all days of survey, identified Resident #4's medical diagnoses included Alzheimer's dementia. A quarterly Minimum Data Set (MDS), dated 04/25/11, identified Resident #4 had long and short term memory problems, severe impairment of daily decision making, and required total assistance of staff for bed mobility, transfers, dressing, toilet use and personal hygiene. Review of Resident Care Notes for Resident #4 identified the following: *08/22/10 - ". . . Noted 2 and 1/2 inch x [by] 2 inch wide bruise - purple in color to R [right] wrist, cause unknown." *08/28/10 - ". . . Small bruises noted to L [left] forearm. Will monitor until resolved." *09/08/10 - ". . . Redness [and] swelling noted to R [right] hand. Will monitor until resolved." *09/17/10 - ". . . Small bruise to Rt [right] outer foot. . . ." *12/23/10 - ". . . Bruise noted to R outer foot above little toe 1.5 cm[centimeters] x 0.5 cm. . . " *01/10/11 - ". . . Scratches to R side of face. . . " *01/28/11 - ". . . Small cut to lower lip noted by CNA [certified nursing assistant]." - Review of Resident #8's medical record occurred on all days of survey and identified a diagnosis of advanced Alzheimer's dementia. An	F 225		

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F 225	Continued From page 8 annual MDS, dated 03/19/11, identified Resident #8 had long and short term memory problems, severe impairment with daily decision making, and rarely/never able to understand others or make himself understood. The MDS identified the resident required total assistance of two or more staff members for bed mobility, transfers, and toilet use; and required total assistance of one staff member for dressing and personal hygiene. Review of Resident Care Notes for Resident #8 identified the following: *10/29/10 - ". . . [Right] upper eye lid had a bruise noted on 10/17/10. Is resolved at this time." (The Resident Care Notes lacked an entry on 10/17/10 identifying the bruise). *11/04/10 - ". . . CNA reported bruise. Upon observation noted Res [resident] has 3 cm x 3 cm reddish purple bruise to [right] elbow. [No] open areas. Cause of bruise is unknown . . . Will monitor daily until resolved." *04/30/11 - ". . . 0.5 cm bruise to right pointer finger . . . will assess QOD [every other day] till resolved." During an interview on 06/29/11 at 2:40 p.m., two administrative nurses (#2 and #3) confirmed the facility failed to investigate the bruises listed for Resident #4 and #8. An administrative nurse (#2) stated facility staff are to complete an Injury of Unknown Origin Report any time a resident has an injury of unknown origin. The facility then uses the reports to investigate the source of the injury. - Review of Resident #18's medical record occurred June 29-30, 2011. An admission MDS, dated 03/30/11, identified Resident #18 as moderately impaired; needing limited assistance	F 225		

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F 225	Continued From page 9 with one person physical assist for bed mobility, transfer, toilet use, and personal hygiene; and needing extensive assistance with one person physical assist for dressing. A Resident Care Note identified the following: "06/05/11, 6:10 p.m., Skin. Purple bruise 6 cm x 4 cm note on [right] posterior [lower] back on the [right] side of the [lower] back. Resident stated did not know how she got the bruise. Denies pain. Plan: will continue to monitor and document status in [treatment] book." During an interview, on the morning of 06/30/11, an administrative staff member (#1) confirmed facility staff failed to investigate Resident #18's bruise identified on 06/05/11.	F 225		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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	F 329		

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F 329	Continued From page 10 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, review of facility policy, and staff interview, facility staff failed to ensure adequate indications for use for 1 of 1 sampled resident (Resident #18) receiving a hypnotic medication. Failure to assess and determine the extent of a resident's sleeping pattern/problems prior to implementing a daily dose has the potential for the resident to receive an unnecessary drug. Findings include: The American Medical Directors Association, Sleep Disorders, Clinical Practice Guideline, dated 2006, states "Offer interim measures to alleviate the sleep disorder. While assessment of the patient's sleep disorder proceeds, it is appropriate to offer interim measures that may promote good sleep hygiene and better sleep quality. Avoid administering hypnotic medications until an adequate assessment has been performed. . . ." Review of the facility procedure "Psychoactive Monthly Flow Record" occurred on 06/30/11. This procedure, dated 03/11, stated, "Purpose: To provide a method for monitoring specific behavior	F 329	A sleep log was completed for resident #18. Based on the results of that log, Resident #18 had her hypnotic medication discontinued. An audit was done to determine other residents who have current orders for routine hypnotic medications. One resident was identified to have a current order. A sleep log was completed for this resident with the results being reported to the primary physician for review. No changes were made. The psychoactive drug policy was revised to include completion of a sleep log prior to implementing a routine hypnotic medication. Information on the completion of a sleep log prior to the implementation of a routine hypnotic was shared with nursing department staff during mandatory nursing staff meetings on 7-18-11, 7-20-11 and 7-25-11. The consultant pharmacist will provide a quarterly report of any new routine hypnotic medications and an audit will be completed to ensure that a sleep log has been documented. Results of the audits will be shared at the monthly Quality Review meeting and the need for continuing audits will be addressed by the Director of Nursing Services. Pharmacist reports will be reviewed & hypnotics monitored quarterly by DON for a year. Carlson per phone call c Jodi ~~Benson~~ DON CT 8/3/11 1pm CT	7-20-11 7-22-11 7-25-11 7-25-11 8-4-11

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F 329	Continued From page 11 and side effects of residents receiving psychoactive medications. . . . 3. Section II: Side Effects . . . When side effects occur, narrative notes may be written in the Nurse's Progress Notes. . . ." Side effects included on the "Psychoactive Monthly Flow Record" for sedative medication included, in part, "sedation/drowsiness, hangover effect, and increased falls/dizziness." - Review of the medical record for Resident #18 occurred June 29-30, 2011. A 30 day Medicare Minimum Data Set, dated 04/21/11, identified the resident did not report trouble falling or staying asleep, or sleeping too much; did not report feeling tired or having little energy, and Resident #18 received hypnotic medications in the last seven days. The medication administration record (MAR) identified Resident #18 received a hypnotic twice during the assessment period. The care plan for Resident #18 failed to identify a problem or interventions for difficulty sleeping. Admission medication orders, dated 03/23/11, for Resident #18 showed an order for Ambien (a hypnotic) 5 milligrams (mg) as needed for sleep. A physician's progress note, dated 05/10/11, stated, ". . . With continued use of the shoulder, there is more pain and with the pain she also is not sleeping well. . . ." A physician communication form, dated 06/20/11, stated, "[Resident #18's name] Requesting Ambien [every] HS [hour of sleep] since 6/14." In response to this communication the physician ordered "Ambien 10 mg [every] HS [hour of sleep] for sleep" on 06/21/11.	F 329		

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(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 329	Continued From page 12 Resident #18's MAR, under the section, "Nurses Medication Notes" (part of the MAR) stated the following: * April 2011 - Requested Ambien for "sleep" on nine days. * May 2011 - Requested Ambien for "sleep" on three days. * June 2011 - Requested Ambien for "sleep" on six days. The MAR identified staff provided Resident #18 with Ambien on 06/14/11 and 06/15/11. A Resident Care Notes, dated 06/15/11, no time given, identified the resident's bed alarm as sounding. Upon entering the room, staff observed Resident #18 sitting on the floor between her bed and her room chair. Staff indicated no obvious injuries to Resident #18 at that time. A note, dated 06/17/11 at 4:00 p.m., identified as follow-up to Resident#18's fall, indicated medication changes of an increase of scheduled oxycodone, adding an as needed dosing, and discontinuation of fentanyl, both pain medications, however, failed to include the use of the hypnotic. A Resident Care Notes, dated 06/25/11 at 9:00 p.m., identified Resident #18's chair alarm sounding. Staff responding to the alarm, observed the resident laying on her left side in the bathroom. Staff indicated no obvious injuries to Resident #18 at that time. In a note, dated 06/28/11 at 2:45 p.m., identified as follow-up to Resident#18's fall, staff noted the following: ". . . undergoing several med [changes] [related to] pain management. She tends to be sensitive to meds. getting confused [and] sedated. . . .She	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355112	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSIDE VILLAGE	4000 24TH AVE S GRAND FORKS, ND 58201

(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 329	Continued From page 13 receives Ambien [at] HS just started 06/21/11. . ." On 06/28/11, during the monthly pharmacy review, the pharmacist identified an irregularity to Resident #18's medication regimen: "[increase] dose of Ambien [and] falls noted 5/11." The pharmacist completed the form to report the irregularity to the director of nursing and physician, which had not yet been acted upon. A Resident Care Notes, dated 06/29/11 at 9:45 a.m., stated: "Data: CNA [certified nurse aide] reported resident as being more stiff to transfer and more confused to listen to redirection or follow direction. Action: called [Resident #18's physician] updated on transfer status. Response: OT [occupational therapy] consult received. Plan: Cont [continue] to monitor transfers [and] update MD [medical doctor] [and] RN [registered nurse]." During an observation of care on 06/29/11, at 4:50 p.m., a CNA (#4) assisted Resident #18 with toileting cares. When the CNA (#4) completed cares and asked the resident to sit in her wheelchair, Resident #18 continued to stand. Resident #18 made comments of being tired and that her arm hurt. The CNA (#4) told the resident to bend her knees and she could sit down, Resident #18 asked if she could sit back down on the toilet. When asked, by the CNA (#4), the resident stated she just wanted to sit down. The CNA (#4) explained to Resident #18 her wheelchair is right behind her and if she turned a little more she could sit in her wheelchair. Resident #18 continued to stand, then slowly pivoted with support from the CNA (#4) and sat in the wheelchair.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 14 Prior to increasing the hypnotic for Resident #18 from an as needed medication to daily, nursing staff failed to assess sleeping patterns and to identify environmental, behavioral and psychosocial factors that may have contributed to the resident's lack of restful sleep; identify medical conditions and medications which could impact Resident #18's sleep (the change of pain medications); identify nonpharmacological interventions to promote sleep; discuss the causes or suspected causes of the resident's sleep problems with the resident or family; and discuss available treatment options along with the risks and benefits of nonpharmacologic and pharmacologic interventions. During an interview, on 06/30/11, at 11:30 a.m., an administrative nursing staff member (#2) agreed facility staff failed to complete the appropriate assessments to determine if Resident #18 required a nightly hypnotic. The medical doctor (#5) stated the order should have been for 5 mg of Ambien nightly.	F 329		