STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8072	A. BUILDING: _____ B. WING _____	08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK ON WEST CENTURY LLC	1000 W CENTURY AVE BISMARCK, ND 58503

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B 000	INITIAL COMMENTS The announced standard licensure survey, conducted August 22-23, 2016, included a complete review of 6 current residents, and focused review of 2 closed records. The survey identified no Tier I findings and six Tier II deficiencies.	B 000		
B1020	33-03-24.1-10,2 FIRE SAFETY 2. Fire drills must be held monthly with a minimum of twelve per year, alternating with all workshifts. Residents and staff, as a group, shall either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. This state licensing rule is not met as evidenced by: Based on review of fire drill records and staff interview, the facility failed to conduct a minimum of twelve fire drills on alternating shifts during 12 of 12 drills held in the previous twelve months (September 2015 through August 2016). Failure to conduct fire drills on a monthly basis and on alternating shifts and ensure all Basic Care residents participated and demonstrated their self-preservation capability in the event of a fire, failed to allow the facility the opportunity to identify and correct identified problems, and placed all residents and staff at potential risk in the event an actual fire occurred. Findings include: Review of fire drill records from September 2015	B1020		

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B1020	Continued From page 1	B1020		

through August 2016 occurred on 08/22/2016, and showed the following:
* Records showed the facility conducted only three drills on the night shift.* A night shift drill on 10/29/2015 stated, " [name of person] conducted a mock drill - FD [fire department] not called - bells [alarms] muted - went over procedures and education. Good Drill."
* A night drill on 02/16/2016 stated, "Mock fire drill. Went over procedure with staff."
* A night drill on 06/29/ (year not identified) stated, "Residents were all in bed and if needed residents would have been taken out through courtyard and exit door located on each hallway. Simulated Drill. Some residents that were up were taken to the dining room."
* Fire drill records showed "simulated drills" occurred during all twelve drills reviewed, including the total evacuation drill conducted on 08/17/2016.
* Fire drill records showed residents residing in the Basic Care facility did not participate in fire drills which required each resident to recognize and use the appropriate escape path due to the fire location being in the assisted living portion of the campus and therefore, did not affect the Basic Care.

During interviews with two administrative/management staff members (#1 and #2) on the afternoon of 08/22/2016, and again with a staff member (#2) on the morning of 08/23/2016, the staff members indicated they did not do separate fire drills for the Basic Care residents which involved demonstration of residents and staff implementing appropriate evacuation practices including the selection of the appropriate escape path and relocation of everyone to the appropriate exit, and/or safe area.

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B1040	33-03-24.1-10,4 FIRE SAFETY 4. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department. This state licensing rule is not met as evidenced by: Based on review of fire drill records and staff interview, the facility failed to ensure all residents participated and demonstrated their self-preservation capability during 12 of 12 drills held in the previous twelve months (September 2015 through August 2016). Failure of residents to demonstrate self-preservation during the event of a fire, and the facility's failure to ensure residents do participate, has the potential to place all residents and staff at risk in the event of an actual disaster. Findings include: Review of monthly fire drill records occurred on 08/22/2016 and showed the following drills in which all residents did not participate: *A night shift drill on 10/29/2015 stated, "[name of person] conducted a mock drill - FD [fire department] not called - bells [alarms] muted - went over procedures and education. Good Drill." * A night drill on 02/16/2016 stated, "Mock fire drill. Went over procedure with staff." * A night drill on 06/29/ (year not identified) stated, "Residents were all in bed and if needed residents would have been taken out through courtyard and exit door located on each hallway.	B1040		

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B1040	Continued From page 3 Simulated Drill. Some residents that were up were taken to the dining room." * Fire drill record on 04/08/16 showed one resident refused to come out of her room. The record failed to indicate what action the facility took to ensure the resident participated in this fire drill, as well as future drills. * Fire drill record on 03/02/2016 showed two residents in the chapel with no indication they participated in the drill or what action the facility took to move these residents to a place of safety. * Fire drill report for 12/09/2015 showed two residents refused to participate, one resident remained on the toilet, and two residents were ill and did not participate. The record lacked evidence of any action taken by the facility to address these circumstances and ensure all residents participate and are evacuated to a place of safety. * Fire drill report for 11/16/2015 showed one resident refused to participate with no action taken by the facility. * Fire drill records showed "simulated drills" occurred during all twelve drills reviewed, including the total evacuation drill conducted on 08/17/2016. During interviews with two administrative/management staff members (#1 and #2) on the afternoon of 08/22/2016, and again with a staff member (#2) on the morning of 08/23/2016, the staff members indicated they did not do separate fire drills for the Basic Care residents which involved demonstration of residents and staff implementing appropriate evacuation practices including the selection of the appropriate escape path and relocation of everyone to the appropriate exit, and/or safe area.	B1040		

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B1120	Continued From page 4	B1120		
B1120	33-03-24.1-11,2 EDUCATION PROGRAMS 2. On an annual basis, all employees shall receive inservice training in at least the following: a. Fire and accident prevention and safety. b. Mental and physical health needs of the residents, including behavior problems. c. Prevention and control of infections, including universal precautions. d. Resident rights. This state licensing rule is not met as evidenced by: Based on review of staff training/education records, personnel files, and staff interview, the facility failed to ensure 10 of 14 staff employed in the Basic Care facility attended/received the four mandatory education/training programs every twelve months. Failure to provide relevant and required staff education/training at least annually (every twelve months) does not allow staff to receive pertinent current information, review facility policies/procedures/protocols, and ensure consistency in the provision of care and services to the residents. Findings include: Review on 08/23/2016, of selected personnel files and facility staff education records from July 2015 through July 12, 2016, showed staff did not attend mandatory annual training as follows: -Seven staff members did not attend, or receive,	B1120		

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B1120	Continued From page 5 the mandatory fire safety training held on 11/19/2015. -Seven staff members did not attend/receive the infection control, resident rights, fire prevention, and mental and physical health needs including behavior problems, held on 01/14/2016. -Four staff members did not attend/receive the accident/incident, severe weather, hazardous materials training held on 04/14/2016. -Five staff members did not attend safety/fire training, weather and back safety held on 07/14/2016. During an interview on the morning of 08/23/2016 with a management staff member (#2), the staff member did not provide information showing the above individuals received the training referenced above, and did not provide information showing the facility had an effective system for ensuring all staff received the required mandatory education at least annually (every twelve months).	B1120		
B1210	33-03-24.1-12,1 RESIDENT ASSESSMENTS/CARE PLANS 1. An assessment is required for each resident within fourteen days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly. This state licensing rule is not met as evidenced by: Based on record review, review of fire drill reports, review of incident reports, and staff interview, the facility failed: (1) to ensure a licensed nurse conducted an assessment of the need and appropriateness of as needed (PRN)	B1210		

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B1210	Continued From page 6	B1210		

medications administered by unlicensed personnel to 3 of 3 residents (Resident #2, #4 and #6; (2) failed to assess each individual resident's self-preservation capabilities through required fire drills during 12 of 12 monthly (July 2015 through August 2016) fire drill records reviewed; and (3) failed to conduct assessments of individual falls to determine the risks/factors contributing to the fall for 2 of 2 residents (Resident #3, and #6) who had experienced falls. Failure to conduct adequate assessments of falls placed Resident #3, and #6 at risk for avoidable falls/injury. Failure of assessment by a licensed nurse prior to and following administration of PRN medications placed Resident #2, #4, and #6, at risk for administration of unnecessary medication, receiving inappropriate treatment and delay in appropriate treatment, and experiencing avoidable prolonged avoidable and untreated symptoms and/or pain. Failure to assess the individual self-preservation capabilities during monthly fire drills placed all facility residents and staff at risk for serious harm in the event of an actual fire.

Findings include:

(1) Refer to B1540 for specific findings regarding the lack of licensed nurse assessment for the need and effectiveness of PRN medications administered by medication assistants (MAs) to Resident #2, #4, and #8.
(2) Refer to B1020 and B1040 for specific findings regarding the lack of resident participation in monthly fire drills and the determination of individual resident self-preservation capability.
(3) An interview occurred on the morning of 08/23/2016 with a management staff member (#2) at which time a request for the facility's

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B1210	Continued From page 7	B1210		

policy/procedure regarding falls occurred. The policies/procedures provided stated: ". . . RESIDENT FALL PROCEDURES Policy: Residents who fall will receive basic first aid, basic assessment for injury and transfer to acute hospital as needed as determined by the licensed nurse. Procedure: When a team member is asked to respond to a reported fall or finds a resident who has fallen, the following procedure will be followed: 1. DO NOT MOVE RESIDENT. Resident will be encouraged to remain where they are until licensed nurse determines whether further assistance is needed. Staff will keep resident as comfortable as possible and stay with the resident until further help arrives and/or resident is safe & secure. . . .2. Notify licensed nurse. If licensed nurse is not available, the on call nurse will be notified immediately. 3. The certified nursing assistant should initiate evaluation of the resident. Evaluation will include: a. Vital signs: . . . b. Circumstances of fall. If fall was not witnessed or resident reports loss of consciousness, notify the licensed nurse immediately. c. Pain: If resident is complaining of acute pain . . . or is not able to use a limb normally, notify the licensed nurse immediately. d. Obvious Deformity: If obvious deformity is present, do not move resident. Notify the licensed nurse immediately. . . . Staff will report all findings to the licensed nurse. Attempt to help the resident up or transfer to hospital will be at the discretion of the licensed nurse."

"POLICY & PROCEDURES for POST - FALL CARE. POLICY: It is the policy to investigate falls in order to determine the cause of the fall, the extent of any injuries, and put interventions in place to prevent similar falls. PROCEDURE: Immediately evaluate the resident to ensure that he/she is safe. Notify Nurse manager/call the on

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call nurse. Do not move the resident if a major injury is suspected. The nurse will notify the physician. . . . The nurse will notify the family and document the contact. . . Document resident's statements about the fall. Document staff member's statements about what was observed. Enter findings and observations on the Resident Incident Report form. Institute follow-up interventions as directed by the nurse or physician. . . . . POST FALL CARE is based on nursing assessment of the injury . . ."

- Review of Resident #3's medical record and incident reports occurred on 08/22/2016, and showed the resident had experienced 5 falls between June 01, 2016 and August 10, 2016. Two falls within this time period resulted in fractures to the resident's left wrist. Falls experienced by Resident #3 included:
* 06/01/2016 - Incident Report stated: "6:05 a.m. CNA [certified nurse assistant] heard [Resident #3] yelling for help. When entering room, CNA found [Resident #3] sitting on the floor between bed and wall. She had left arm resting on bed. She said she fell trying to make bed. Said [resident] 'left arm broken' . . . . Resident is diabetic - unsure of BG [blood glucose] level at time. Resident was very sweaty and clammy feeling to touch. R.O.M. [range of motion] done. Determined no injury to legs or back - Resident wanted to get up and sit on couch. She was helped onto couch. Nurse called." Nurses' Progress notes indicated the CNA notified the nurse via phone call at 6:30 a.m. The nurse called the resident's family who came and transported the resident to the emergency room. The emergency room identified Resident #3 had a fracture (in two places) to her left wrist.

FACILITY STAFF FAILED TO FOLLOW THE

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B1210	Continued From page 9 ABOVE REFERENCED FACILITY POLICY/PROCEDURES. The CNA did not immediately call the licensed nurse, did not wait for the licensed nurse to arrive, functioned outside his/her scope of practice by conducting an assessment of the resident for injury, and moved the resident from the floor to the couch without waiting for the licensed nurse. A licensed nurse reviewed the incident report on 06/06/2016. The review determined "All proper procedures taken." The incident report and nurses note on 06/01/2016 did not address the resident's diabetes and "sweaty and clammy feeling on touch," as observed by the CNA. Corrective action for preventing future incidents included only, "Continue safety checks on [Resident #3]." * 06/19/2016 - Incident Report completed by a CNA stated: "10:45 a.m. - Resident was sleeping in her chair and observed 2 minutes prior to fall. When CNA was returning she noted resident laying on floor by chair. Resident stated she fell from chair. Called nurse on call. After taking vitals and R.O.M. nurse came and we assisted her to stand - able to walk. . . . Had not eaten yet. She had been sleeping and refusing to get up. Apparently had been up during night so staff let her sleep. . . .She had fallen 2 weeks ago and broke her left wrist which is in a cast. She has been trying to navigate with the cast and walker." The incident report identified no corrective action in response to the fall, including resident "trying to navigate with cast on left wrist and a walker," and the resident having not eaten and a diagnosis of diabetes. *06/29/2016 - Incident Report stated: "12:30 p.m. - CNA was walking past and saw [Resident #3] kneeling on the floor in front of her couch. She could not tell me what happened. Had last eaten at 8:30 a.m. Just wearing socks [at time of fall]. Unknown if attempting to use bathroom. A cast	B1210		

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B1210	Continued From page 10 on the left arm could have caused her to lose balance." The incident report included no corrective action or further investigation/assessment of the contributing factors related to the fall, i.e., floor wet or dry, resident incontinent, resident hungry, blood glucose level, balance, transfer sitting to standing, and ambulation difficulty due to fracture/cast and use of walker. *07/28/2016 - Nurses' note - "Left wrist fracture healed." *08/10/2016 - Incident Report stated: "7:00 a.m. - [Resident #3] was yelling for help. CNA went into her room and found [Resident #3] laying on the floor lying on her back. [Resident #3] had a cut upper lip and was complaining of pain in her left wrist. Called nurse on call, took vitals and had son come and take resident to emergency room. Unknown when resident last ate. Resident barefoot [when found on floor]. "No further assessment/investigation or causative investigation conducted. Corrective action identified as, "3 stitches to upper lip, left ulna fracture." Following the above referenced falls, investigation/assessment of all factors resulting in or potentially contributing to the fall did not occur. The lack of adequate assessment and appropriate responsive corrective action and care plan revisions resulted in potentially avoidable falls and injury to Resident #3. - Resident #6's medical record and incident reports, reviewed 08/23/2016, showed the resident had experienced seven falls from August 22, 2015 through August 23, 2016. The incident reports identified four of the seven falls were unwitnessed. Incident reports and nurses' notes identified the following factors contributing to	B1210		

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B1210	Continued From page 11 Resident #6's falls and/or risk for falling: *08/22/2015 - Incident Report - "10:30 a.m., Resident found on floor in front of the toilet." The incident report indicated the education provided staff in follow-up to this incident: "As [Resident #6] progresses with dementia we need to be assisting her as she is starting to misjudge when she goes to sit down." The incident report lacked evidence of the following at the time of the fall: condition of the bathroom floor (wet or dry), lighting within the bathroom/room, when did resident last receive toileting assistance, what were results of most recent toileting experience. * 10/08/2015 - Incident Report - "1:00 p.m., CNA found [Resident #6] kneeling on the right knee and the left knee was up. Her hands were in front of her. Has been complaining of her tailbone hurting the last 2 days." No further description of where in the room Resident #6 fell, condition of surroundings and the environment including lighting (natural and artificial), what resident stated or what resident appeared to be trying to do at time of fall, and resident's mental and physical state when last observed (resident has diagnoses of anxiety and depressive disorder), what was resident doing when last seen (five minutes prior to the fall), when did resident last void and/or receive toileting assistance, when did resident last eat, is resident hungry/thirsty? The incident report identified the reasonable cause of the fall as: "Has a shuffle gait. Lose balance at times when walking on the carpet." The record identified no further assessment of this identified cause/problem associated with Resident #6's current fall and potential for further falls. * 05/18/2016 - Incident Report - "9:30 a.m., unwitnessed fall while walking in the dining room. Shoes stick to carpet. Resident has been unsteady on her feet and also unbalanced when attempting to sit in a chair or toilet." The licensed	B1210		

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B1210	Continued From page 12 nurse review of the report identified the following as the reasonable cause for the fall, "Unable to judge when sitting down. Has poor perception." The resident has a diagnosis of glaucoma. Plan for preventing further incidents, "Staff to be aware of [Resident #6's] surroundings and to assist with [Resident #6] when she sits down if noted." The record lacked any further assessment of Resident #6's unsteadiness, balance problems and poor perception related to lighting, colors, footwear, flooring, time of day these problems most prevalent, etc. * 07/01/2016 - Incident Report - "Activity Room 11:25 a.m., [Resident #6] was going to sit in a chair for exercise but missed the chair and fell on her left buttocks between 2 chairs." Incident report lacked evidence of assessment of implementation of prior corrective action regarding staff assistance as referenced in prior fall on 05/18/2016. The incident report indicated the licensed nurse established the reasonable cause for the fall as, "[Resident #6] attempted to sit between 2 chairs rather than on one chair. Depth and space perception affected by cognitive decline and dementia." The record lacked evidence of assessment of other contributing factors to the resident's depth and space perception, and identified no actions to prevent further instances of falls except to assist the resident to sit with cueing and verbalizing. During an interview with a management staff member (#2) on the morning of 08/23/2016, the staff member provided no additional information in regard to the above referenced findings and the lack of further assessment of the risk factors contributing to the falls experienced by Resident #3 and #6.	B1210		

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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) COMPLETE DATE
B1240	Continued From page 13	B1240		
B1240	33-03-24.1-12,4 RESIDENT ASSESSMENTS/CARE PLANS 4. The care plan must be updated as needed, but no less than quarterly. This state licensing rule is not met as evidenced by: Based on record review, review of fire drill reports, review of incident reports, and staff interview, the facility: (1) failed to ensure a licensed nurse conducted, or determined an onsite assessment was not necessary, developed an individualized plan, including alternative interventions other than the use/need for the medication, for 3 of 3 residents (Resident #2, #4 and #6), who had PRN (as needed) medication administered by unlicensed personnel; (2) failed to implement a plan of care addressing each individual resident's self-preservation needs/problems as exhibited in required monthly fire drills during 12 of 12 fire drill records (July 2015 through 08/2016) reviewed; and (3) failed to develop and implement individualized plans of care responsive to the assessed causative/contributing risk factors of falls experienced by 2 of 2 residents (Resident #3, and #6). Failure to develop and implement individualized plans of care placed residents at risk for potential recurring falls and avoidable injury; receive unnecessary/ineffective medication/drugs; and place all residents and staff at risk for harm in the event of an actual fire. Findings include: (1) Refer to B1540 for specific findings regarding the lack of licensed nurse assessment and development of responsive plans of care in regard to specific problem/need requiring the use	B1240		

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	8072	A. BUILDING: _____ B. WING _____	08/23/2016

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B1240	Continued From page 14 of PRN medications for Resident #2, #4, and #6. Review of the records of Resident #2, #4, and #6, showed medication assistants (MAs) administering PRN medications without acknowledgement by a licensed nurse an onsite assessment was not required, and development of written parameters by the licensed nurse for use by the MAs when administering the specific PRN medication to the individual resident. (2) Refer to B1020 and B1040. Failure by the facility to conduct specific required fire drills for the basic care residents' participation resulted in a lack of individualized plans of care addressing necessary interventions to assist the individual resident with evacuation to safety. (3) Review of medical records and incident reports on August 22-23, 2016, showed Resident #3, and #6 had experienced multiple falls. The care plans of each of these residents lacked identified risk for falls, either prior to the falls they experienced or following the falls they incurred. Based on fall risk assessments and assessment/investigation of falls experienced by the resident, the facility did not establish a plan of care for each resident identifying their individual fall risk factors and responsive interventions to prevent recurring falls and resulting injury. Refer to B1210.	B1240		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers	B1540		

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B1540	Continued From page 15 labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to properly administer medications consistent with Chapter 33-43-01 Nurse Aide Training, Competency Evaluation, and Registry, 33-43-01-18 Pro Re Nata (PRN) Medications, and Section 33-43-01-19 Medication Interventions That May Not Be Delegated, for 3 of 3 residents (Resident #2, #4, and #6) receiving PRN (as needed) medication administered by unlicensed personnel (medication assistants) without assessment by a licensed nurse. Failure of the facility to ensure only a licensed nurse assessed the need for and result/response for all PRN medications and medication assistants (MAs) administered PRN medications only within their specific scope of practice, placed residents at risk for avoidable harm, delay in healing, and/or avoidable complications. Findings included: Chapter 33-43-01 Nurse Aide Training, Competency Evaluation, and Registry, 33-43-01-18 Pro Re Nata Medications, and Section 33-43-01-19 Medication Interventions That May Not Be Delegated, require: 33-43-01-18 - "1. The decision to administer pro re nata medications cannot be delegated in situations where an onsite assessment of the client is required prior to administration. 2. Some situation allow the administration of pro re nata medications without directly involving the licensed	B1540		

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B1540	Continued From page 16 nurse prior to administration. a. The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse. b. Written parameters specific to an individual client's care must be written by the licensed nurse for use by the medication assistant when an onsite assessment is not required prior to administration of a medication. The written parameters: (1) Supplement the physician's pro re nata order; and (2) Provide the medication assistant with guidelines that are specific regarding the pro re nata medication." 33-43-01-19 - "The medication assistant I or II, . . .may not perform the following acts even if delegated by a licensed nurse: 1. Conversion or calculation to medication dosage; 2. Assessment of client need for or response to medications; and 3. Nursing judgment regarding the administration of pro re nata medications." During an interview with a management staff member (#2) on the afternoon of 08/22/2016, the staff member identified three facility policies regarding the administration of PRN medications. The three policies identified by the staff member lacked consistency from policy to policy and did not conform to the previously stated requirements. - Review of Resident #2's medical record including medication administration records (MARs) occurred on 08/22/2016, and identified a medication assistant (MA) administered PRN medication to the resident as follows: * "7/20/2016 - 2:30 [a.m. or p.m. not indicated] Ibuprofen 200 mg [milligram] two tablets for complaint of a headache. "The MAR showed the MA identified the medication as "Ineffective" at an unspecified time. The record lacked no evidence of an onsite assessment by a licensed nurse prior	B1540		

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B1540	Continued From page 17	B1540		

to administration of the Ibuprofen, or the result/response to the medication. The record lacked evidence a licensed nurse had determined an onsite assessment was not necessary and provided written parameter for the medication assistants' use in the administration of this medication to Resident #2.
* A MA administered Imodium 4 mg to Resident #2 at 9:15 a.m. on 05/03/2016, at 9:35 a.m. on 05/04/2016, at 10:40/2016 on 02/08/2016, at 10:50 a.m. on 02/10, and 9:30 a.m. on 02/22/2016 a.m., for "Res [resident] had loose stool." On each date, at an unspecified time, the MA identified the medication was "effective." The record lacked evidence of involvement of licensed nurse regarding assessment prior to administration and the response following administration of the Imodium. The record lacked evidence a licensed nurse had determined an onsite assessment was not necessary and provided written parameters for the medication assistants' use in the administration of this medication to Resident #2, including instructions for determining effectiveness and within what time frame following administration.
* A MA administered Imodium at 1:40 [a.m. or p.m. not indicated] on 02/20/2016, with no indication of the reason for administering the medication and no evidence of the response/result. The record lacked evidence of involvement of a licensed nurse in regard to the administration of this medication.
Resident #2's record lacked evidence a licensed nurse had assessed the cause/reason for Resident #2's loose stools in the morning, and implemented a plan of care to prevent morning loose stools.

- Review of Resident #4's medical record including medication administration records

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B1540	Continued From page 18 (MARs) occurred on 08/22/2016, and identified a MA administered PRN Ibuprofen to the resident on two occasions in January 2016. On 01/24/2016 the MA administered Ibuprofen 400 mg at 7 p.m. for "pain and swelling /wrist." At an unidentified time the MA identified the medication was "effective." The record provided no assessment by a licensed nurse of the resident's painful and swollen wrist. The record provided no further information or indication of Resident #4 experiencing a painful and swollen wrist prior to, or following administration of the Ibuprofen. Resident #4 also received Ibuprofen on 01/03/2016, with no evidence of the amount administered, the reason for administration and the result/response to the Ibuprofen. - Review of Resident #6's medical record including medication administration records (MARs) occurred on 08/22/2016, and identified a MA held the residents prescribed Docusate Sodium on 05/04/2016, 05/06/2016 at 8 p.m., 05/07/2016 at 8 a.m., 05/13/2016 at 8 p.m., and on 05/22/2016, at 8 p.m., due to "loose stools." The record lacked evidence a licensed nurse conducted an assessment, and determined the medication should be held on these dates, as well as determining the cause/condition for the resident's loose stools and implementing a responsive plan of care.	B1540		