STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLOOMINGTON REHABILITATION & HCC	**1925 SOUTH MAIN STREET BLOOMINGTON, IL 61701**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to notify the Physician and Power of Attorney (POA) regarding a resident's change in condition for two of three residents (R1, R2) reviewed for notification of change in the sample list of nine. Findings include: The facility's Notification for Change in Resident Condition or Status policy with a revised date of 12/7/17 documents, The facility and/or facility staff shall promptly notify appropriate individuals (i.e. Administrator, DON {Director of Nursing} Physician, Guardian, HCPOA (Health Care Power of Attorney, etc) of changes in the resident's medical/mental condition and or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual signs or symptoms 3. Unrelieved by measure already prescribed. e. A significant change in the resident's physical, emotional or mental condition; h. A need to transfer the resident to a hospital or treatment center; k. Onset of temperature of two degrees higher than baseline; l. symptoms of any infectious process; p. Abnormal complaints of pain. 2. The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the afore mentioned situations. 5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 1.) R1's Physician order [REDACTED]. R1's Nurse's Progress Notes dated 5/9/20 document R1 had a bloody nose most of the day. There is no documentation that R1's Physician was notified regarding this nose bleed. 2.) R2's POS dated 5/1/20-5/31/20 documents R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's Nurse's Progress Notes dated 3/21/20 at 5:00 AM documents complaints of a runny nose, sore throat, occasional non-productive cough. There is no documentation in this Nurse's note of notification of the Physician or Power of Attorney (POA). R2's Nurse's Progress Note dated 3/22/20 at 5:00 AM documents a temperature of 99.1 and does not document any notification of the Physician or POA. R2's Nurse's Progress Note dated 3/23/20 at 10:00 AM documents pale color, audible wheezes, Rhonchi in bilateral upper lobes. This note documents the Nurse Practitioner was notified and an antibiotic order but there is no documentation of the POA being notified. R2's Nurse's Progress Note dated 4/11/20 documents xray results of the abdomen but does not document notification of the POA of the results. On 8/18/20 at 3:19 PM, V2 Director of Nursing stated V2 expects the nurses to notify the Physicians and POA of any changes in resident's condition and they should document the notification.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to assess and monitor for a change in condition for two of three residents (R1, R2) reviewed for changes in condition in the sample list of nine. Finding include: The facility's Notification for Change in Resident Condition or Status policy with a revised date of [DATE] documents,The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON {Director of Nursing}, Physician, Guardian, HCPOA {Health Care Power of Attorney}, etc) of changes in the resident's medical/mental condition or status. The nurse/supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual signs or symptoms 3. Unrelieved by measures already prescribed e. significant change in the resident's physical/emotional/metal condition; h. A need to transfer the resident to a hospital/treatment center; k. Onset of temperature of a temperature two degrees higher than baseline; l. Symptoms of any infectious process; p. Abnormal complaints of pain 5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The facility's COVID-19 Control Measures with a revised date of [DATE] documents, Purpose: To prevent transmission of the COVID-19 Virus and to control outbreaks. Symptoms: Fever, Cough, Shortness of Breath, Nasal congestion, Runny nose, Sore throat, Diarrhea/Vomiting, Extreme fatigue, Muscle pain, Loss of Taste/Smell. Monitoring and Surveillance-Residents 1. Monitor all residents for new onset of fever, cough, shortness of breath, sore throat, nausea, vomiting, diarrhea, extreme fatigue, muscle pain, loss of taste and/or smell. Complete vital signs and pulse oximetry every 8 hours. 1.) R1's Physician order [REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 is cognitively intact and requires extensive assistance of one staff for Activities of Daily Living (ADL). R1's Nurse's Progress Note dated [DATE] at 1:00 PM documents R1 had a bloody nose most of day. The next nurses note documented is dated [DATE] at 5:30 AM, this note documents, (R1's) O2 (oxygen) (saturation) @ (at) 82% (percent) room air, temp (temperature) 99.1, c/o (complaints of) severe body aches (with) headache. Shivering. O2 n/c (nasal canula) applied (at) 3L (liters). (Saturation) increased to 95% but then decreased to 85%. (POA) notified. Signed by an unidentified nurse. R1's nurses notes do not document any monitoring or assessments between [DATE] and [DATE]. On [DATE] with no time documented, there is a nurses note that documents, Droplet precautions d/t (due to) COVID 19 pos (positive). (R1) sent to the hosp (hospital) d/t (decreased) sat (saturation). R1's Emergency Department provider note by V16 Emergency Physician dated [DATE] at 5:58 AM documents R1 is positive for shortness of breath, myalgias (muscle pain), weakness, confusion, R1 is ill appearing, skin is pale, R1 is confused and blood pressure ,[DATE]. R1's summary of hospital care dated [DATE] at 9:08 PM documents R1 was found to have bilateral pneumonia and was placed on a broad spectrum antibiotic. R1 was also found to have an elevated D-dimer (blood clot indicator) and was placed on an anticoagulant. R1 received [MEDICAL TREATMENT] on [DATE] and at 8:51 PM on [DATE] a code blue was called. This note documents R1 was given medications, CPR (Cardio [MEDICAL CONDITION] Resuscitation) and defibrillation but was pronounced dead at 9:08 PM. R1's Death Certificate with a certified date of [DATE] documents the cause of death [MEDICAL CONDITION] due to pneumonia, bilateral pneumonia and End Stage [MEDICAL CONDITION]. This Certificate also documents the significant condition contributing to the death as COVID -19. On [DATE] at 3:19 PM, V2 Director of Nursing (DON) stated since COVID started the nurses are suppose to do vitals and assess every shift. V2 stated there should have been some documentation of assessment somewhere and V2 confirmed there was not any documentation in R1's nurses notes from [DATE] to [DATE] when R1 had a change in condition. 2.) R2's Physician order [REDACTED]. R2's MDS dated [DATE] documents R2 severely cognitively impaired and requires extensive assistance of one staff for ADLs. R2's Nurse's Progress Note dated [DATE] at 3:15 PM documents a temperature of 100.1 degrees and a chest xray ordered. R2's Nurse's Progress Note dated [DATE] at 4:00 PM documents a temperature of 99.0 degrees and an antibiotic started for an Upper Respiratory Infection. R2's Nurse's Progress Notes dated

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

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [DATE] and [DATE] document continued antibiotic for an Upper Respiratory Infection. There is no documentation of an assessment or monitoring in R2's Nurse's Progress Notes on [DATE] or [DATE]. R2's Nurse's Progress Note dated [DATE] at 7:50 PM documents R2 is out to the hospital. There is no documentation in R2's Nurse's Progress Notes of when or why R2 was sent to the hospital. R2's hospital records document on [DATE] at 12:00 AM R2 had a chest xray with findings of poor inspiratory effort and calcified [DIAGNOSES REDACTED] in the right lung. R2's hospital records document a CT (Computerized Tomography) of R2's chest dated [DATE] with findings of bilateral [MEDICAL CONDITION] infiltrates. R2's hospital records document on [DATE] R2's breathing is labored, R2 has a temperature of 102.9 degrees, R2 is diaphoretic (heavily sweating), and unresponsive. This record documents R2 has terminal dyspnea, terminal [MEDICAL CONDITIONS] bilateral pneumonia due to COVID-19. This record also documents R2 is on palliative sedation. The hospital's Record of Death documents R2 died on [DATE] at 4:05 AM. R2's Death Certificate dated [DATE] documents R2's cause of death was Pneumonia (COVID 19). On [DATE] at 3:19 PM, V2 DON stated nurses are suppose to be assessing and monitoring residents every shift since COVID 19 started. On [DATE] at 2:34 PM, V2 confirmed there is no assessments or monitoring documented in R2's nurse's notes on [DATE] or [DATE]. V2 stated there is nothing documented to tell us why R2 was in the hospital.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** Based on interview, and record review, the facility failed to complete weekly monitoring of multiple pressure ulcers (R8) complete daily skin monitoring for high risk residents (R8 and R9) and update a care plan after the development of pressure ulcers (R9) for two of three residents reviewed for pressure ulcers on the sample list of nine. Findings include: 1. R8's Wound Evaluation and Management Summary form, documents on 5/7/2020 by V7 (Wound Physician): shear wound to scrotum, wound size: 4 centimeters (cm) by 2.5 cm. Shear wound to right buttock, wound size: 3 cm by 3 cm by 0.1 cm. Stage 4 pressure wound of the left buttock, wound size: 11 cm by 11 cm by 0.1 cm. R8's Wound Care Telemedicine Follow up Evaluation form, documents on 6/4/2020 by V7 (Wound Physician): shear wound to scrotum, wound size: 1 cm by 0.5 cm. Shear wound of the right buttock, wound size: 4 cm by 2.5 cm by 0.1 cm. Stage 4 pressure wound of the left buttock: 3 cm by 1.5 cm by 0.1 cm. R8's medical record does not document weekly skin monitoring (size and characteristics) of R8's open pressure areas from 5/8/2020 to 6/4/2020. R8's care plan documents, problem/need: pressure ulcers, approach/interventions: nurse to measure and monitor wound status progression or deterioration every week. On 8/11/2020 at 9:40 AM V2 Director of Nursing stated, I am not able to locate any weekly wound monitoring/ measurements for R8 from 5/8/2020 to 6/3/2020. 2. R8's Braden Scale for Predicting Pressure Ulcer Risk form documents on 4/14/2020 a total score of 12, indicating high risk for pressure ulcers, and a total score of 13 on 7/15/2020 indicating high risk for pressure ulcers. R8's care plan documents, problem/need: pressure ulcers, approach/interventions: Braden scale score 13, high risk. High risk- daily skin check with documentation and as needed with any new open area. R8's May, June, July and August 2020 Treatment Administration Records (TAR's) do not document the completion of daily skin checks. 3. R9's Wound Evaluation and Management Summary form documents on 7/9/2020 by V7: unstageable DTI (deep tissue injury) of the left lateral ankle, etiology: pressure, wound size: 1 cm by 0.5 cm. Shear wound buttock, wound size: 2 cm by 0.6 cm by 0.1 cm. R9's Wound Evaluation and Management Summary form documents on 7/23/2020 by V7: unstageable (due to necrosis) of the left lateral ankle, etiology: pressure, wound size: 1.3 cm by 1.3 cm. Shear wound buttock, wound size: 1 cm, by 0.4 cm by 0.05 cm. Unstageable DTI of the right lateral ankle, etiology: pressure, wound size: 1.5 cm by 1.7 cm. R9's undated care plan documents Problem/need: R9 is high risk for pressure ulcer per Braden Risk assessment. Braden risk score is 16 per last risk assessment, see current risk assessment for current risk score. Risk factors include: obesity, causes friction and poor movement ability, rarely out of bed, skin is frequently moist. Strengths include: able to move self in bed, able to determine discomfort and move self accordingly, fluid and food intake adequate. Resident specific information: had previous wound to right thigh which healed quickly. Goal: will have no new open areas caused by friction or pressure for the next day days. Approach/ intervention: High risk: daily skin check with documentation and as needed with any new open areas. Dietary consult to consider nutrition/ hydration factors treating related risk factors. Apply theraworx to peri area with every incontinent episode and as needed. Toilet/ change brief when wet and upon rising at hs and after meals. Encourage to do wheelchair pushups/ change position, allow choice for meals and activities. Keep fluids at bedside and offer during cares unless contraindicated. Assess skin- if open or bruised areas noted, report to MD (physician) and responsible party. Daily sponge bath. Bed bath as needed, skin check daily during cares and during bath/shower. Place bilateral half side rails in up position for use while in bed to promote bed mobility. Invite and encourage participation in activities especially those including exercise or active game type or where snacks/ drinks are provided. R9's pressure ulcer care plan does not document R9's shearing to right buttock and pressure wounds to left and right ankles. R9's May, June, July and August 2020 Treatment Administration Records (TAR's) do not document the completion of daily skin checks. On 8/17/2020 at 10:30 AM, V11 Care Plan Coordinator stated, R9's pressure ulcer care plan has not been updated regarding R9's open pressure areas that started on 7/6/2020. V11 stated R9's care plan in R9's medical record is the most up to date care plan. 8/18/2020 at 2:20 PM V2 DON stated if a resident is high risk for skin breakdown, daily skin checks should be documented on the TAR's using the CROPS code. If they are at moderate risk they are weekly skin checks on the TAR's. The facility's policy, with a revision date of January 2018, titled Decubitus Care/Pressure Areas documents, Policy: It is the policy for his facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. Procedure: 5) Documentation of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form. The assessment must include: i) Characteristic (i.e: size, shape,depth, color, presence of granulation tissue, necrotic tissue, etc). 8) When a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers. The facility's policy, with a revision date of January 2018 titled Pressure Sore Prevention Guidelines documents, Policy: it is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. Procedure: The following guidelines will be implemented for any resident assessed at a Moderate or High skin risk. Intervention: Daily Skin Checks for High Risk, comments: Follow protocol for coding the skin condition. C- clear, R- red, O- other, P- pressure, S- skin tear.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to recognize an incident as a fall, failed to investigate the fall and conduct a root cause analysis of the incident, failed to identify and develop targeted interventions as a result of the incident, and failed to report the fall pursuant to the facility's Fall Prevention Policy. These failures relate to one of three residents (R1) reviewed for falls in the sample list of nine. Findings include: The facility's Fall Prevention policy with a revised date of 11/10/18 documents, 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses note or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be written on the care plan. R1's Physician order [REDACTED]. R1's Minimum Data Sheet ((MDS) dated [DATE] documents R1 is totally dependant on two people and a mechanical lift for transfers. R1's undated Care Plan documents R1 requires two person assist with a mechanical lift for transfers. R1's unsigned Nurse's Progress Note dated 5/5/20 at 9:00 AM documents, given pain med (medication) prn (as needed). Transferring from chair to bed, (left) knee buckled and RN (Registered Nurse) lowered to floor safely. (blood pressure) 148/78, (temperature) 97.5, (pulse) 75, (respirations) 20, (oxygen saturation) 95%. The facility's accident and incident log for May, 2020 does not document a fall for R1. On 8/18/20 at 2:34 PM, V2 confirmed R1's fall on 5/5/20 was not reported or investigated and confirmed there were no injuries. On 8/19/20 at 8:29 AM, V11 MDS/Care Plan Coordinator stated Therapy had written a clarification order that R1 could be a one to two person transfer on non [MEDICAL TREATMENT] days but on [MEDICAL TREATMENT] days when R1 was more weak, R1 needed to stay a two person assist with a mechanical lift for transfers. V11 confirmed this fall on 5/5/20 was not a [MEDICAL TREATMENT] day for R1.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document the completion of physician ordered blood glucose monitoring, and the administration of physician ordered insulin for three of three (R1, R4 and R9) of three residents reviewed for medication administration on the sample list of nine. Findings include: 1.) R1's Physician order [REDACTED]. This POS documents orders for Accuchecks before meals and at bedtime and record. This POS documents an order for [REDACTED]. This POS also documents [REDACTED]. R1's Medication Administration Record (MAR) dated 5/1/20-5/31/20 documents R1's accuchecks were not documented as complete at 5:00 PM on 5/11/20, and at 8:00 PM on 5/8/20 and 5/10/20. R1's Medication Administration Record (MAR) dated 5/1/20-5/31/20 documents the Basaglar 6 units at bedtime was not given on 5/7/20 and on 5/10/20. This MAR also documents that R1's Humalog sliding scale insulin was not administered at 7:30 AM on 5/11/20 when R1's blood glucose level was 168 and R1 should have received 2 units of Humalog. This MAR also documents R1's Humalog sliding scale was not administered at 5:00 PM on 5/1/20 when R1's blood glucose level was 236 and should have received 4 units of Humalog. R1's MAR continues document Humalog not being administered on 5/4/20 at 5:00 PM when R1's blood glucose level was 322 and should have received 8 units of Humalog. R1's MAR documents on 5/7/20 that R1's Humalog insulin was not given at 5:00 PM when R1's blood glucose level was 194 and should have received 2 units of Humalog. This record documents on 5/9/20 at 5:00 PM R1's blood glucose level was 210 and should have received 4 units of Humalog and it was not administered. ON 5/10/20 at 5:00 PM R1's blood glucose level was 364 and should have received 10 units of Humalog and it was not administered. R1's MAR documents at 8:00 PM on 5/1/20, 5/4/20 and on 5/5/20 R1 did not receive the sliding scale Humalog as ordered. On 5/1/20 R1's blood glucose level was 236 and should have received 4 units of Humalog, on 5/4/20 R1's blood glucose level was 300 and should have received 6 units of Humalog and on 5/5/20 R1's blood glucose level was 170 and should have received 2 units of Humalog and R1's MAR has no documentation to show Humalog was administered at these times. R1's MAR dated 4/1/20-4/30/20 documents an order for [REDACTED]. This record documents that R1's accuchecks were not completed on 4/13/20 at 7:00 AM, 4/12/20 at 11:30 AM, 4/6/20 and 4/9/20 at 5:00 PM, and 4/1/20, 4/12, 4/18, 4/20, 4/23, 4/24, and 4/29/20 at 8:00 PM. This MAR documents an order dated 2/15/20 for Humilin N 100units/ml (milliliter) inject 4 units sub cutaneously before meals, hold if blood glucose below 150 or not eating. This MAR documents R1 did not receive this ordered Humilin N on 4/11/20 at 11:00 AM, 4/17/20 at 11:00 AM, 4/19/20 at 7:30 AM and 11:00 AM, on 4/20/20 at 3:00 PM and 4/22/20 at 3:00 PM. R1's MAR dated 3/1/20-3/31/20 documents an order for [REDACTED]. This record documents that R1's accuchecks were not completed on 3/10/20, 3/16/20, 3/27/20, and 3/30/20 at 11:30 AM and documents that accuchecks were not completed on 4/3/20, 4/15/20 and 4/17/20 at 8:00 PM. This MAR documents an order for [REDACTED]. This MAR documents R1 did not receive the Humilin N on 4/2/20 at 7:00 AM, on 4/2/20, 4/16/20, 4/18/20 and on 4/25/20 at 11:00 AM. On 8/18/20 at 3:19 PM, V2 Director of Nursing stated if medication is not given or an accucheck is not completed the nurse is expected to circle the time on the MAR and turn it over and document the reason why it was not administered or completed. 2. R4's medical record documents under physician orders: Accu Check (blood glucose monitoring) twice daily and record at 7:00 AM and 8:00 PM dated 2/15/19, [MEDICATION NAME] (insulin) inject 30 units SQ (subcutaneous) every bedtime at 8:00 PM dated 12/10/19 and [MEDICATION NAME] (insulin) inject 13 units three times a daily before meals at 7:00 AM, 11:30 AM and 5:00 PM. R4's June MAR's (Medication Administration Records) do not document the administration of [MEDICATION NAME] (insulin) 30 units subcutaneous (SQ) at 8:00 PM on 6/7/2020, 6/11/2020 and 6/23/2020. These same MAR's do not document the administration of [MEDICATION NAME] (insulin) SQ 13 units at 11:00 AM on 6/3/2020 and 6/19/2020. R4's August MAR's do not document the completion of physician ordered Accu Check (blood glucose monitoring) on 8/7/2020 at 7:00 AM. These same MAR's do not document the administration of physician ordered [MEDICATION NAME] (insulin) on 8/7/2020 at 7:00 AM and 11:00 AM and physician ordered [MEDICATION NAME] (insulin) 30 units SQ on 8/2/2020 at 8:00 PM. 3. R9's medical record documents under physician orders: Accu Check (blood glucose monitoring) twice daily at 6:00 AM and 8:00 PM dated 8/12/19 and Basaglar (insulin) inject 20 units SQ every bedtime at 8:00 PM dated 8/12/19. R9's May MAR's do not document the completion of physician ordered Accu Checks (blood glucose monitoring) on 5/13/2020 at 6:00 AM, 5/10/2020 and 5/16/2020 at 8:00 PM. These same MAR's fail to document the administration of physician ordered Basaglar (insulin) 20 units on 5/10/2020 at 8:00 PM. R9's August MAR's do not document the completion of physician ordered Accu Checks (blood glucose monitoring) on 8/1/2020 at 6:00 AM. 8/18/2020 at 2:20 PM V2 DON (Director of Nursing) stated all medications, once administered should be signed out with initials on the Medication Administration Records. The facility's policy, with a revision dated of 11/18/17, titled Medication Administration documents, Definition: The complete act of administration entails removing an individual dose form a previously dispensed, properly labeled container, verifying it with the physician's orders [REDACTED]. Procedure: After a drug is given, record the date, time,, name of drug, dose and route on the resident's individual Medication Administration Record.