Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304851961M
Compliance #: HL304859744C

Date Concluded: September 11, 2024

Name, Address, and County of Licensee Investigated:
The James Inc.
4533 Normandale Boulevard
Bloomington MN, 55438
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to administer medications as prescribed by his physician because staff were unable to access the resident's medications due to a broken lock. Additionally, the facility documentation indicated the resident skipped medications. As a result, the resident required psychiatric intervention.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility staff documented they gave the resident his medications, however the resident's medical records indicated the pharmacy informed his physician the facility reported they lost his medications. The pharmacy required the physician to renew his medications so they could refill them. The duration the resident went without medications was unknown due to conflicting facility records and pharmacy records. The resident attended a psychiatric (mental health) appointment during this time and told his physician he took his medications and denied feeling emotional distress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the pharmacy and a case worker. The investigation included review of the resident records, pharmacy records, and related facility policy and procedures. Also, the investigator observed unlicensed personnel (ULP) administer and document medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia. The resident's service plan included assistance with medication management. The resident's nursing assessment indicated he was alert and orientated but had behavior concerns including paranoia.

During an interview, a case worker said the resident had a court order requiring him to take medications as prescribed by his physicians. The case worker said she went to the facility approximately every month to see the resident, but she received inconsistent information about the resident's medication acceptance. Staff members told the case worker the resident "skipped" medication, but the documentation was unclear. The case worker said during a visit with the resident, a staff member also told her the lock to the medication cabinet was broke and they were unable to access the resident's medications or records. The case worker said she did not believe the resident received his medications, but the duration was not known. The case worker said she asked the facility to provide the resident's medication records, however the facility failed to provide them. The case worker said the resident did not require hospitalization and his behavior appeared consistent with his diagnoses.

Medical records indicated the resident's physician received a message from the pharmacy which read, "[the facility] lost patients meds, need refills for replacement meds ASAP please." Medical records indicated the resident attended a medical appointment with a physician the following day and he told the physician took his medications. The records indicated the resident told the physician his mood was good.

The medication administration record (MAR) documentation indicated the resident received his medications.

During an interview, pharmacy staff reported the delivery dates of an as needed medication, Trazadone (used for sleep). There was approximately a three-month gap between delivering dates of a 30-day supply.

During investigative interviews, the facility staff reported the resident took Trazadone every day.

During an interview, a nurse said the facility did not lose the resident's medications. The nurse said the lock was to medication cabinet was not broke and the staff have a key to it. The nurse said she the resident received his medications.

The facility was issued a licensing order related to their lack of documentation of medication administration in present time.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Refused.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility took the resident to his medical appointment.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30485	A. BUILDING: _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	4533 NORMANDALE HIGHLANDS DR BLOOMINGTON, MN 55437

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL304859744C/HL304851961M On August 19, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL304859744C/HL304851961M, tag identification 1650, 1690, and 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 1 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review, and interview the licensee failed to ensure the service plan contained the required content including a description of the services to be provided, the fees for the services, and the frequency of each service (according to the resident's current assessment and preferences), the identification of the staff or categories of staff who will provide the service, the schedule and methods of	01650		

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01650	Continued From page 2 monitoring assessments, the schedule and methods of monitoring staff providing the service, and a contingency plan for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, at 11:05 a.m. the surveyor provided a list of document requests to owner (OW)-A. The request included R1's service plan. OW-A acknowledged an understanding of the document request and said the licensee kept all resident records off site and would provide the surveyor the requested documents. R1 admitted to licensee for a diagnosis including Schizophrenia. R1' s records lacked a service plan. R2 admitted to licensee for diagnosis including schizophrenia. R2's records lacked a service plan. R3 admitted to the licensee for a diagnosis including a personality disorder and a psychotic disorder. R3's record lacked a service plan. R4 admitted to the licensee for diagnoses including cocaine dependence and bipolar disorder. R4's record lacked a service plan.	01650		

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01650	Continued From page 3 R5 admitted to the licensee for diagnoses including respiratory failure and hypertension. R5's record lacked a service plan. On September 10, 2024, at 8:52 a.m., OW-A said the licensee does not have separate documents containing service plan. OW-A said the assisted living contract was the service plan. The licensee's assisted living contract referenced a service plan attachment, but did not include a service plan. The licensee's policy titled, Service Plan, dated November 10, 2021, indicated all residents receiving assisted living services will have a service plan in places. Service plans were based on the outcomes of the initial and subsequent assessments, reassessments, monitoring, and individual reviews of the residents needs and preferences. The service plans would include: a description of the services to be provided, the fees for services, and the frequency of each service according to the resident's current assessment and resident preferences, the identification of staff or categories of staff who will provide the services, the scheduled and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services; and a contingency plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living	01690		

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01690	Continued From page 4 facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances met federal code requirements of being within a secured safe within a locked room. This directly affected one of five residents (R3) with controlled	01690		

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01690	Continued From page 5 substances, but had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 admitted to licensee for diagnoses including personality disorder and psychotic disorder. R3's home care services agreement, undated, indicated he required assistance with medication administration. R3's MAR dated August 1, 2024, through August 31, 2024, indicated R3 required the following medication: -Valium 5 milligrams (mg) (for anxiety): Take one tablet by mouth twice a day. On August 19, 2024, at 9:27 a.m., unlicensed personnel (ULP)-E said the licensee kept resident medications in a locked cabinet located in the kitchen area. ULP-E said she passed medications to the residents and documented the medication administration in the book where the licensee kept the medication administration records (MAR). When asked about narcotics and controlled substances, ULP responded, "The nurse can answer you." ULP-E gave no further answers to the surveyor's questions regarding monitoring and storing controlled substances. On August 19, 2024, at 9:30 a.m., the surveyor	01690		

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01690	Continued From page 6 observed the locked medication cabinet. When ULP-E opened the medication cabinet, the surveyor observed three long shelves with residents' medications located on the shelves. The licensee labeled the bottom of the shelf with the resident's name and kept that resident's medications in the general area where they wrote the resident's name. There were no barriers between the residents' medications, and once the cabinet was opened, all resident medications were accessible. The surveyor observed cards of residents' medications, set up as "dose" packs put together by the pharmacy. There were also cards of as needed "PRN" medications and bottles of "bulk" medications. The surveyor did not observe any further locked areas, or compartments. ULP-E informed the surveyor she completed medication administration for the morning and gave the surveyor the binder which contained the MAR's. The surveyor did not observe any documentation for medication counts, or identification of controlled substances. On September 3, 2024, at 11:56 a.m., registered nurse (RN)-D said the licensee kept narcotics in a separate area, double locked, on the other side from where resident medications were stored, but the licensee did not have any residents who took narcotics. RN-D said valium is not considered a controlled substance. Benzodiazepines (valium) is a schedule IV controlled substance. Web address titled, medlineplus.gov, dated 2024, indicated valium is a controlled substance in the class of medications called benzodiazepines. This medication may be habit forming. Federal regulation, under the Drug Enforcement	01690		

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01690	Continued From page 7 Administration, CFR Title 21, Chapter 2, Part 1301.729(b) Security Requirements, indicated controlled substances schedules III, IV and V required storage to be in a safe or steel either weighing 750 pounds or securely bolted or mounted to the floor or wall in such a way it cannot be readily removed and stored within a building that limits access during working hours with either self-closing, self-locking doors that is kept closed and locked at all times except within use and under direct observation. Locking devices can be combination or key-locked with restricted access to limited, authorized employees. In addition, controlled substances schedules III IV and V can be stored together with noncontrolled substances, but must meet the requirements of storage for controlled substances. The licensee's policy titled, Medication Management-Administration and Setup, dated April 1, 2022, indicated the licensee would develop policies and procedures to identify how the provider will ensure security and accountability for the overall management of controlled substances. TIME PERIOD FOR CORRECTION: Seven (7) days.	01690		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760		

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01760	Continued From page 8 and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document medication administration in resident records, for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to licensee for a diagnosis including Schizophrenia. R1's assisted living contract dated May 1, 2022, indicated the licensee provided medication administration. R1's medication administration record (MAR) dated August 1, 2024, through August 31, 2024, indicated the licensee failed to document administration of the following medications: PEG 3350 POW (for constipation): Mix one packet in full glass of water and drink daily as	01760		

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01760	Continued From page 9 directed. The licensee failed to document medication administration on the following dates: - August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Senna-Time S 8.6-50 milligram (mg) tablet (for constipation): Take one tablet by mouth twice daily. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Celexa 40 mg tablet (for depression): Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13,15, 16, and 19. Benztropine 1 mg tablet (for symptoms that effect movement): Take one tablet mouth twice daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Multivitamin tablet (for supplement): Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, 19. Risperdal 50 mg injection (for schizophrenia): Inject 50 mg intramuscularly every two weeks. The MAR failed to identify the date and time R1 should receive the medication. The MAR was "blank" which indicated R1 did not receive the medication in August 2024 prior to the surveyor's arrival on August 19, 2024. R1's physician records dated January 19, 2024, indicated R1 required clozapine 100 mg (for schizophrenia) take five tablets (500 mg) by mouth at bedtime.	01760		

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01760	Continued From page 10 R1's MAR indicated the licensee inaccurately spelled the medication. The medication was spelled as "clozanne". The MAR read, "clozanne 100 mg tablets take 5X100 tab at bedtime." The license failed to document medication administration on August 2, 2024. The MAR lacked accurate, clear directions for medication administration including the correct spelling of the medication and the correct dosage to be administered. R2 Admitted to licensee for diagnosis including schizoaffective disorder. R2's home care services agreement, not dated, indicated he required medication set up and administration. R2's MAR dated August 1, 2024, through August 31, 2024, indicated the licensee failed to document administration of the following medications: Atrovastatin 40 mg tablet (for cholesterol): Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, and 19. Metoprolol succinate 25 mg extended release (ER) tablet (for blood pressure and pulse): Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, and 16. Vitamin D3 1,000 units capsule (supplement): Take one capsule by mouth daily. The licensee failed to document medication administration on the following dates:	01760		

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01760	Continued From page 11 -August 6, 7, 10, 11, 12, 13, 15, and 16. Nystatin 100000 powder (for yeast): Apply to affected areas topically twice daily. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, and 16. Docusate sodium 100 mg capsule (for constipation): Take one capsule by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 6,7, 10, 11, 12, 13, 15, and 16. Prilosec 20 mg capsule (for gastric reflux): Take one capsule by mouth daily. The licensee failed to document mediation administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, and 16. Risperidone 3mg tablet (for schizophrenia): Take two tablets by mouth at bedtime. The licensee failed to document medication administration on the following dates: -August 2 Bupropion HCL 300mg Xl tablet (for depression): Take on tablet by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Benztropine 0.5 mg tablet (for symptoms that effect movement): Take one tablet by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. On August 19, 2024, at 9:18 a.m., the surveyor entered the facility and was greeted by	01760		

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	30485	A. BUILDING: _____ B. WING _____	C 08/19/2024

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01760	Continued From page 12 unlicensed personnel (ULP)-E. ULP-E said she was the only ULP working when the surveyor arrived. ULP-E called owner (OW)-A and registered nurse (RN)-D and told them the surveyor arrived. At 9:30 a.m., ULP-E said the ULPs document medication administration in the "medication book." ULP-E said she completed medication administration for the morning and no residents required further morning medications. The surveyor took the medication book which contained the resident's MAR and observed there were no medications signed out as administered for August 19, 2024. On August 19, 2024, at 9:55 a.m., OW-A arrived and RN-D shortly after. The surveyor met with OW-A and RN-D in an office located in the lower-level of the building. The surveyor still had the medication book with her at this time. RN-D said licensee's staff members completed all documentation on paper. At 10:20 a.m., RN-D asked the surveyor for the medication book, and left the office. The surveyor then followed RN-D and observed RN-D and ULP-E in another room,. ULP-E was signing her name to the MAR which had been previously unsigned. ULP-E and RN-D acknowledged they were documenting in the MAR, so the surveyor asked RN-D why she told ULP-E to document at this time, after ULP-E said she already gave medications. RN-D then told ULP-E she was required to document medication administration at the time medication administration was performed. R3 Admitted to the licensee for a diagnosis including a personality disorder and a psychotic disorder. R3's home care services agreement, undated, indicated he required medication administration.	01760		

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01760	Continued From page 13 R3's MAR dated August 1, 2024, through August 31, 2024, indicated the licensee failed to document administration of the following medications: Latuda 40 mg tablet (for psychosis): Take one tablet by mouth daily with evening meal. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Risperdal 4 mg tablet (for psychosis): Take one tablet by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 1 through August 19 Zoloft 100 mg tablet (for depression): Take two tablets by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Valium 5 mg tablet (for anxiety/psychosis): Take one tablet my mouth twice a day. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Haloperidol 5 mg tablet (for psychosis): Take two tablets by mouth daily. The licensee failed to document medication administration on the following dates: August 6, 7, 10, 11, 12, 13, 15, 16, and 19. R4 Admitted to the licensee for diagnoses including cocaine dependence and bipolar disorder. R4's service plan agreement dated January 10, 2018, indicated she required medication administration.	01760		

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01760	Continued From page 14 R4's MAR dated August 1, 2024, through August 31, 2024, indicated the licensee failed to document administration of the following medications: Haloperidol 5 mg tablet (for psychosis): Take one tablet by mouth at bedtime. The licensee failed to document medication administration on the following dates: -August 2, 17, and 18. Symbicort 80-4.5 (for asthma). Inhale two puffs by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Atorvastatin 40 mg tablet (for cholesterol). Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 4, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Glucophage 1000 mg tablet (for blood sugar). Take one tablet by mouth twice a day with meals. The licensee failed to document medication administration on the following dates: -August 2, 4, 6, 7, 10, 11, 12, 13, 17, 18, and 19. Zyprexa 20 mg tablet (for psychosis). Take one and one-half tablet by mouth at bedtime. The licensee failed to document medication administration on the following dates: -August 2, 17, and 18. Latanoprost 0.005% solution (for glaucoma). Place one drop into the right eye at bedtime. The license failed to document medication administration on the following dates: -August 12, 13, 14.	01760		

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01760	Continued From page 15 Acetaminophen 650 mg extended release (ER) tablet (for pain). Take one to two tablets by mouth three times a day. The licensee failed to document medication administration on the following dates: -August 1 through 19 (noon administration dosage). -August 2, 4, 6, 7, 10, 11, 12, 13, 15, 16, and 19. R5 R5 admitted to the licensee for diagnoses including respiratory failure and hypertension. R5's service plan, no date, indicated she required medication administration. R5's MAR dated August 1, 2024, through August 31, 2024, indicated the licensee failed to document administration of the following medications: Polyethylene glyc 3350 NF powder (for constipation): Dissolve 17 grams in 8 ounces of liquid and drink daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Thera-M enhanced tablet (supplement): Take one tablet by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Risperidone 0.25 mg (for psychosis). Take one tablet by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Vitamin D 3 1000 units capsule (supplement). Take one capsule by mouth daily. The licensee	01760		

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01760	Continued From page 16 failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Atorvastatin 40 mg tablet (for cholesterol). Take one tablet by mouth at bedtime. The licensee failed to document medication administration on the following dates: -August 2. Docusate sodium 100 mg capsule (for constipation). Take one capsule by mouth daily. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13, 15, 16, and 19. Milk of Magnesia 1200/15 suspension (for constipation). Take 30 milliliters (ml) by mouth daily. The licensee failed to document medication administration on the following dates: -August 5, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Stool softener 8.6-50mg tablet: Take one tablet by mouth twice a day. The licensee failed to document medication administration on the following dates: -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. Celexa 20 mg tablet (for depression). Take one tablet by mouth every morning. The licensee failed to document medication administration on the following dates: -August 6, 7, 10, 11, 12, 13 15, 16, and 19. Acetaminophen 325 mg tablet (for pain). Take two tablets by mouth three times a day. The licensee failed to document medication administration on the following dates: -August 1 through 19 (noon administration dosage).	01760		

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01760	Continued From page 17 -August 2, 6, 7, 10, 11, 12, 13, 15, 16, and 19. On August 21, 2024, at 1:04 p.m., OW-A said he checks at the end of the day to make sure unlicensed personnel (ULP) sign they administer medications, but sometimes he misses it. On September 3, 2024, at 11:56 a.m., RN-D said her or OW-A check the MAR weekly and monthly. RN-D said she directs ULP's to perform the five rights of medication administration, and place your first initial in the MAR, administer the medication, then come back to complete the documentation after the resident has accepted the medication. RN-D said ULP's place a circle in the MAR if a resident refuses medication. The licensee's policy titled, Medications and Treatments, dated April 1, 2022, indicated the licensee would document medication administration accurately in the resident's record. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		