STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455662	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of McAll	900 S 12th St McAllen, TX 78501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 40872 Based on interview and record review, the facility failed to immediately notify the resident physician regarding a change in resident's condition for one (Resident #11) of three residents reviewed for changes in condition in that: The facility failed to inform the physician of Resident #11's swelling to his right leg. This failure could place residents' representative/physician at risk of not being aware of any changes in their conditions and could result in delay in treatment and decline in residents' health and well-being. The findings included: Record review of Resident #11's face sheet dated 08/09/24 reflected [AGE] year-old male with admitted [DATE] with diagnoses of Alzheimer's Disease Unspecified, Muscle Weakness (Generalized), and Unspecified Psychosis not due to substance known physiological condition. Record review on 08/09/24 of Resident #11's Quarterly MDS dated [DATE] indicated a BIMS of 2 indicating severe cognitive impairment. Bed mobility required one-person physical assist for support. Transfer from bed to wheelchair required one-person physical assist for support. Record review of facility's Incident/Accident Log dated 04/2024 through 06/2024 reflected no history of falls for Resident #11. Record review of Resident #11's progress notes reviewed from 06/16/24 through 06/17/24 found no progress notes indicating Resident #1 was assessed by LVN P for swelling on right leg. During an interview on 08/09/24 at 1:52 p.m., CNA B said on 06/16/24 she noticed swelling to Resident #11's right leg when she changed his briefs. She said he did not show grimace or signs of pain at that time. She said she reported it immediately to LVN P. LVN P was attempted to be reached via telephone on 08/09/24 at 2:20 p.m. and 4:34 p.m., attempts were unsuccessful with no answered or returned phone calls. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/09/24 at 2:40 p.m., the Administrator said that he was informed 06/17/24 by LVN M, that she assessed Resident #11's leg after being informed by CNA B that his leg looked swollen and had complained of pain. She told the Administrator that the physician was informed and an x-ray was ordered and found the resident had a fracture to his right hip. Administrator said Resident #11 was sent to the hospital for treatment. Administrator said they immediately conducted an investigation and reported the incident to HHS. He said Resident #11 did not return to facility after this incident and was transferred to another facility as per family request. The Administrator also said that upon investigation he found that LVN P was informed Resident #11's swelling and he assessed Resident #11 but did not document nor did he inform neither the physician or the next nurse on shift. Administrator said that LVN P spoke with the resident's physician on 06/16/24 in reference to a non-related issue regarding Resident #11 but did not mention the swelling. Administrator said that after the internal facility's investigation it was decided to terminate LVN P due to failing to report to physician and failure to document incident. Administrator also said that upon investigation they were unable to determine how Resident #11 obtained the fracture as no falls were reported and Resident #11 did not have a history of falls. He said all staff was in serviced on reporting any change in condition, notifying physician and also Resident Abuse and Neglect. During an interview on 08/09/24 at 4:53 p.m., LVN M said when she began her shift at 6:00 a.m. on 06/17/24, CNA B reported to her that Resident #11 had swelling on his right leg and he was complaining of pain. LVN M said she conducted a head to toe assessment and Resident #11 grimaced and made sounds of pain when she was assessing him. LVN M said she gave the resident pain medication and contacted his physician and ordered an x-ray. She said the x-ray revealed a hip fracture and Resident #11 was sent to hospital for treatment. During an interview on 08/09/24 at 6:53 p.m., the DON said that she interviewed LVN P during the investigation of this incident and found that LVN P did not document or notify physician when he assessed Resident #11 for swelling to his leg. DON said LVN P should have documented and notified physician. She said LVN P had been in serviced on notifying physician and documenting any change in condition of Residents prior to this incident and all staff had been in serviced on this after this incident. She said since LVN P failed to do so, so it was decided that he would be terminated. As per Administrator, the facility does not have a policy on Change of Condition Notifications. Record Review of Facility's In Service Training Report Titled Medication Administration/MARS Signing/Immunizations dated 03/07/24 revealed, Contents or Summary of Training Session: Nursing Staff is to administer medications properly, and sign emar after administration of medications .proper documentation to be done in timely manner, change of conditions to be done and notify md in a timely manner.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on interview and record review, the facility failed to periodically review and revise the comprehensive person-centered care plan by a team of qualified persons after each assessment, including both the comprehensive and quarterly review assessments for 2 of 3 residents (Resident #1 and Resident #2) reviewed for care plans, in that: 1. The facility failed to ensure Resident #1's most recent care plan reflected a witnessed fall with injury on 12/21/2023. 2. The facility failed to ensure Resident #2's most recent care plan reflected an unwitnessed fall with serious injury on 12/12/2023. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #1's face sheet dated 08/01/24 reflected Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 had diagnoses of unspecified dementia, muscle wasting and atrophy, muscle weakness, difficulty in walking, age-related physical debility, and mood disorder. Record review of Resident #1's Quarterly MDS dated [DATE] reflected the resident: BIMS score of 06 which indicated Resident #1's cognition was severely impaired. Dependent for self-care except eating required supervision/touching assistance. Partial/moderate assistance for mobility. No falls since prior assessment. Record review of Resident #1's most recent comprehensive care plan reflected: Resident #1 had risk for falls related to limited mobility, weakness, unsteady gait/balance; Dx: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites; Muscle Weakness (Generalized); Difficulty in Walking, Not Elsewhere Classified; Age-Related Physical Debility Date Initiated: 05/23/2024 Revision on: 07/30/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 05/23/2024. Educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 05/23/2024. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Date Initiated: 5/23/2024 Revision on: 05/23/2024. Record review of Incident Report from the facility dated 12/21/23 revealed resident had an unwitnessed fall with injury at 5:08 pm. Care plan was not revised for an actual fall on 12/21/23 with updated interventions for that fall. On 8/1/24 at 10:42 am interview with the MDS Care Management Specialist said that the fall for Resident #1 was captured on the MDS but not on the care plan. He said that for falls or anything acute, the ADON or DON update the care plan and add interventions. He said that if falls were not care planned, they could possibly not have proper interventions in place which could possibly cause another fall. On 8/1/24 at 11:00 am interview with the ADON, she said that the DON was responsible for updating falls with interventions on the care plans. The ADON said that she only helps the DON with care plans if needed. The ADON said that she did not help in updating Resident #1's care plan for the fall on 12/21/23. On 8/1/24 at 1:16 pm interview with the DON, she said that she thinks she was out on leave when the fall occurred for Resident #1. She said that the DON, ADON and MDS were responsible for updating care plans for any acute fall. She said, It's a step to complete or we can get a tag for it. She said that Resident #1 received the interventions. She said they did what they had to do for therapy and pain management and neuro checks would be in place. She said that in-services for falls and for neglect were done. She said that Resident #1 was not a frequent faller, so there would not have been other interventions, such as mats because they would place the resident more at risk for falls due to resident ambulatory at the time. She said that there were other options to inform staff than placing the fall on the care plan. The DON said that since they always do in-services after a fall, the staff would have been made aware of the fall and interventions at that time. She said that if there were new staff, they would make them aware as well during daily meetings. She said that the resident was care planned as a risk for falls prior to the actual fall. The DON refused to directly answer the question of what could happen if the fall was not care planned with interventions. 2. Record review of Resident #2's face sheet dated 08/01/24 reflected Resident #2 was admitted on [DATE] and was [AGE] years old. Resident #2 had diagnoses of age-related physical debility, history of falls, repeated falls, mood disorder, restlessness and agitation, and type 2 diabetes mellitus. Record review of Resident #2's Discharge MDS dated [DATE] reflected the resident: BIMS score of 01 which indicated Resident #2's cognition was severely impaired. Required substantial/maximal assistance for self-care except eating which required supervision or touching assistance, oral hygiene and upper body dressing which required partial/moderate assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Required partial/moderate assistance for mobility except for roll left and right, sit to lying, and lying to sitting on side of bed which required supervision or touching assistance. Record review of Resident #2's most comprehensive care plan reflected: Resident #2 had a risk for falls r/t limited mobility, weakness, unsteady gait/balance, history of falls, repeated falls; Age-Related Physical Debility; Need for Assistance with personal care. Date Initiated: 04/04/2023 Revision on: 07/30/2024. Interventions included: Anticipate and meet the resident's needs. Date Initiated: 04/04/2023. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 04/04/2023 Revision on: 05/29/2024. Educate the resident about safety reminders and what to do if a fall occurs. Date Initiated: 05/04/2023 Revision on: 05/29/2024. Ensure that the resident is wearing appropriate footwear when ambulating. Date Initiated: 05/04/2023 Revision on: 05/29/2024. Had an alteration in musculoskeletal status related to history of fracture of the fourth and fifth right ribs Date Initiated: 12/15/2023. Revision on: 05/29/2024. Interventions: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date Initiated: 12/15/2023. Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness. Date Initiated: 12/15/2023. Monitor/document for risk of falls. Educate resident, family, and caregivers on safety measures that need to be taken in order to reduce risk of falls. (If resident has a care plan for falls, refer to this). Date Initiated: 12/15/2023. Record review of Incident Report from the facility dated 12/12/23 revealed resident had an unwitnessed fall with injury at 7:30 pm. Care plan was not revised for an actual fall on 12/12/23 with updated interventions for that fall. On 8/1/24 at 10:42 am interview with the MDS Care Management Specialist said that the fall for Resident #2 was captured on the MDS but not on the care plan. He said that for falls or anything acute, the ADON or DON update the care plan and add interventions. He said that if falls were not care planned, they could possibly not have proper interventions in place which could possibly cause another fall. On 8/1/24 at 11:00 am interview with the ADON said that she did not help in updating Resident #2's care plan for fall on 12/12/23. On 8/1/24 at 1:16 pm interview with the DON, she said that she was notified by the night shift nurse when the fall occurred for Resident #2. She said that the actual fall was not care planned, but the resident received the interventions under his care plan for alteration in musculoskeletal status r/t history of fractures of the fourth and fifth right ribs initiated on 12/15/23. She said that in-services for falls and for neglect were done. She said that the resident was care planned as a risk for falls prior to the actual fall. Record review of facility's Care Plan Revisions Upon Status Change policy dated 10/24/22 reflected: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 4 Residents (Residents #3 and #4) reviewed for medical records accuracy, in that: 1. Resident #3's [DATE] Medication Administration Records documentation was incomplete. Staff did not document or sign off on the administration of physician ordered anxiety medication, Lorazepam. 2. Resident #4's [DATE] Medication Administration Records documentation was incomplete. Staff did not document or sign off on the administration of physician ordered pain medication, Gabapentin. These failures could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: 1. Record review of Resident #3's face sheet, dated [DATE], revealed the resident was [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Other specified anxiety (feeling of fear, dread, uneasiness) disorders, acute (sudden onset) pain due to trauma, bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), current episode mixed, unspecified, chronic embolism (blood clot or any foreign substance that moves through blood stream until it blocks a blood vessel) and thrombosis(occurs when a blood clot blocks a vein) of unspecified deep veins of lower extremity, bilateral and delusional (unshakable belief in something that's untrue) disorders. Record review of Resident #3's state optional Minimum Data Set assessment, dated [DATE], revealed Resident #3 had a BIMS score of 14, indicating he was cognitively intact. Record review of Resident #3's care plan, with an initiated date of [DATE] revealed Resident #3 had a problem of, [Resident #3] uses anti-anxiety medications (Alprazolam) r/t Anxiety disorder with an initiated date of [DATE] and an intervention of Administer ANTI-ANXIETY medication as ordered by physician. with an initiated date of [DATE]. Record review of Resident #3's physician's orders, dated [DATE], revealed orders for: 1. LORazepan Tablet 0.5MG with directions to Give 1 tablet by mouth two times a day for Anxiety with a start date of [DATE] and end date of [DATE]. Record review of Resident #3's Medication Administration Record for [DATE] revealed an unsigned section on [DATE] at the scheduled time of 2000 (8:00pm) for the following physician orders: 1. LORazepan Tablet 0.5MG with directions to Give 1 tablet by mouth two times a day for Anxiety with a start date of [DATE] and end date of [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of staff scheduled for [DATE] provided by the DON revealed she had identified LVN A as the nurse who worked with Resident #3 on [DATE]. During an interview with Resident #3 on [DATE] at 11:14am he stated he was taking an anxiety medication in June of 2023 and had received it every day and stated staff had not missed any doses when providing him his medication and further stated LVN A had not missed providing him with any doses of his anxiety medication. Resident #3 did not recall which specific medication he was taking for anxiety. LVN A was attempted to be reached via telephone on [DATE] at 5:11pm and 5:59pm, attempts were unsuccessful with no answered calls and no returned phone calls. During an interview and record review with the DON on [DATE] at 6:18pm she stated LVN A was responsible for administering and documenting Resident #3's Lorazepam on [DATE] at his scheduled 2000 (8:00pm) time. The DON reviewed Resident #3's [DATE] MAR and confirmed there was an unsigned blank section for Resident #3's scheduled dose of Lorazepam on [DATE] at 2000 (8:00pm). The DON stated a blank/unsigned section on the MAR mean that staff had not documented and was unable to ensure if the medication was given or not. The DON was unable to ensure if LVN A provided Resident #3 with his scheduled medication of Lorazepam on [DATE] at the scheduled time of 2000 (8:00pm). The DON stated the MAR should have been signed off and did not know why it was not. The DON stated it was important to sign off on the MAR because it was something their assigned to do and so they could know the last time a medication was given, or to know if any medication was causing a side effect. The DON stated staff had been trained over documentation in July of 2024. The DON stated as per facility policy documentation needed to be completed properly and in a timely manner and stated in this situation staff had not followed their policy. The DON stated in order to ensure accurate documentation they would review the MAR and their documentation software on a daily basis and at the end of each shift prior to staff leaving to ensure they had signed and provided everything. The DON stated she was unable to answer if Resident #3 was impacted or not as she was not working at the facility at the time of identified failure in [DATE]. Record review of facility in-service dated [DATE] revealed the training covered medication administration and the electronic medication administration record and was presented by the ADON to staff, which included LVN A. 2. Record review of Resident #4's face sheet, dated [DATE], revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: Alzheimer's disease, unspecified (progressive disease that destroy memory and other important mental functions), pain in unspecified joint (where 2 or more bones meet), unspecified osteoarthritis (occurs when flexible tissue (cartilage) at the end of bones wear down), unspecified site, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and type 2 diabetes mellitus (high blood sugar) without complications. Record review of Resident #4's discharge Minimum Data Set assessment, dated [DATE], revealed Resident #4 had a BIMS score of 15, indicating she was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's care plan, with an initiated date of [DATE] revealed Resident #4 had a problem of, [Resident #4] has pain r/t Depression, Diabetic neuropathy, disease process (PVD) with an initiated date of [DATE] and an intervention to Administer medication Gabapentin Capsule 300 MG as ordered. with an initiated date of [DATE]. Record review of Resident #4's physician's orders, dated [DATE], revealed orders for 1. Gabapentin Oral Capsule 300 MG with directions to Give 1 capsule by mouth three times a day for pain with a start date of [DATE] and end date of [DATE]. Record review of Resident #4's Medication Administration Record for [DATE] revealed unsigned sections on [DATE], [DATE], [DATE] at 1600 (4:00pm) and on [DATE] at 8:00am and 12:00pm for the following physician orders: 1. Gabapentin Oral Capsule 300 MG with directions to Give 1 capsule by mouth three times a day for pain with a start date of [DATE] and end date of [DATE]. Record review of staff scheduled for [DATE], [DATE], [DATE] and [DATE] provided by the DON revealed she had identified the following staff were responsible for administering and documenting Resident #4's Gabapentin: 1. MA B - [DATE] for scheduled time of 1600 (4:00pm). 2. RN C - [DATE] for scheduled time of 1600 (4:00pm). 3. RN C - [DATE] for scheduled time of 1600 (4:00pm). 4. RN D - [DATE] for scheduled time of 8:00am and 12:00pm. Resident #4 was attempted to be reached via telephone on [DATE] at 1:57pm and 2:40pm, attempts were unsuccessful with no answered or returned calls. During an interview with the Administrator on [DATE] at 10:25am he stated he was pretty sure he had previously received notice the Resident #4 had already expired. RN C was attempted to be reached via telephone on [DATE] at 3:52pm and 4:09pm, attempts were unsuccessful with no answered or returned calls. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN D on [DATE] at 3:54pm she stated she did not recall the exact date of [DATE] (Saturday) but stated if it was a Saturday then she worked because she worked doubles on Saturdays. RN D stated sometimes the facility had a nurse go in and be the med aide on the weekend and was not able say if she or the med aide was responsible for administering and documenting Resident #4's Gabapentin on [DATE] at 8:00am and 12:00pm. RN D stated she could not remember if she had to give gabapentin when a med aide was not there. RN D stated she was unable to answer what a blank on the MAR meant because medications were given by the med aide and nursing only provided injections and narcotics. RN D then stated she always provided Resident #4 her gabapentin unless she refused and if she did refuse, she would notify the NP or MD but clarified that she never had any issues with Resident #4 refusing. RN D stated Resident #4's MAR should have been signed off and could not tell say why it was not. RN D stated it was important to sign off on the MAR so that medication errors did not occur. RN D stated she did not think she had been trained or in serviced over documentation of medication provided at the facility. RN D stated she did not know the facility policy on documentation of medication provided, RN D stated she always documented her administered meds and stated as far as the gabapentin not being signed for the individual responsible had not followed the facility policy. RN D stated she did not know the facility procedure for monitoring the records to ensure accurate documentation. RN D stated incorrect/incomplete documentation could negatively impact a resident because if a resident received a medication, it looked like they did not get it. During a telephone interview with MA B on [DATE] at 4:10pm she sated she worked on [DATE] but did not recall Resident #4. MA B stated a blank on the MAR meant it was not provided. MA B stated the med aides were responsible for providing Gabapentin to residents. MA B stated she could not recall [DATE] and did not recall a time she had not provided a dose of gabapentin to a resident and stated provided gabapentin to all residents who had the order. MA B stated the MAR should have been signed off and did not know why it was not and stated it was important to sign off on the MAR because it was proof it was given. MA B stated she had been in services previously over documentation of medication provided. MA B stated facility policy stated if you give a medication you sign for it, MA B stated she was unable to answer if she followed the facility policy because she did not recall that specific day. MA B stated she did not know the facility's procedure for monitoring the records to ensure accurate documentation. MA B was unable to answer how incorrect/incomplete documentation could negatively impact a resident and stated she did not remember Resident #4. During an interview and record review with the DON on [DATE] at 6:18pm she reviewed staff schedules and stated the following staff were responsible for administering and documenting Resident #4's Gabapentin: 1. MA B - [DATE] for scheduled time of 1600 (4:00pm). 2. RN C - [DATE] for scheduled time of 1600 (4:00pm). 3. RN C - [DATE] for scheduled time of 1600 (4:00pm). 4. RN D - [DATE] for scheduled time of 8:00am and 12:00pm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455662	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of McAll	900 S 12th St McAllen, TX 78501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated when MA B was not working, they had a nurse go in and cover the med aide and if they were unable to get nurse to cover the med aide position then the nurse on the floor would be responsible. The DON reviewed Resident #4's [DATE] MAR and confirmed there was unsigned blank sections for Resident #4's scheduled dose of Gabapentin on [DATE], [DATE], [DATE] at 1600 (4:00pm) and on [DATE] at 8:00am and 12:00pm. The DON stated a blank/unsigned section on the MAR mean that staff had not documented and was unable to ensure if the medication was given or not. The DON was unable to ensure if staff provided Resident #4 with her scheduled medication of Gabapentin on [DATE], [DATE], [DATE] at 1600 (4:00pm) and on [DATE] at 8:00am and 12:00pm. The DON stated the MAR should have been signed off and did not know why it was not. The DON stated it was important to sign off on the MAR because it was something their assigned to do and so they could know the last time a medication was given, or to know if any medication was causing a side effect. The DON stated staff had been trained over documented in July of 2024. The DON stated as per facility policy documentation needed to be completed properly and in a timely manner and stated in this situation staff had not followed their policy. The DON stated in order to ensure accurate documentation they would review the MAR and their documentation software on a daily basis and at the end of each shift prior to staff leaving to ensure they have signed and provided everything. The DON stated she was unable to answer if Resident #4 was impacted or not. Record review of facility Inservice documentation revealed MA B had completed an in-service over the electronic medication administration record on [DATE]. Record review of facility Inservice documentation revealed RN C had completed multiple in-services over medication administration and electronic medication administration record signatures on [DATE], [DATE], and [DATE]. During an interview with the DON on [DATE] at 6:18pm she stated she recalled completing a write up for RN D over missing signature documentation but stated RN D resigned after that and did not have any training to provide for her. Record review of facility policy titled, Documentation in Medical Record with an implementation date of [DATE] included verbiage that reflected, 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred and f. Sign each entry with name and credentials of the person making the entry.