STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK HEALTHCARE CENTER	230 E ADAMS BLVD LOS ANGELES, CA 90011

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 observation, interview, and record review the facility failed to ensure medications were administered as ordered by the physician for 10 of 10 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10). The facility failed to document medications were administered as soon as given and failed to document the reasons why the medications were not administered for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. The facility failed to ensure a routine controlled medication and [MED] medication were administered as prescribed by the physician and medications were readily available to be administered for one of 10 sampled residents (Resident 10). The facility failed to ensure Resident 10 received the correct dose of [MEDICATION NAME] (an anticonvulsant to treat [MEDICAL CONDITION]) as prescribed to prevent duplication in therapy or medication errors. These deficient practices caused an increased risk in the administered medications side effects, the potential for medication errors; medication duplication; and delay in care and treatment to meet the needs of each resident. Findings: a. A review of the Admission Record indicated Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, resident assessment and screening tool), dated 12/5/19, indicated Resident 7 cognitive skills (a mental action of acquiring knowledge and understanding) was moderately impaired. Resident 7 required limited one-person physical assistance for eating, extensive one-person physical assistance for dressing and personal hygiene, and was totally dependent upon two or more-person physical assistance with bed mobility, transfer from bed to wheelchair, and toilet use. A review of Resident 7's Medication Administration Record [REDACTED]. -[MEDICATION NAME]-[MEDICATION NAME] ([MEDICATION NAME], used to treat symptoms of [MEDICAL CONDITION], symptoms include tremors (shaking), stiffness, and slowness of movement) 25 mg/100 mg, one tablet by mouth three times a day was not signed as administered at 9 a.m., on 12/14/19, at 1 p.m., on 12/4/19, and at 5 p.m., on 12/1, 12/9/, and 12/23/19. -[MEDICATION NAME] (Vitamin B-12 supplement) 250 micrograms (mcg), one tablet daily for [MEDICAL CONDITION] (a deficiency of red blood cells) was not signed as administered at 9 a.m., on 12/14/19. -Multivitamins with Minerals Supplement was not signed as administered at 9 a.m., on 12/14/19 -HPN (High Protein Nourishment) 4 ounces three times a day for weight maintenance was not signed as administered at 9 a.m., on 12/14/19, at 2 p.m., on 12/9/19, and at 8 p.m., on 12/9, 12/20, 12/23 and 12/30/19. According to a review of Resident 7's 12/2019 MAR indicated [REDACTED]. During an interview on 1/24/20 at 4:28 p.m., a registered nurse (RN 1) stated Resident 7 was alert and had no [DIAGNOSES REDACTED]. The MAR must be signed off by the nurse to acknowledge administration of the medications to the resident. b. A review of the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 8 had intact cognition. Resident 8 required supervision and setup help only for bed mobility, transfer from bed to wheelchair, locomotion on and off the unit, dressing, eating, personal hygiene, and limited one-person physical assistance for toilet use. According to a review of Resident 8's Medication Administration Record [REDACTED]. -[MEDICATION NAME] Solution (used to treat constipation) 10 mg/ 15 milliliters (ml), give 30 ml by mouth in the evening was not signed as administered at 5 p.m. nightly on 12/1 and 12/20/19. -Latanoprost Solution ([MEDICATION NAME], used to treat high pressure inside the eye) 0.005 % (percent) instill one drop in to both eyes at bedtime for normal tension, was not signed as administered at 9 p.m. nightly on 12/1, 12/9, 12/14, 12/20, and 12/23/19. -[MEDICATION NAME] (a supplement used to help with sleep-wake cycle) one tablet by mouth at bedtime was not signed as administered at 9 p.m., on 12/1, 12/9, 12/14, 12/20, and 12/23/19. -[MEDICATION NAME] ([MEDICATION NAME], used to treat GERD) 20 mg was not signed as administered at 6:30 a.m., on 12/15 and 12/21/19. -[MEDICATION NAME] ([MEDICATION NAME], used to treat depression) 45 mg tablet at bedtime for depression manifested by verbalization of sadness was not signed as administered at 9 p.m., on 12/1, 12/9, 12/14, 12/20 and 12/23/19. -[MEDICATION NAME] ([MEDICATION NAME], used to treat high blood pressure) 5 mg by mouth two times a day was not signed as administered and blood pressure was not documented as monitored at 5 p.m., on 12/1, 12/20, and 12/23/19. -Galantamine ([MEDICATION NAME], used to treat confusion related to [MEDICAL CONDITION]) 8 mg by mouth two times a day was not signed as administered at 5 p.m., on 12/1 and 12/20/19. -Artificial Tears, instill one drop in to both eyes three times a day for dry eyes was not signed as administered at 1 p.m., on 12/2 and 12/19/19 and at 5 p.m., on 12/1 and 12/20/19. A review of Resident 8's 12/2019 MAR indicated [REDACTED]. c. A review of the Admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 9 had intact cognition. Resident 9 required supervision and setup help only for eating, limited one-person physical assistance for locomotion on and off the unit, and extensive one-person physical assistance for bed mobility, transfer from bed to wheelchair, dressing, toilet use, and personal hygiene. A review of Resident 9's Medication Administration Record [REDACTED]. d. A review of the Admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 10 had intact cognition. Resident 10 required supervision and setup help only for eating, extensive one-person physical assistance for bed mobility, transfer from bed to wheelchair, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of Resident 10's Medication Administration Record [REDACTED]. -[MEDICATION NAME] ER ([MEDICATION NAME] sodium) Extended-Release Tablets, 250 mg by mouth at bedtime for [MEDICAL CONDITION] disorder (a mental condition marked by alternating periods of elation and depression) with an order date of 12/12/19 and a discontinue order date of 12/31/19 was not signed at 9 p.m., on 12/14, 12/20, 12/23, and 12/30/19. -[MEDICATION NAME] ER 500 mg, give 2500 (5 tablets of 500 mg each) by mouth at bedtime for mood disorder was not signed at 9 p.m., on 12/1, 12/9, 12/14, 12/20, 12/23, and 12/30/19. -[MEDICATION NAME] ([MEDICATION NAME], used for nerve pain) 300 mg, one capsule by mouth at bedtime was not signed as administered at 9 p.m., on 12/1, 12/9, 12/14, 12/20, 12/23, and 12/30/19. -[MEDICATION NAME] 3 mg, one tablet by mouth at bedtime for inability to sleep was not signed as administered at 9 p.m., on 12/1, 12/9, 12/14, 12/20, 12/23, and 12/30/19. -[MEDICATION NAME] ([MEDICATION NAME]) 75 mg, give three capsules (225 mg) by mouth at bedtime for mood disorder was not signed as administered at 9 p.m., on 12/1, 12/9, 12/14, 12/20, 12/23, and 12/30/19. -Magnesium Oxide (supplement) 800 mg by mouth two times a day for pain management was not signed as administered at 5 p.m., on 12/1 and 12/30/19. -[MEDICATION NAME] Gel 2 %, apply to right shoulder topically three times a day for right shoulder pain was not documented as administered at 1 p.m., on 12/3, 12/16, 12/19/19, and at 5 p.m., on 12/1/19 and 12/30/19. Resident 10's pain level was not documented during the same time period. -[MEDICATION NAME][MEDICATION NAME] ([MEDICATION NAME], is a Schedule II controlled substance that carries a high risk of abuse and addiction, used to treat attention deficit [MEDICAL CONDITION] disorder (ADHD)) 10 mg by mouth two times a day for attention/ADHD was not signed as administered at 12 p.m., on 12/3, 12/16, and 12/19/19. Further review of Resident 10's 12/2019 MAR indicated [REDACTED]. A review of Resident 10's 12/2019 physician order [REDACTED]. A review of a telephone

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)

order for Resident 10, dated 12/12/19 timed at 7:43 p.m., documented [MEDICATION NAME] ER 250 mg by mouth nightly at bedtime. A review of Resident 10's Psychiatric Consultation dated 12/12/19 indicated, He (Resident 10) had some increase in his depressive symptoms and anxiety symptoms as of lately as there was a disruption in his [MEDICAL CONDITION] medication regimen. During the interview, the patient has been somewhat emotional, tearful. Recommendations [MEDICATION NAME] 2500 mg at bedtime, [MEDICATION NAME] 225 mg at bedtime, [MEDICATION NAME] 10 mg twice a day, [MEDICATION NAME] 3 mg at bedtime. However, there was a discrepancy with Resident 10's [MEDICATION NAME] order as there was no documented or recommended new order for [MEDICATION NAME] ER 250 mg indicated on Resident 10's Psychiatrist Consultation report dated 12/12/19. On 1/24/20 at 8:50 a.m., during a medication pass observation and interview, licensed vocational nurse 1 (LVN 1) stated in the presence of LVN 2 that Resident 10's [MEDICATION NAME] medication was not available and had not been delivered by the pharmacy. LVN 1 stated she would follow up with the pharmacy. On 1/24/20 at 9:16 a.m. during the medication pass observation for Resident 10, LVN 2 checked the resident's blood sugar and stated it was 221. Then prepared 8 units of [MEDICATION NAME] ([MED] [MEDICATION NAME] Pen-injector, a fast-acting [MED]) [MEDICATION NAME] and administered to Resident 10 by injection just under the skin into the lower left side of the stomach. [MED] medication was not observed administered 15 minutes before a meal. A review of Resident 10's physician order [REDACTED]. Give 15 minutes before meals. On 1/24/20 at 3:21 p.m., during an interview LVN 1 stated Resident 10 should be administered [MEDICATION NAME] daily at 7 a.m. and 12:30 p.m. and that the 7 a.m. dose was not available for administration today. LVN 1 stated the [MEDICATION NAME] dose arrived at 1:30 p.m. today (1/24/20) and the medication was administered to the resident. During a concurrent record review of Resident 10's MARs for 12/2019 and 1/2020, LVN 1 stated that the check marks on the MAR indicated [REDACTED]. LVN 1 confirmed the MAR indicated [REDACTED]. LVN 1 reviewed Resident 10's nursing progress notes and stated there was no documentation to indicate why the resident was not administered his routine medication during the month of 12/2019. LVN 1 stated the MAR indicated [REDACTED]. During an interview on 1/24/20 at 5:28 p.m., inside of Resident 10's room, Resident 10 stated, It was quite a few times that I did not get my medications. I did not receive my [MEDICATION NAME] for a couple of weeks. I did not get [MEDICATION NAME] on and off. Mood medications should not be stopped and started. That is hard on me. They had a list of my medications from the hospital when I arrived. They (facility's licensed nurses) did not give my [MED] with or right before a meal like they were supposed to. They often gave [MED] after a meal and take the blood sugar level long after a meal. [MED] should be given 10 minutes before a meal and they do not give it like that. Sometimes they do not give the [MED] at all. My blood sugar is not controlled. I spoke once to a psychiatrist after I was here a month. I do not know why it took so long. I had to tell them the medication regimen was not correct and took another week to correct the medications. During Christmas is a rough time. I become depressed and anxious a lot. That is when I came and it was more difficult not having my medications. Resident 10 stated the [MEDICATION NAME] delivery from the pharmacy was often delayed by waiting for the prescriber to sign off on the order timely and that there should be more contact between the physician and pharmacist to prevent delays and interruptions in receiving his [MEDICATION NAME] medication. Resident 10 stated, I did get my [MEDICATION NAME] this afternoon. The nurse called the pharmacy today. The nurses try and it is the pharmacy that does not deliver the [MEDICATION NAME] medication on time. On 1/24/20 at 5:02 p.m., during an interview regarding Resident 7, 8, 9, and 10, the director of nursing (DON) stated if the MAR indicated [REDACTED]. The DON stated, The nurse must sign after each medication is administered to a resident. The potential effect puts the resident at risk of complications for the indications of the medication. If they (facility's licensed nurses) are not documenting right away, they may not remember if the medication was administered to the resident or not. There is a potential for duplication of therapy or missed therapy. The licensed nurses should have followed up to ensure the residents did not miss so many doses of medication. On 2/5/20 at 3:02 p.m., during an interview, the facility's consultant pharmacist (CP) stated that she had not been to the facility since 10/2019 and had other consultant pharmacist covering the facility with the expectation for covering CP to document deficient practices observed in the facility. The CP stated for sliding scale [MED] administration should be given just before a meal or with a meal. Two hours away from a meal is too long. During a concurrent review of the pharmacist monthly regimen review for 12/2019, the CP stated that she did not see anything documented in the monthly report about charting gaps or missed medication administration to Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10. The CP stated, If the residents are not receiving their medications as ordered, the physician should always be notified of any missed doses. We have a lot on our plate monitoring medications. We are not documenting charting gaps. The medical records should audit. If medications are missed or unavailable, they should be ordered right away. A review of the facility's policy titled, Medication Administration - General Guidelines, effective date 10/2017, indicated medications are administered as prescribed. A review of the facility's policy titled, Charting and Documentation, revised 7/2017, indicated the following information is to be documented in the resident medical record, Medications administered. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: -The date and time the procedure/treatment was provided; -The name and title of the individual(s) who provided the care; -The assessment data and/or any unusual findings obtained during the procedure/treatment. A review of the facility's policy titled, Medication and Treatment Orders, revised 7/2016, indicated drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. A review of the facility's policy titled, Medication Regimen Review (Monthly Report), effective date 12/2016, indicated resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported. e. A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 1 was oriented to year, month and day. Resident 1 needed one person physical assistance with bed mobility, dressing, toilet use, personal hygiene and bathing. Resident 1 needed two or more person physical assistance with transfers. A review of Resident 1's Medication Administration Record [REDACTED]. A review of the Admission Record indicated Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated ,[DATE], indicated Resident 2 was disoriented to year and day. Resident 2 needed one person physical assistance with activities of daily living (ADLs). According to a review of the MAR indicated [REDACTED]. A review of the Admission Record indicated Resident 3 was admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS dated [DATE], indicated Resident 3 was oriented to year, month and day. Resident 3 needed two or more person assist with transfer and one person assist with the rest of ADLs. A review of the MAR for the month of 12/2019 indicated the following medications ordered by the physician was not signed to indicate administration to the resident that included: -[MEDICATION NAME] acid (vitamin C) tablet 500 mg by mouth one time a day on 12/20/19, at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -[MEDICATION NAME] (used to treat and prevent vitamin D deficiency) tablet 2000 units on 12/20/19 at 9 am, [DATE] at 9 am and 12/29/19 at 9 a.m. -[MEDICATION NAME] (used to treat [MEDICAL CONDITIONS]) 325 mg on 12/20/19 at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -[MEDICATION NAME] (used to treat high blood pressure) 5 mg given on 12/20/19, at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -Multiple vitamins mineral 1 tablet on 12/20/19, at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -[MEDICATION NAME] (supports blood flow and contributes to wound healing) packet 12/20/19, at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -[MEDICATION NAME] (nerve pain medication and [MEDICAL CONDITION]) capsule 300 mg by mouth on 12/20/19 at 9 a.m., [DATE] at 9 am and 12/29/19 at 9 a.m. -[MEDICATION NAME] (oral diabetes tablet that helps control blood sugar levels) 500 mg on 12/20/19 at 7 a.m., [DATE], at 7 a.m. and 12/29/19, at 7 a.m. -[MED] [MEDICATION NAME] (medication given to control high blood sugar level) 20 units subcutaneously (SQ, one time a day for [MEDICAL CONDITION]) on 12/20/19, at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. - [MED] [MEDICATION NAME] (medication given to control high blood sugar level) 5 units 12/20/19, at 7 a.m., 12/20/19 at 12 p.m., [DATE] at 7 a.m., [DATE] at 12 p.m., 12/29/19 at 7 a.m. and 12/29/19 at 12 p.m. -[MED] [MEDICATION NAME] solution SQ three times a day for [MEDICAL CONDITION] inject as per sliding scale (progressive increase in the pre-meal or nighttime [MED] dose based on predefined blood glucose ranges). In addition, the blood sugar level (BSL) was not obtained on 12/20/19 at 7:30 a.m., 12/20/19 at 11:30 a.m., [DATE] at 7:30 a.m., [DATE] at 11:30 a.m., 12/29/19 at 7:30 a.m., and [DATE] at 11:30 a.m., 12/29/19 at 7:30 a.m. and 12/29/19 at 11:30 a.m. h. A review of the Admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS dated [DATE], indicated Resident 4 was rarely/never understood. Resident 4 had short and long term memory problems. Resident 4 needed one person physical assist with ADLs. According to a review of the MAR for 12/2019, the following medications ordered by the physician was not signed to indicate administration to the resident that included: -[MEDICATION NAME] capsule (used to treat and prevent low levels of

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) calcium and bone disease) on 12/20/19 at 9 a.m. and [DATE] at 9 a.m. -[MEDICATION NAME] tablet (used to treat the symptoms of overactive bladder) on 12/20/19 at 9 a.m. and [DATE] at 9 a.m. -[MEDICATION NAME] (HCL, medication to lower calcium in the blood) on 12/20/19, at 7 a.m., and [DATE], at 7 a.m. i. A review of the Admission Record indicated Resident 5 was admitted on [DATE] and readmitted on [DATE] with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS, dated [DATE], indicated Resident 5 was oriented to year, month and day. Resident 5 needed one to two person physical assistance with ADLs. A review of the MAR for 12/2019 indicated the following medications ordered by the physician was not signed to indicate administration to the resident that included: -[MEDICATION NAME] (pain medication) give 30 to 60 minutes prior to wound care on 12/20/19 7a.m. during the 7 a.m. to 3 p.m. shift, [DATE] during the 7 a.m. to 3 p.m. shift and 12/29/19 during the 7 a.m. to 3 p.m. shift. - [MEDICATION NAME] (medication for gout (an arthritis characterized by severe pain, redness and tenderness in joints) on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 am -[MEDICATION NAME] capsule give units on 12/29/19 at 9 a.m. -Lactobacillus capsule ([MEDICATION NAME], can aid digestion and help maintain healthy digestion) on 12/20/19 at 9 a.m., [DATE], at 9 a.m. and 12/29/19, at 9 a.m. -Multiple vitamins mineral tablets (supplement) on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 a.m. -[MEDICATION NAME] tablet (treat and prevent heartburn) on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 a.m. -Cranberry tablet (prevent infection in the kidneys, bladder and urethra) on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 a.m. -[MEDICATION NAME] sodium (stool softener) 100 mg on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 a.m. -[MEDICATION NAME] Acid 500 mg on 12/20/19 at 9 a.m., [DATE] at 9 a.m. and 12/29/19 at 9 a.m. -[MEDICATION NAME] capsule (used for nerve pain) 400 mg on 12/7/19 at 2 p.m., 12/8/19 at 6 a.m., 12/20/19 at 2 p.m., 12/24/19 at 6 a.m., [DATE] at 2 p.m., [DATE] at 2 p.m. and 12/29/19 at 2 p.m. -[MEDICATION NAME] tablet (pain medication) 50 mg on 12/20/19 at 9 a.m. and 1 p.m., [DATE] at 9 a.m. and 1 p.m. and 12/29/19 at 9 a.m. and 1 p.m. j. A review of the Admission Record indicated Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. A review of the MDS dated [DATE], indicated Resident 6 was disoriented to year, month and day. Resident 6 needed one person physical assistance with ADLs. According to a review of the MAR for 12/19, the following medications ordered by the physician was not signed to indicate administration to the resident that included: -Folic Acid supplement that helps the body makes healthy new cells) on 12/14/19 at 9 a.m., -[MEDICATION NAME] Sodium tablet 125 mcg on 12/15/19 at 6 a.m. and 12/28/19 at 6 a.m. -[MEDICATION NAME] capsule (treat conditions where there is too much acid in the stomach) 20 mg on 12/15/19 at 6:30 a.m., 12/21/19 at 6:30 a.m. and 12/28/19 at 6:30 a.m. -[MEDICATION NAME] HCL (used to prevent or treat low levels of vitamin B1) on 12/14/19 at 9 a.m. -[MEDICATION NAME] HCL (for heart rhythm problems) 100 mg on 12/1/19 at 5 p.m., 12/9/19 at 5 p.m., 12/14/19 at 9 a.m., 12/23/19 at 5 p.m. and 12/29/19 at 5 p.m. -[MEDICATION NAME] Sodium 100 mg on 12/9/19 at 5 p.m., 12/14/19 at 9 a.m., 12/23/19 at 5 p.m. And 12/30/19 at 5 p.m. -[MED] tablet (helps prevent blood clots from forming) 2.5 mg on 12/1/19 at 5 p.m., 12/9/19 at 5 p.m., 12/14/19 at 9 a.m., 12/23/19 at 5 p.m. and 12/30/19 at 5 p.m. -Magnesium tablets (supplement) on 12/1/19 at 5 p.m., 12/9/19 at 5 p.m., 12/14/19 at 9 a.m., 12/23/19 at 5 p.m., and 12/30/19 at 5 p.m. -[MEDICATION NAME] tablet (treat high blood pressure, chest pain and heart failure) 25 mg on 12/1/19 at 5 p.m., 12/9/19 at 5 p.m., 12/14/19 at 7 a.m., 12/23/19 at 7 a.m., 12/23/19 at 5 p.m. and 12/30/19 at 5 p.m. -Sodium Chloride tablet (used to treat or prevent sodium loss) on 12/1/19 at 5 p.m., 12/4/19 at 1 p.m., 12/14/19 at 9 a.m. and 1 p.m., 12/23/19 at 5 p.m. and 12/30/19 at 5 p.m. During an interview on 1/24/19 at 2:51 p.m., LVN 4 stated when medications are given, the MAR indicated [REDACTED]. During an interview and record review of Resident 2's MAR, on 1/24/20 at 3:54 p.m., LVN 6 stated the night shift nurses would give the 6:30 dose of the medication. LVN 6 stated the MAR indicated [REDACTED]. LVN 6 stated the if the medication was not given or not signed, the reason should be documented. During a telephone interview and concurrent record review on 2/11/20 at 3 p.m., the MAR for 12/2019 for Resident 1, Resident 3, Resident 4, Resident 5 and Resident 6 were reviewed with the director of nursing (DON). The DON stated the MAR indicated [REDACTED]. The DON stated if the medication was not signed as given, there should be documentation as to why the MAR indicated [REDACTED]. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. If a dose of regularly scheduled medication is withheld, refused, or given at other than the sche