STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 document review and interview, the facility failed to ensure medications were obtained and administered as ordered, and also failed to ensure accurate documentation of medication given, to provide a clear picture of medications administered, which affected 4 of 4 residents reviewed (R1, R2, R3, and R4) for medication administration. Findings included: R1's census record in the electronic medical record (eMR) showed R1 admitted to the facility on [DATE], and had two hospital admissions on [DATE]-[DATE], and [DATE]-[DATE]. R1's hospital discharge summary dated [DATE], noted R1 had been discharged to the facility for transitional care, with history of cognitive disorder, alcohol liver disease complicated by hepatic [MEDICAL CONDITION] ([MEDICAL CONDITION] caused by liver failure), type 2 diabetes, chronic diastolic heart failure ([MEDICAL CONDITION]), and stage 4 [MEDICAL CONDITION]. R1's admission Minimum Data Set ((MDS) dated [DATE], noted [DIAGNOSES REDACTED]. R1 did not have signs or symptoms of [MEDICAL CONDITION], or any refusal of care, at the time of the MDS assessment. R1's Care Plan had a cognition focus dated [DATE], which noted R1 had intact cognition based on the Brief Interview for Mental Status (BIMS) score ,[DATE]. Goals included R1 functioning at the highest possible level with no further decline in cognition. Interventions included giving medication as prescribed by the physician. R1's [DATE] Medication Administration Record (MAR) had an order from R1's admission for 550 milligrams (mg) twice daily of [MEDICATION NAME], an antibiotic used to treat R1's hepatic [MEDICAL CONDITION]. Review of the May MAR did not provide evidence that R1 received [MEDICATION NAME] as ordered for the a.m. or p.m. dose on [DATE], because the nurse's initials were circled on the MAR for each dose, as a sign that the medication was not given. There were no notes written on the MAR or in the nursing progress notes to explain why the medication was not given, such as whether the resident declined the medication or was unavailable at the time of administration, or whether the medication was not available. There was also an order [REDACTED]. This medication was never given until the order changed on [DATE], for 15 mL to be scheduled twice daily. Staff signed that they gave the [MEDICATION NAME] only once in the morning on [DATE], and twice on [DATE]. On [DATE], the [MEDICATION NAME] order changed to give R1 15 mL three times every day, and staff signed the medication as given per the order for the rest of May. R1's [DATE] MAR showed again that R1 did not receive [MEDICATION NAME] as ordered for the a.m. or p.m. dose on [DATE], and again for the a.m. dose on [DATE], because the doses were circled on the MAR. The [DATE] p.m. dose was not signed out with initials at all. On the back of the MAR, there was a note dated [DATE], that there was, no [MEDICATION NAME] and staff had, ordered from pharmacy. R1's progress note dated [DATE], mentioned R1 was not responding appropriately to questions, within his baseline, and the nurse practitioner on call ordered R1 to go to the emergency room (ER). R1's hospital discharge summary noted R1 was admitted [DATE] and discharged back to the facility on [DATE]. His principle problem was acute hepatic [MEDICAL CONDITION], as R1 presented to the ED with decreased level of consciousness. Hospital notes it was unclear what precipitated the acute hepatic [MEDICAL CONDITION]. The hospital provided R1 with [MEDICATION NAME] and [MEDICATION NAME], and R1 did improve as evidenced by knowing who he was, and being able to answer yes and no questions. R1 was discharged with an order for [REDACTED]. Upon return to the facility [DATE], R1's MAR showed [MEDICATION NAME] was given once on [DATE], Once on [DATE], and then not again until [DATE]. Staff missed two 60 mL doses of [MEDICATION NAME] on [DATE], and one dose on [DATE]. R1's progress note dated [DATE], mentioned R1 was not responding appropriately, and had a fixed stare. The nurse practitioner ordered staff to send R1 to the hospital for evaluation for altered mental status. R1's Hospital Admission History and Physical dated [DATE], described R1 as being confused but able to stated he, doesn't feel right. R1 was brought to the hospital due to altered mental status. The note about history clarified that this was R1's fourth admission for similar symptoms in the past ,[DATE] months, and he was recently discharged from the hospital on [DATE] after his hepatic [MEDICAL CONDITION] cleared with administration of [MEDICATION NAME]. Palliative care (interdisciplinary medical caregiving approach aimed at optimizing quality of life and suffering among people with serious, complex illness) was consulted in the hospital, and wrote in a consultation note dated [DATE], that R1 had been given [MEDICATION NAME] in the hospital, and felt R1's readmission was, likely due to non-adherence of medications, despite being in TCU (transitional care unit) where medications are administered by nursing. Recommendations for reinforcement of medication compliance communicated to both patient and facility. The note described R1 as being compliant with medications, and taking them as scheduled in the hospital. When talking with R1 in the hospital, he was confused, disoriented, and unable to make meaningful conversation about his goals of care. The assessment noted that further information was needed from the TCU to find out whether R1 was refusing medications, or if nursing was not administering the medications as prescribed. R1 was described as, likely medically appropriate for hospice however this was not discussed as the goals of care were unclear at the time. The hospital discharge orders dated [DATE], noted R1 was discharged back to the TCU, and no changes were made to the [MEDICATION NAME] and [MEDICATION NAME] orders. The discharge orders included communication to nursing to record the frequency and nature of stools every 24 hour period, with the goal to have ,[DATE] semi solid bowel movements per day. If R1 was not meeting this goal, nursing staff were to contact the provider to adjust the [MEDICATION NAME] order. On [DATE], at 12:00 p.m. the director of nursing (DON) confirmed R1 was in the hospital, but would be returning later that day. DON described R1 as declining medically before the most recent hospital admission [DATE], as evidenced by the orders for [MEDICATION NAME] increasing from only getting them as needed, to being scheduled 15 mL twice daily, then three times daily, and then increasing to 60 mL three times daily. DON stated she measured the amount of [MEDICATION NAME] left in the bottles, and compared that to the amount that should have been given, and felt that the proper doses of [MEDICATION NAME] had been given, but that nursing had not consistently signed it out as being given on the MAR. DON believed that one nurse had already been educated about this documentation issue yesterday, as the facility had started looking into the documentation concern. On [DATE], at 12:08 p.m. licensed practical nurse (LPN)-A was asked about why [MEDICATION NAME] looked as though it had not been administered in June before R1's hospitalization starting [DATE]. LPN-A stated that the facility ran out of [MEDICATION NAME], and it was an expensive medication which required a prior authorization before the pharmacy could send more. LPN-A remembered being off the schedule for a while, and when she came back to work on [DATE], she noticed that the medication was out, and had not been given since [DATE]. After that realization, LPN-A called the pharmacy and was told she needed prior authorization to send the medication because of the high cost. LPN-A then called the DON to get verbal authorization for the medication to be sent, called the pharmacy back and gave them the authorization, and the medication was approved. LPN-A stated the next dose was received to be given on [DATE]. LPN-A was asked why R1 did not get [MEDICATION NAME] before the hospital stay starting [DATE]. LPN-A remembered the medication had run out and she called to order it from the pharmacy on [DATE], and made note of the order on the back of the MAR. At that time the pharmacy needed pre-authorization, so LPN-A had to get it from the DON, and then get that information back to the pharmacy, which was why R1 did not get the medication on [DATE] or [DATE] before being sent to

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 0755

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)

the hospital. LPN-A stated R1 never refuses any medications offered by LPN-A. When asked about R1's cognition since return from the hospital, LPN-A described R1 as being cognitively back at his baseline. On [DATE], at 3:41 p.m. the facility's pharmacist was asked about how [MEDICATION NAME] worked to prevent hepatic [MEDICAL CONDITION], and stated the medication was an antibiotic that worked to reduce the number of bacteria in the digestive tract that produced ammonia. When asked whether missing days of [MEDICATION NAME] could cause acute hepatic [MEDICAL CONDITION] requiring hospitalization , the pharmacist was unable to say clinically if that was the cause of the acute episode. On [DATE], at 3:59 p.m. R1's medical doctor (MD) explained that upon admit to the facility, R1 had already had recent previous history of multiple hospitalization s for hepatic [MEDICAL CONDITION] as R1 had deteriorating [MEDICAL CONDITION] of the liver, and was very fragile. MD explained R1's initial [MEDICATION NAME] order was only to be given as needed, to ensure R1 was having bowel movements to remove ammonia. MD stated that order was not enough for him, so they ordered [MEDICATION NAME] to be scheduled. Then R1 went to the hospital, and at first they thought it was due to not enough [MEDICATION NAME], so they increased the dose upon discharge, and everything seemed to be going perfectly, and the laboratory test results looked good, and then all of a sudden R1 would quickly decline. MD stated R1's [MEDICAL CONDITION] was, end stage and because R1 was very fragile, any little thing could trigger acute hepatic [MEDICAL CONDITION]. MD could not say that missing a few doses of [MEDICATION NAME], or [MEDICATION NAME] was the cause of the hospitalization , because R1 was so medically complex and fragile, and had this history of acute hepatic [MEDICAL CONDITION] multiple times prior to admission. MD did confirm that many times she was not aware that medications were not given, and added that, a lot of the time it was unclear whether medications were given due to the way staff documented medication administration in the paper records. MD stated she would prescribe something, and has no way of knowing whether medications were received and given without coming to the nursing home and looking through the paperwork herself because staff did not always communicate when a medication was unavailable. MD stated staff would only tell her if a lifesaving medication was gone. When the medication was very significant for the resident, the staff might tell her if it was unavailable, but otherwise staff only circled the dose on the MAR and MD wouldn't find out it was unavailable until she visited a week later and looked through the paper records. For example, upon discharge from the hospital, residents arrive at the facility with a list of medications needed, and some of the medications might not be typical, like [MEDICATION NAME]. Those less typical medications might not be available immediately at the nursing home, and staff need to call me if the medications are unavailable, and they do not. MD explained that if a resident was admitted to the nursing home the evening after MD visited the nursing home, and there was no medication available, MD might not find out about the medication issue for a week until she visited again. MD expected the nursing home to monitor availability of ordered medications, and stated she needed to know if something was not available, because then she could find an alternative. Again, MD mentioned that sometimes staff just circled the medication dose on the MAR, and that meant the medication was not given. MD explained that the circle did not explain why a medication was not given, just that it was not given, so then MD had to ask staff why a medication was circled for days. MD stated sometimes the medication was refused, sometimes it was unavailable, but staff did not document the reason why. MD stated best case scenario, if something was unavailable the staff would let her know right away. MD wondered if maybe staff did not have the medical knowledge to know which medications were important. For refusals, maybe it was hard for staff to distinguish the very important medications, but MD wanted to be notified by the next day for sure if important medications were not taken. For less important orders, MD gave the example of a nutritional shake, staff could alert her of refusals using a communication book. On [DATE], at 4:28 p.m. the DON stated she was not aware that R1 had not received [MEDICATION NAME] as ordered until R1 was hospitalized [DATE], and the DON began looking at R1's medication records. The DON expected nurses to call her right away if a medication was not available in-house, and to follow-up with the pharmacy right away. The DON expected nursing staff to call the doctor after the first missed medication dose to communicate. The DON expected nursing staff to circle any missed dose on the MAR, and then document on the back of the sheet why the medication was not given. When asked what blank entries on the MAR meant, the DON felt that meant the nurse failed to document the dose given, rather than the nurse failing to give the medication. During telephone interview on [DATE], at 9:23 a.m. R1's resident representative (RR)-E stated the situation was egregious in that R1 did not get [MEDICATION NAME] for multiple days, and was sent to the hospital. RR-E explained in the hospital, at first the staff wondered whether R1 should remain designated as full code (choosing to receive CPR if the heart stopped beating, and receiving full medical treatment) due to the progression of his hepatic [MEDICAL CONDITION]. RR-E wondered if this situation could have been a result of not getting medication, when there was really no reason to not provide the medication, and felt that was egregious. R2's admission MDS dated [DATE], included moderate cognitive impairment with a BIMS score of ,[DATE]. During the seven day look back, R2 rejected care daily. [DIAGNOSES REDACTED]. The admission record listed primary [DIAGNOSES REDACTED]. R2's care plan dated [DATE], included a focus on [MEDICAL CONDITION] related to prior medical history of [REDACTED]. The goal was for R2 to be free of [MEDICAL CONDITION], and interventions included providing anticonvulsant medication per the doctor's order. The care plan also noted on [DATE], that R2 was resistive to cares, treatment, and medications. The goal was for R2 to participate in care and take medications as prescribed. Interventions included allowing R2 to make decisions about treatment regime to provide sense of control, re-approaching five to ten minutes later if R2 resisted care, and notifying R2's family for encouragement. R2's progress notes throughout February 2020 documented that R2 regularly refused medications, or needed much encouragement to take medications. The census in the eMR showed R2 was hospitalized [DATE]-[DATE]. R2 had orders for 500 mg levetiracetam (anti-convulsant medication) twice daily, starting [DATE]. The [DATE] MAR showed all doses of levetiracetam given until [DATE], when R2 was out of the facility. Progress notes showed R2 was in the hospital [DATE]-[DATE] (unrelated to [MEDICAL CONDITION]). Upon return from the hospital on [DATE], the MAR had a circled morning dose, and no documentation for the evening dose on [DATE] and [DATE]. There was no evening dose documented at all on [DATE]-[DATE], [DATE], [DATE]-[DATE], and [DATE]. There was no documentation on the MAR for why R2 did not receive the doses above. There was no documentation in the progress notes for why R2 did not receive the doses above, and whether R2 had refused any of the doses. Progress notes showed R2 was in the hospital again from [DATE]-[DATE] related to unresponsiveness, and [MEDICAL CONDITION] episodes. Upon return from the hospital, the order increased to 750 mg levetiracetam twice daily starting [DATE]. R2's progress note dated [DATE], described R2 as awake and staring at the wall with no verbal response. R2 was leaning back in his chair, unable to sit up straight. R2's head dropped back, eyes were moving from side to side, and head was moving for about one minute. Staff called the on-call provider, who ordered R2 to be sent to the hospital. R2 continued to have six of these episodes until medics arrived and to take R2 to the hospital, where he was admitted to the neurology unit. R2's hospital discharge paperwork dated [DATE], noted R2 presented to the ED with recurrent [MEDICAL CONDITION] episodes. The initial head CT (computed topography) did not show anything, so neurology was consulted. The levetiracetam dose was increased from 500 mg to 750 mg twice daily. R2 also had an acute kidney injury, which had been happening recurrently due to poor oral intake. The paperwork noted R2 needed frequent monitoring to ensure oral intake and compliance with medication. With multiple medication changes and improvement in oral intake, R2's mental status improved before he was discharged from the hospital [DATE]. On [DATE], at 12:00 p.m. the DON stated at the time of R2's hospitalization [DATE]-[DATE], she performed a medication review because R2 had gone to the hospital for [MEDICAL CONDITION] activity, and the documentation made it look like R2 had not been given his anti-convulsant medication. The DON described reviewing the dates that levetiracetam medication had been delivered from the pharmacy, and comparing that with the number of doses that should have been given, and the number of pills missing from the supply. DON stated that according to her review, it appeared that all of the medication had been given as ordered, except for four times when R2 had refused. The lack of documentation made it difficult to determine if R2's [MEDICAL CONDITION] and subsequent hospitalization s were a result of not receiving the medications as ordered. On [DATE], at 1:54 p.m. LPN-A stated if a resident declined to take their medication, she would circle the dose on the MAR, and then on the back of the MAR she would write a comment that the resident refused to take the medication. On [DATE], at 4:28 p.m. the DON was asked whether she kept any of the medication cards from March, to help explain how she counted the doses that were actually given, versus the doses that were documented. The DON had calculations on paper, but had not kept the cards. When asked how she knew there were four refusals in March, because on the MAR only two doses were circled suggesting refusal, the DON could not remember. The DON felt that the staff gave the medication but forgot to document the medication as given, and acknowledged that the facility was working on proper documentation. According to the DON, in March and [DATE] there were MAR documentation audits three times a week, but once COVID-19 became a focus the audits stopped and documentation became a problem again. DON stated they were working on staff training for how to properly document on the MAR. R2's [DATE] MAR lacked initials that the morning dose of levetiracetam was given on [DATE] and [DATE]. There was no documentation on the MAR as to why the doses had not been signed

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) as given. R2's [DATE] MAR lacked initials that the morning dose of levetiracetam was given on [DATE] and [DATE]. The MAR also lacked initials that the evening dose had been given on [DATE]. There was no documentation on the MAR as to why the doses had not been signed as given. There was no documentation in the progress notes about whether these doses had been given or not. R2 needed encouragement to take medications, but documentation on the MAR made it difficult to tell if R2 had refused medications, or had not been offered medications ordered by the physician to prevent [MEDICAL CONDITION]. R3 annual MDS dated [DATE], noted R3 was cognitively intact and did not refuse cares. R3's census record showed R3 admitted to the facility on [DATE], with history of [MEDICAL CONDITION] disorder, major [MEDICAL CONDITION], and post-traumatic stress disorder ([MEDICAL CONDITION]), and type 2 diabetes mellitus. R3 care plan dated [DATE], had a diabetes mellitus focus which noted R3 needed monitoring and medication. Intervention included diabetes medication as ordered by physician. R3 care plan had a focus which noted R3 uses oxygen therapy related to chronic [MEDICAL CONDITION]. Intervention included R3 uses oxygen via nasal prongs as ordered. R3 care plan included a focus on chronic pain. Intervention included administer [MEDICATION NAME] as per orders. R3 care plan included a focus where R3 received antidepressant medications related to depression and chronic pain. Intervention included giving antidepressant medications ordered by the physician. R3's [DATE] Medication Administration Record (MAR) had an order for [REDACTED]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the June MAR revealed no evidence R3 received this medication for one dose on [DATE], for two doses on [DATE] and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the June MAR revealed no evidence R3 received this medication for one dose on both [DATE] and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the June MAR revealed no evidence R3 received this medication for one dose on both [DATE] and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the June MAR revealed no evidence R3 received this medication for one dose on both [DATE] and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the June MAR revealed no evidence R3 received this medication for one dose on both [DATE] and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order to check oxygen sats every shift and document oxygen liters utilized to treat chronic [MEDICAL CONDITION]. Review of the June MAR revealed no evidence R3 received oxygen for one shift on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], two shifts on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the May MAR revealed no evidence R3 received this medication on [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the May MAR revealed no evidence R3 received this medication for two doses on [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the May MAR revealed no evidence R3 received this medication for one dose on [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R3's [DATE] MAR had an order for [REDACTED]. Review of the May MAR revealed no evidence R3 received this medication for one dose on [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R4 quarterly MDS dated [DATE], noted R4 was cognitively intact and did not refuse cares. R4's [DIAGNOSES REDACTED]. R4 care plan dated [DATE], had a diabetes mellitus focus which noted R4 needed monitoring and medication. Intervention included diabetes medication as ordered by physician. R4 care plan had a [MEDICAL CONDITION] focus. Intervention included daily weights. R4 care plan included a focus on nutrition due to dysphasia. Intervention included monitoring tube feeding for adequacy and tolerance. R4's [DATE] MAR had an order for [REDACTED]. Review of [DATE] MAR revealed no evidence R4 received the medication on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R4's [DATE] MAR had an order for [REDACTED]. Review of [DATE] MAR revealed no evidence R4 received the medication on [DATE], [DATE], [DATE], and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the medication wasn't given. R4's [DATE] MAR had an order for [REDACTED]. Review of [DATE] MAR revealed no evidence R4 received the tube feeding on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. There were no notes written on the MAR or in the nursing progress notes indicating an explanation of why the tube feeding wasn't given. During an interview dated [DATE], at 12:40 p.m. registered nurse (RN)-A verified if a blank is noted on the MAR it signified a medication wasn't given. During an interview dated [DATE], at 12:48 p.m. RN-B indicated when giving medications the 5 rights to a medication pass were performed, the medication is given, RN-B watched the resident swallow the medication, and then comes back to the MAR and documents the medication given by writing initials in the space provided. RN-B verified if a blank was noted on the MAR it signified a medication wasn't given. During an interview dated [DATE], at 1:58 p.m. RN-C indicated that when a medication is refused or not given, the initials on the MAR are circled and the page turned over with the explanation of why the medication wasn't given. RN-C verified that if a blank was noted on the MAR it signified a medication wasn't given. During and interview dated [DATE], at 4:28 p.m. director of nursing (DON) indicated when a medication is missed the staff should initial the MAR, place a circle around the initials, turn the MAR over and write an explanation on the back of why the medication wasn't given. When asked what blank entries on the MAR meant, the DON indicated it meant the nurse failed to document the dose given, rather than the nurse failing to give the medication. During an interview dated [DATE], at 3:59 p.m. the medical director (MD) indicated that staff just circled their initials on the MAR, which meant the medication was not given. MD explained the circled initials did not explain why a medication was not given, just it was not given, MD had to ask staff why a medication would be circled for days. MD stated sometimes the medication was refused, sometimes it was unavailable, but staff did not document the reason why, but should. The facility Medication Administration policy, dated [DATE] indicated staff are to make sure the resident swallows the medication and then sign off the medication given on the MAR.