

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/31/2023
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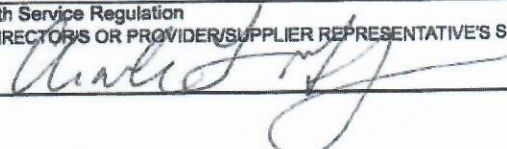
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/29/23 to 08/30/23 with an exit via telephone on 08/31/23.	{D 000}		
{D 125}	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: The Type B Violation was abated. Deficient practice continues. Based on interviews and record reviews, the facility failed to ensure the 5-hour medication aide training was completed for 1 of 6 medication aides (MA) prior to administering medications to the residents (Staff F) and an additional 10- hour medication training within 60 days of hire for 1 of 6 MAs (Staff E). The findings are:	{D 125}	Director of Clinical and/or designee to audit all med tech training files for NC 15 Hour Training compliance and provide education to Director of Resident Care, Executive Director and Business Office Manager on NC med tech required documentation process by 10/5/2023. Executive Director and/or designee will remove any med tech not in compliance and provide the appropriate 15 Hour Training before return to med cart.	10/5/2023

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



REGIONAL DIRECTOR OF OPERATIONS

10/16/23

STATE FORM

6899

EURD12

If continuation sheet 1 of 54

Reviewed and Acknowledged K.M. 10/16/23

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{D 125}	Continued From page 1 1. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E's date of hire was 05/24/22. -There was documentation Staff E completed the state approved 5-hour MA training on 06/03/22. -There was no documentation Staff E completed the state approved 10-hour MA training. -There was documentation she passed the state approved written medication aide exam in 10/02/06. -There was documentation she completed the Medication Clinical Skills Checklist on 06/03/22. Review of a resident's Medication Administration Record (MAR) revealed Staff E administered medications for 7 days in August 2023. Attempted telephone interview with Staff E on 08/31/23 at 12:00pm unsuccessful. Telephone interview with the Business Office Manager (BOM) on 08/31/23 at 2:50pm revealed: -She was responsible to ensure the training was completed and had scheduled 5 separate trainings in June or July 2023 for the 5-hour, 10-hour, and 15-hour MA training to get all the MAs in compliance. -She knew Staff E had not completed the 5-hour training. -Staff E did not attend the trainings. -She informed the former DRC that Staff E did not attend the trainings. Refer to the telephone interview with the Executive Director (ED) on 08/31/23 at 2:20pm. 2. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F's date of hire was 05/04/22. -There was no documentation Staff F completed	{D 125}			

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{D 125}	Continued From page 2 the state approved 5-hour MA training. -There was documentation Staff F completed the state approved 10-hour MA training. -There was documentation she passed the state approved written medication aide exam on 12/19/14. -There was documentation she completed the Medication Clinical Skills Checklist on 05/19/22. Review of a resident's Medication Administration Record (MAR) revealed Staff F administered medications for 2 days in August 2023. Attempted telephone interview with Staff F on 08/31/23 at 12:02pm unsuccessful. Telephone interview with the Business Office Manager (BOM) on 08/31/23 at 2:50pm revealed: -She was responsible to ensure the training was completed and had scheduled 5 separate trainings in June or July 2023 for the 5-hour, 10-hour, and 15-hour MA training to get all the MAs in compliance. -Staff F had completed the 10-hour training but the BOM did not know Staff F had not completed the 5-hour training. -Staff F did not attend the trainings. -She informed the former DRC that Staff F did not attend the trainings. Refer to the telephone interview with the Executive Director (ED) on 08/31/23 at 2:20pm. Telephone interview with the ED on 08/31/23 at 2:20pm revealed: -The BOM was responsible for scheduling required MA training for new hires. -She knew the MAs had to have their 5-hour training when they were hired. -She did not know that Staff E and Staff F had not	{D 125}		

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{D 125}	Continued From page 3 completed the required 15-hours of MA training.	{D 125}			
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the primary care provider (PCP) was notified for 1 of 5 sampled residents (#1) who had an order to notify the PCP if there was a weight change of three or more pounds. The findings are: Review of Resident #1's current FL2 dated 04/26/23 revealed: -Diagnoses included atrial fibrillation, cardiomegaly, and mitral insufficiency. -There was an order to check Resident #1's weight three times per week on Monday, Wednesday, and Friday and to notify the primary care provider (PCP) if there was a weight loss or gain of three or more pounds. Observation of Resident #1 on 08/29/23 at 9:20am and on 08/30/23 at 2:45pm revealed she was sitting up in her room with compression stockings on and had no visible edema or swelling. Review of Resident #1's July 2023 medication administration record (MAR) from 07/03/23 through 07/31/23 revealed:	{D 273}	Director of Resident Care and/or designee to get resident physician orders, by using the MARs, signed and updated by the resident's primary care physician and sent to pharmacy by 9/15/2023. Director of Resident Care and/or designee will complete MAR to Cart audit based on signed physician orders on all med carts by 9/20/2023 to ensure all meds are available. Director of Clinical (RN) and/or designee will complete med tech education with all med techs to include Basic Med Administration and test competency by 10/10/2023.		9/15/2023 9/20/2023 10/10/2023

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{D 273}	Continued From page 4 -There was an entry for weight check three times weekly every Monday, Wednesday and Friday and notify the PCP if loss or gain of greater than 3 pounds. -There was documentation Resident #1's weight was checked every Monday, Wednesday and Friday from 07/03/23 through 07/31/23. -There was no documentation of what Resident #1's weights were or if the PCP had been contacted regarding a weight increase or decrease of greater than 3 pounds. Review of Resident #1's weight flowsheet for July 2023 from 07/03/23 through 07/31/23 revealed her weight ranged from 148.0 pounds to 150.0 pounds. Review of Resident #1's August 2023 MAR from 08/01/23 through 08/29/23 revealed: -There was an entry for weight check three times weekly every Monday, Wednesday and Friday and notify the PCP if loss or gain of greater than 3 pounds. -There was documentation Resident #1's weight was checked every Monday, Wednesday and Friday from 08/01/23 through 08/29/23. -There was no documentation of what Resident #1's weights were or if the PCP had been contacted regarding a weight increase or decrease of greater than 3 pounds. Review of Resident #1's weight flowsheet for August 2023 from 08/01/23 through 08/29/23 revealed: -Resident #1's weight on 08/19/23 was 147.2 pounds, and on 08/20/23 was 152.1 pounds, indicating a weight increase of 4.9 pounds. -There was no documentation Resident #1's PCP had been contacted on 08/20/23 to report the weight increase.	{D 273}			

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{D 273}	Continued From page 5 -Resident #1's weight on 08/24/23 was 151.0 pounds, and on 08/25/23 was 147.2 pounds, indicating a weight decrease of 3.8 pounds. -There was no documentation Resident #1's PCP had been contacted on 08/25/23 to report the weight decrease. -Resident #1's weight on 08/27/23 was 147.1 pounds, and on 08/28/23 was 150.2 pounds, indicating a weight increase of 3.1 pounds. -There was no documentation Resident #1's PCP had been contacted on 08/28/23 to report the weight increase. -From 08/01/23 through 08/29/23, Resident #1's weight ranged from 147.1 pounds to 152.1 pounds. Interview with Resident #1 on 08/30/23 at 2:50pm revealed: -The MAs told her what her weight was whenever they did a weight check on her. -Her most recent weight had been around 150 pounds. -She did not have any shortness of breath, but she was supposed to be weighed due to the swelling in her legs. -The swelling to her legs seemed to have improved in the previous week. -When the swelling in her legs was worse, her PCP sometimes ordered a medication for her to help get rid of the excess fluid. Interview with a MA on 08/30/23 at 3:05pm revealed: -Resident #1 had an order for her weight to be checked every Monday, Wednesday and Friday. -Resident #1 had some swelling in her legs, but she was never short of breath. -Resident #1's PCP reviewed her weight flowsheet every week when she was at the facility.	{D 273}			

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{D 273}	Continued From page 6 -She had obtained Resident #1's weight on 08/20/23, 08/25/23 and 08/28/23 when her weight had increased or decreased by 3 or more pounds. -She had faxed Resident #1's weight sheet to the PCP on 08/20/23, 08/25/23 and 08/28/23. -She did not have the fax transmittal receipts from when she faxed Resident #1's weight flowsheet to the PCP. -She had not received any new orders from the PCP based on Resident #1's weight fluctuations of 3 or more pounds. Telephone interview with Resident #1's PCP on 08/31/23 at 1:10pm revealed: -Resident #1 had an order for a weight check three times per week, because she had congestive heart failure and her fluid retention fluctuated. -She had not received any communication or faxes from the facility staff regarding Resident #1's weight increasing or decreasing more than 3 pounds. -She would have wanted to be notified about Resident #1's weights on 08/20/23, 08/25/23 and 08/28/23, because she would have asked the staff if she was having any increase in swelling or other symptoms. -Depending on Resident #1's weight and if she had any symptoms, she might have prescribed a short course of diuretic medication. -She had not received any reports of symptoms of increased edema for Resident #1. Telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm revealed: -He was not aware of Resident #1's order for weight checks three times per week and to notify the PCP if her weight increased or decreased 3 or more pounds.	{D 273}			

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{D 273}	Continued From page 7 -The facility's previous DRC had been conducting audits of the medication administration record (MAR) which included reviewing Resident #1's weight flowsheet, but he did not know how often the audits were done or when the last audit had been completed. -He started the role of DRC one week prior and had not had the opportunity yet to audit Resident #1's MAR and weight flowsheet. -Resident #1's PCP reviewed her weight flowsheet on Thursdays when she was at the facility. -The MA who obtained Resident #1's weight check would be responsible for following the order and notifying the PCP as the order instructed. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She was not aware of Resident #1's order for weight checks three times per week and to notify the PCP if her weight increased or decreased 3 or more pounds. -She was not aware the MA had not contacted the PCP as ordered for Resident #1's weight fluctuations of 3 or more pounds three times in August 2023. -The facility's previous DRC had been auditing Resident #1's weight sheet so it would have been about two weeks since the last audit had been completed. -Whichever MA checked Resident #1's weight and noted it to be up or down 3 or more pounds from the last weight check was responsible for faxing the weight flowsheet to the PCP and also letting the DRC know so that the DRC could ensure follow up was completed if any new orders were received. -If an MA sent a fax to the PCP's office, the MA was expected to keep the fax transmittal receipt	{D 273}			

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{D 273}	Continued From page 8 for documentation and follow-up.	{D 273}			
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#1) who had an order for weight checks three times per week. The findings are: Review of Resident #1's current FL2 dated 04/26/23 revealed: -Diagnoses included atrial fibrillation, cardiomegaly, and mitral insufficiency. -There was an order to check Resident #1's weight three times per week on Monday, Wednesday, and Friday. Review of Resident #1's weight flowsheet for July 2023 from 07/03/23 through 07/31/23 revealed: -There was no weight documented for Friday, 07/07/23. -There was no weight documented for Monday, 07/17/23. -There was no weight documented for Monday, 07/24/23.	{D 276}	Director of Resident Care and/or designee to get resident physician orders, by using the MARs, signed and updated by the resident's primary care physician and sent to pharmacy by 9/15/2023. Director of Resident Care and/or designee will complete MAR to Cart audit based on signed physician orders on all med carts by 9/20/2023 to ensure all meds are available. Director of Clinical (RN) and/or designee will complete med tech education with all med techs to include Basic Med Administration and test competency by 10/10/2023. Director of Resident Care and/or designee will conduct daily MAR reviews for holes and/or meds not available for 4 weeks then weekly and as needed. Executive Director and/or designee will spot check MARs daily for 4 weeks then weekly. Director of Resident Care and/or designee will follow up with errors and complete any corrective action.	9/15/2023 9/20/2023 10/10/2023 10/2/2023	

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{D 276}	Continued From page 9 -There was no weight documented for Wednesday, 07/26/23. -There was no weight documented for Friday, 07/28/23. -From 07/03/23 through 07/31/23, Resident #1's weight ranged from 148.0 pounds to 150.0 pounds. Review of Resident #1's weight flowsheet for August 2023 from 08/01/23 through 08/29/23 revealed: -There was no weight documented for Wednesday, 08/02/23. -There was no weight documented for Friday, 08/04/23. -There was no weight documented for Wednesday, 08/09/23. -There was no weight documented for Friday, 08/11/23. -There was no weight documented for Monday, 08/14/23. -There was no weight documented for Wednesday, 08/16/23. -From 08/01/23 through 08/29/23, Resident #1's weight ranged from 147.1 pounds to 152.1 pounds. Observation of Resident #1 on 08/29/23 at 9:20am and on 08/30/23 at 2:45pm revealed she was sitting up in her room with compression stockings on and had no visible edema or swelling. Interview with Resident #1 on 08/30/23 at 2:50pm revealed: -The medication aides (MAs) did not weigh her three times per week. -She thought it had been more than one month since someone at the facility last weighed her. -Her most recent weight had been around 150	{D 276}			

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{D 276}	Continued From page 10 pounds. -She did not have any shortness of breath, but she was supposed to be weighed due to the swelling in her legs. -The swelling to her legs seemed to have improved in the previous week. Interview with a MA on 08/30/23 at 3:05pm revealed: -Resident #1 had an order for her weight to be checked every Monday, Wednesday and Friday. -Resident #1 had some swelling in her legs but she was never short of breath. -Resident #1's primary care provider (PCP) reviewed her weight flowsheet every week when she was at the facility. -The days where there was no weight documented, she checked Resident #1's weight, but forgot to write it down on the weight flowsheet. Telephone interview with Resident #1's PCP on 08/31/23 at 1:10pm revealed: -Resident #1 had an order for a weight check three times per week because she had congestive heart failure and her fluid retention fluctuated. -She was aware that Resident #1's weights were not always done three times per week because she saw the missing dates when she checked the weight flowsheet. -She had reminded the staff to remember to check Resident #1's weights as ordered, but they may have forgot. Telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm revealed: -He was not aware of Resident #1's order for weight checks three times per week. -The facility's previous DRC had been conducting	{D 276}			

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{D 276}	Continued From page 11 audits of the medication administration record (MAR) which included reviewing Resident #1's weight flowsheet, but he did not know how often the audits were done or when the last audit had been completed. -He started in the role of DRC one week prior and had not had the opportunity yet to audit Resident #1's MAR and weight flowsheet. -Resident #1's PCP reviewed her weight flowsheet on Thursdays when she was at the facility. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She was not aware of Resident #1's order for weight checks three times per week or that they were not being completed as often as ordered. -The facility's previous DRC had been auditing Resident #1's weight sheet so it would have been about two weeks since the last audit had been completed. -The DRC had not reported any missed weights to her for Resident #1. -The DRC should have followed up with the MA who was working on the days Resident #1's weights were missed to find out why the weight was not checked or why it was not documented on the weight flowsheet.	{D 276}			
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	{D 358}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 12 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 4 of 4 residents (#6, #7, #8, #9) observed during the medication pass who had orders for an antidepressant, pain medication, eye drops and a diuretic (#9), a pain medication, a non-steroidal anti-inflammatory medication, eye drops and acid reflux medication (#6), an acid reflux medication (#7), a topical analgesic (#8); and for 3 of 5 sampled residents (#5, #4, #3) for record review who had an order for a topical antifungal medication (#5), an iron supplement (#4), a urinary frequency medication (#3). The findings are: The medication error rate was 31% as evidenced by 10 errors out of 32 opportunities during the 8:00am medication pass on 08/30/23. 1. Review of Resident #9's current FL2 dated 09/06/22 revealed diagnoses included atrial fibrillation, coronary artery disease, chronic kidney disease, dry eyes, dementia, neuropathy, and osteoarthritis. a. Review of Resident #9's signed physician's order dated 05/04/23 revealed there was an order for torsemide (a diuretic used to treat fluid retention) 10mg every morning.	{D 358}	Director of Resident Care and/or designee to get resident physician orders, by using the MARs, signed and updated by the resident's primary care physician and sent to pharmacy by 9/15/2023. Director of Resident Care and/or designee will complete MAR to Cart audit based on signed physician orders on all med carts by 9/20/2023 to ensure all meds are available. Director of Clinical (RN) and/or designee will complete med tech education with all med techs to include Basic Med Administration and test competency by 10/10/2023. Director of Resident Care and/or designee will conduct daily MAR reviews for holes and/or meds not available for 4 weeks then weekly and as needed. Executive Director and/or designee will spot check MARs daily for 4 weeks then weekly. Director of Resident Care and/or designee will follow up with errors and complete any corrective action.	9/15/2023 9/20/2023 10/10/2023 10/2/2023

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{D 358}	Continued From page 13 Observation of the morning medication pass on 08/30/23 at 9:05am revealed: -The medication aide (MA) removed 3 oral medications and a nasal spray from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The medication card for torsemide contained torsemide 20mg tablets, each tablet in a separate bubble on the card, with label instruction to administer 4 tablets (80mg) every morning. -The MA popped one torsemide 20mg tablet from the medication card and added it to the medication cup with 2 and 1/2 other tablets. -The MA administered the nasal spray along with 3 and 1/2 tablets to Resident #9 in applesauce with a cup of nectar-thickened water and observed Resident #9 taking and swallowing the tablets in the medication cup. Review of Resident #9's August 2023 MAR revealed: -There was an entry for torsemide 10mg, give 1 tablet every morning, scheduled at 8:00am. -There was documentation torsemide 10mg was administered on 08/30/23 at 8:00am. Observation of medication on hand for Resident #9 on 08/30/23 at 12:03pm revealed: -There was one medication card for torsemide 20mg tablets, take 4 tablets (80mg) every morning. -The medication card had a dispensed date of 12/22/22 and a quantity of 26 out of 30 tablets remaining. Observation of Resident #9 on 08/30/23 at 3:30pm revealed there was no visible edema present to her arms or legs.	{D 358}			

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{D 358}	Continued From page 14 Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:00pm revealed: -Resident #9 had a current order for torsemide 10mg, take 1 tablet every morning. -The prescription for torsemide 10mg every morning was renewed by the primary care provider (PCP) on 04/27/23. -On 04/27/23 the pharmacy dispensed 30 tablets of torsemide 10mg which would last one month. -There was no documentation that the pharmacy had received a refill request for torsemide 10mg since it was last dispensed on 04/27/23. Interview with the MA on 08/30/23 at 3:05pm revealed: -She did not usually work in the area where Resident #9 resided and was less familiar with her medications. -She usually compared each medication card and dose to the order on the MAR but did not see the discrepancy between the torsemide 20mg tablet she had administered and the instruction on the MAR which was for torsemide 10mg. Telephone interview with Resident #9's hospice nurse on 08/31/23 at 11:30am revealed: -Resident #9's current dose of torsemide was to take 10mg daily. -She last saw Resident #9 on 08/29/23 and she did not have any symptoms of edema or swelling. -On 08/08/23, Resident #9 had some swelling to her fingers, but that had since resolved. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed: -He was not aware of the discrepancy between Resident #9's torsemide 20mg medication card and the current dose of torsemide 10mg listed on	{D 358}			

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{D 358}	Continued From page 15 the MAR. -The MAs were expected to compare each medication to the entry on the MAR prior to administering each medication to ensure they were administering the ordered dose. -There should not have been a medication card from December 2022 on the medication cart. -If there was any question about what Resident #9's current dose of torsemide was, the MA should not have administered any amount of torsemide until clarification had been received. Telephone interview with Resident #9's PCP on 08/31/23 at 1:10pm revealed: -Resident #9 was prescribed torsemide due to her diagnosis of congestive heart failure (CHF) and a history of having swelling to her legs. -Since Resident #9's recent admission to hospice services, she had been more bedbound and had not been having symptoms of edema. -Being administered 20mg of torsemide instead of 10mg could cause dehydration, but it would likely not cause dehydration if she had just received one double dose. -She had not been notified that Resident #9 had received torsemide 20mg instead of 10mg. -She expected the MAs to administer medications as they were ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -Resident #9's torsemide medication card from December 2022 should have been caught during a medication cart audit, and removed from the medication cart to prevent medication errors. -The MAs were expected to administer medications as they were ordered, which included comparing the label on the medication card to the entry on the MAR. -If there was a discrepancy between the	{D 358}			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FOREST HEIGHTS SENIOR LIVING COMMUNIT

**2500 POLO RIDGE COURT
WINSTON SALEM, NC 27106**

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{D 358}	Continued From page 16 medication card and the entry on the MAR, the MA was expected to contact the pharmacy or the DRC for clarification on the correct dose to administer. Based on observations, record reviews and interviews, it was determined Resident #9 was not interviewable. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. b. Review of Resident #9's current FL2 dated 09/06/22 revealed there was an order for duloxetine (an antidepressant medication used to treat depression) 20mg daily. Observation of the morning medication pass on 08/30/23 at 9:05am revealed: -The medication aide (MA) removed 3 oral medications and a nasal spray from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The MA administered the nasal spray along with 3 and 1/2 tablets to Resident #9 in applesauce with a cup of nectar-thickened water and observed Resident #9 taking and swallowing the contents in the medication cup. -The MA did not administer duloxetine 20mg, because it was not available in the medication cart for administration. Review of Resident #9's July 2023 MAR revealed it was not available for review upon request. Review of Resident #9's August 2023 MAR	{D 358}		

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{D 358}	Continued From page 17 revealed: -There was an entry for duloxetine 20mg take 1 capsule every morning scheduled at 8:00am. -There was documentation duloxetine 20mg was not administered on 08/30/23 at 8:00am. -There was documentation duloxetine 20mg was not administered 20 out of 30 opportunities for August 2023. -There was documentation on the back side of the MAR on 08/02/23, 08/08/23 and 08/22/23 that duloxetine 20mg was not administered due to the medication being on order with the pharmacy. Observation of medication on hand for Resident #9 on 08/30/23 at 12:03pm revealed there was no duloxetine 20mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:00pm revealed: -Resident #9 had a current order for duloxetine 20mg take 1 tablet every morning. -The pharmacy last dispensed duloxetine 20mg for Resident #9 on 04/29/23 for a quantity of 30 tablets which would last one month. -There was no documentation the facility had requested a refill of Resident #9's duloxetine since it was last dispensed on 04/29/23. Interview with the MA on 08/30/23 at 3:05pm revealed: -She reordered medications that were running low when the quantity was down to 12 doses. -If a medication did not arrive from the pharmacy within 3 days of being reordered, the MAs were supposed to notify the Director of Resident Care (DRC). -She did not normally work on Resident #9's hall during the 8:00am medication pass often so she did not know if the other MAs had requested a	{D 358}			

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{D 358}	Continued From page 18 refill for Resident #9's duloxetine or not. -She had not noticed any symptoms of depression for Resident #9. Telephone interview with a MA on 08/31/23 at 11:10am revealed: -She last worked on Resident #9's hall and administered medications to her on 08/27/23. -She was aware that Resident #9 was out of duloxetine. -She had faxed a refill request for Resident #9's duloxetine to the pharmacy earlier in the month of August 2023, but she could not remember when. -A few days after faxing the pharmacy a refill request for Resident #9's duloxetine, she noticed the medication still had not arrived, so she re-faxed the request; she did not remember the date she re-faxed the refill request. -She did not remember if she told the DRC about Resident #9 being out of duloxetine. -She had administered Resident #9's duloxetine to her before but she could not remember when Resident #9 ran out of the duloxetine. -Sometimes if the pharmacy did not send a medication refill to the facility, it was because there were no refills remaining and the prescription needed to be renewed, but nobody at the facility kept track of renewing prescriptions. -Resident #9 was recently admitted to hospice services so she did not know if hospice was responsible for obtaining Resident #9's medication refills. -She had not noticed any signs or symptoms of depression in Resident #9 aside from a physical decline in her health since her recent admission to hospice. -She tried to do medication cart audits every Monday, but she had not been doing them regularly because nobody told her she had to. -It was the responsibility of all the MAs and the	{D 358}			

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{D 358}	Continued From page 19 DRC to ensure that all medications were available on the medication cart for administration. Telephone interview with Resident #9's hospice nurse on 08/31/23 at 11:30am revealed: -Resident #9 was admitted to hospice services on 08/04/23. -Hospice did not provide or obtain medication refills for Resident #9 so the facility was responsible for ordering refills prior to the medications running out. -She was not aware that Resident #9 had ran out of duloxetine. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed: -He was not aware Resident #9 had ran out of duloxetine 20mg. -The MAs were expected to request medication refills prior to the medications running out, when the medication was down to a 7-day supply. -The facility's contracted pharmacy requested that medication refills to be sent one week in advance to ensure the refill arrived prior to the medication running out. -If a medication ran out, the MA was responsible for contacting the pharmacy for a refill that same day. -The MAs were supposed to notify hospice if Resident #9 ran out of a medication. -Since starting the position of DRC, one week prior he had not have the opportunity to audit the medication carts yet. Telephone interview with Resident #9's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #9 was prescribed duloxetine to treat depression.	{D 358}			

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{D 358}	Continued From page 20 -If Resident #9 had missed more than a couple of doses of duloxetine she could suffer an increase in her depression symptoms. -She had not been notified Resident #9 was out of duloxetine or needed a new prescription sent to the pharmacy. -Resident #9 had been admitted to hospice a couple of weeks prior and occasionally appeared depressed or worried. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -Resident #9's duloxetine being out should have been caught during a medication cart audit. -She did not know when the last medication cart audit had been completed. -Each MA who documented Resident #9's duloxetine as not administered should have notified the DRC that the medication was not on the medication cart and called the pharmacy to request the refill. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. c. Review of Resident #9's signed physician's order dated 05/04/23 revealed there was an order for Refresh Optive Advanced 0.5%-1%-0.5% eye drops (lubricating eye drops used to treat dry eyes), instill 1 drop into both eyes three times daily. Observation of the morning medication pass on 08/30/23 at 9:05am revealed: -The medication aide (MA) removed 3 oral medications and a nasal spray from the medication cart and compared each medication	{D 358}			

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{D 358}	Continued From page 21 bottle label to the medications due on the paper medication administration record (MAR). -The MA administered a nasal spray along with 3 and 1/2 tablets to Resident #9 in applesauce with a cup of nectar-thickened water and observed Resident #9 taking and swallowing the contents in the medication cup. -The MA did not administer Refresh Optive Advanced eye drops to Resident #9. Review of Resident #9's August 2023 MAR revealed: -There was an entry for Refresh Optive Advanced 0.5%-1%-0.5% eye drops, instill 1 drop into both eyes three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -There was no documentation Refresh Optive Advanced eye drops were administered on 08/30/23 at 8:00am; the documentation space on the MAR was blank. Observation of medication on hand for Resident #9 on 08/30/23 at 12:03pm revealed: -There was one box of Refresh Optive Advanced 0.5%-1%-0.5% eye drops with 3 out of 30 single-use containers remaining in the box. -The box was not labeled with Resident #9's name, dispensed date, or instructions for use. Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:00pm revealed: -Refresh Optive Advanced eye drops were on backorder and unavailable to the pharmacy. -She was not able to find information on when or if they had ever dispensed Refresh Optive Advanced eye drops to the facility for Resident #9. Interview with the MA on 08/30/23 at 3:05pm	{D 358}			

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{D 358}	Continued From page 22 revealed: -She did not normally work on Resident #9's hall during the 8:00am medication pass often so she was less familiar with her medications. -She usually looked at every page of each resident's MAR to ensure she did not miss a medication, but she had overlooked Resident #9's Refresh Optive Advanced eye drops. -She did not know why Resident #9's eye drops were not labeled or if Resident #9's family had purchased them over-the-counter and brought them to the facility. -She had not noticed that she missed administering Resident #9's eye drops. Telephone interview with Resident #9's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #9 was prescribed Refresh Optive Advanced eye drops to help treat dry eyes. -Not receiving Refresh Optive Advanced eye drops could result in Resident #9 experiencing dry eyes and it could be uncomfortable to blink her eyes. -She was not aware that Resident #9 did not receive her Refresh Optive Advanced eye drops on 08/30/23. -She expected the MAs to administer Refresh Optive Advanced eye drops to Resident #9 as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She was not aware that Resident #9 did not receive Refresh Optive Advanced eye drops during the morning medication pass on 08/30/23. -She expected the MAs to review each page of each resident's MAR so that medications were not missed during the medication pass. -She expected medications to be administered as	{D 358}			

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{D 358}	Continued From page 23 ordered by the doctor. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. d. Review of Resident #9's physician's order dated 08/08/23 revealed an order for Tylenol (used to treat pain) 500mg take 1 tablet twice daily. Observation of the morning medication pass on 08/30/23 at 9:05am revealed: -The medication aide (MA) removed 3 oral medications and a nasal spray from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The MA administered a nasal spray and 3 and 1/2 tablets to Resident #9 in applesauce with a cup of nectar-thickened water and observed Resident #9 taking and swallowing the contents in the medication cup. -The MA did not administer Tylenol 500mg to Resident #9. Review of Resident #9's August 2023 MAR revealed: -There was an entry hand-written on the last page of the MAR for Tylenol 500mg three times daily, scheduled at 8:00am, 2:00pm, and 8:00pm. -There was no documentation Tylenol 500mg was administered on 08/30/23 at 8:00am; the documentation space on the MAR was blank. Observation of medication on hand for Resident #9 on 08/30/23 at 12:03pm revealed: -There was one medication card for Tylenol	{D 358}			

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NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 24 500mg give one tablet twice daily. -The medication card had a dispensed date of 08/11/23 and there were 10 out of 30 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:00pm revealed: -Resident #9 had an order dated 08/11/23 for Tylenol 500mg take 1 tablet twice daily. -The pharmacy dispensed 30 tablets of Tylenol 500mg to the facility on 08/11/23. Interview with the MA on 08/30/23 at 3:05pm revealed: -She did not normally work on Resident #9's hall during the 8:00am medication pass often so she was less familiar with her medications. -She usually looked at every page of each resident's MAR to ensure she did not miss a medication, but she had overlooked Resident #9's Tylenol 500mg order because it was handwritten on the last page of the MAR since it was a new order. -She had not noticed that she missed administering Resident #9's Tylenol 500mg. -Resident #9 did not appear to be and had not complained of pain during her shift that day on 08/30/23. Telephone interview with Resident #9's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #9 was prescribed scheduled Tylenol 500mg twice daily to help treat generalized pain along with ongoing pain to her left shoulder from a previous inoperable injury. -Not receiving Tylenol 500mg as ordered could result in Resident #9 being in pain. -She was not aware that Resident #9 did not	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 358}	Continued From page 25 receive her Tylenol on 08/30/23. -She expected the MAs to administer Tylenol to Resident #9 as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She was not aware Resident #9 did not receive Tylenol 500mg during the morning medication pass on 08/30/23. -She expected the MAs to review each page of each resident's MAR so that medications were not missed during the medication pass. -She was not aware that Resident #9's Tylenol order was written on the MAR to be administered three times daily instead of twice daily. -She expected medications to be administered as ordered by the doctor. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 2. Review of Resident #6's current FL2 dated 06/07/23 revealed diagnoses included chronic kidney disease stage 3, hypertension, dementia, gastroesophageal reflux disease (GERD), and allergies. a. Review of Resident #6's current FL2 dated 06/07/23 revealed there was an order for Celebrex (a non-steroidal anti-inflammatory medication used to treat pain) 100mg daily. Observation of the morning medication pass on 08/30/23 at 8:15am revealed: -The medication aide (MA) removed 6 oral medications from the medication cart and compared each medication bottle label to the	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 26 medications due on the medication administration record (MAR). -The MA said there were 4 medications she was missing and not able to administer after looking for the medications in the medication cart. -The MA handed a plastic medication cup to Resident #6 with a cup of water and Resident #6 asked the MA where the rest of her pills were. -Resident #6 was advised by the MA that she needed to reorder the rest of her medications because they had ran out. -The MA observed Resident #6 taking and swallowing her medications. -The MA did not administer Celebrex, because it was not available in the medication cart for administration. Review of Resident #6's August 2023 MAR revealed: -There was an entry for Celebrex 100mg take 1 capsule daily scheduled at 8:00am. -There was documentation Celebrex was administered on 08/30/23 at 8:00am. Observation of medication on hand for Resident #6 on 08/30/23 at 12:03pm revealed there was no Celebrex 100mg available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/30/23 at 12:20pm revealed: -Resident #6 had a current order for Celebrex 100mg take 1 tablet every morning. -The pharmacy last dispensed Celebrex 100mg for Resident #6 on 07/29/23 for a quantity of 30 tablets which would last one month. -There was no documentation the facility had requested a refill of Resident #6's Celebrex since it was last dispensed.	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{D 358}	Continued From page 27 Interview with Resident #6 on 08/30/23 at 11:55am revealed: -She noticed she was missing some of her pills in her medication cup earlier that morning. -She thought she had received all of her medications yesterday on 08/29/23. -She did not have any increase in her pain that day after not receiving Celebrex. Interview with the MA on 08/30/23 at 3:05pm revealed: -She reordered medications that were running low when the quantity was down to 12 doses. -If a medication did not arrive from the pharmacy within 3 days, the MAs were supposed to notify the Director of Resident Care (DRC). -She did not normally work on Resident #6's hall during the 8:00am medication pass often so she did not know if the other MAs had requested a refill for Resident #6's Celebrex or not. -She had documented Resident #6's Celebrex as administered that morning in error. Telephone interview with a second MA on 08/31/23 at 11:10am revealed: -She last worked on Resident #6's hall and administered medications to her on 08/27/23. -She was aware that Resident #6 was out of Celebrex, but did not know exactly when she had ran out. -She had called Resident #6's family member because she thought the family member was responsible for picking up her medications from the pharmacy; she did not remember which day she had contacted him. -She did not document her phone call to Resident #6's family member to request a refill of Celebrex. -She did not tell the DRC about Resident #6 being out of Celebrex because she had contacted the family member instead.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 28 -It was the responsibility of all the MAs and the DRC to ensure that all medications were available on the medication cart for administration. Telephone interview with Resident #6's family member on 08/31/23 at 11:45am revealed: -He had received a phone call several days prior regarding Resident #6 being out of a few of her medications. -He was not responsible for reordering, refilling, or picking up any of Resident #6's prescriptions. -He sometimes offered to pick up Resident #6's prescriptions if she ran out of medication, because he did not want her to miss any doses of her medications. -Resident #6's pharmacy was able to deliver her medications to the facility free of charge and he had asked the staff to request refills of her medications from the pharmacy directly. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed he was not aware that Resident #6 had ran out of Celebrex 100mg. Telephone interview with Resident #6's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #6 was prescribed Celebrex to treat generalized joint pain. -Not receiving Celebrex as ordered could result in Resident #6 having pain. -She expected the facility staff to reorder medications prior to them running out. -If a new prescription was needed, she wanted to be notified 7 days prior to the medication running out. -She expected the MAs to administer Resident #6's Celebrex as ordered.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
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{D 358}	Continued From page 29 Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She had been notified by the DRC after the morning medication pass on 08/30/23 that Resident #6 had not received Celebrex as ordered. -Resident #6's Celebrex running low should have been caught during a medication cart audit and reordered prior to it running out. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. b. Review of Resident #6's current FL2 dated 06/07/23 revealed there was an order for omeprazole (a proton-pump inhibitor used to treat heartburn) 20mg daily. Observation of the morning medication pass on 08/30/23 at 8:15am revealed: -The medication aide (MA) removed 6 oral medications from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The MA said there were 4 medications she was missing and not able to administer after looking for the medications in the medication cart. -The MA handed a plastic medication cup to Resident #6 with a cup of water and Resident #6 asked the MA where the rest of her pills were. -Resident #6 was advised by the MA that she needed to reorder the rest of her medication because they had ran out. -The MA observed Resident #6 taking and swallowing her medications. -The MA did not administer omeprazole, because	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
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{D 358}	Continued From page 30 it was not available in the medication cart for administration. Review of Resident #6's August 2023 MAR revealed: -There was an entry for omeprazole 20mg take 1 capsule daily scheduled at 8:00am. -There was documentation omeprazole was not administered on 08/30/23 at 8:00am. Observation of medication on hand for Resident #6 on 08/30/23 at 12:03pm revealed there was no omeprazole 20mg capsules available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/30/23 at 12:20pm revealed: -Resident #6 had a current order for omeprazole 20mg take 1 capsule every morning. -The pharmacy last dispensed omeprazole for Resident #6 on 05/02/23 for a quantity of 30 tablets which would last one month. -There was no documentation the facility had requested a refill of Resident #6's omeprazole since it was last dispensed. Interview with Resident #6 on 08/30/23 at 11:55am revealed: -She noticed she was missing some of her pills in her medication cup earlier that morning. -She thought she had received all of her medications yesterday on 08/29/23. -She had not been experiencing symptoms of heart burn or acid reflux. Interview with the MA on 08/30/23 at 3:05pm revealed: -She reordered medications that were running low when the quantity was down to 12 doses.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 31 -If a medication did not arrive from the pharmacy within 3 days, the MAs were supposed to notify the Director of Resident Care (DRC). -She did not normally work on Resident #6's hall during the 8:00am medication pass often so she did not know if the other MAs had requested a refill for Resident #6's omeprazole or not. -Resident #6 had never complained to her about having symptoms of heartburn or acid reflux. Telephone interview with a MA on 08/31/23 at 11:10am revealed: -She last worked on Resident #6's hall and administered medications to her on 08/27/23. -She was aware that Resident #6 was out of omeprazole but she did not know how long she had been out of omeprazole. -She had administered omeprazole to Resident #6 in the past. -She had called Resident #6's family member, because she thought the family member was responsible for picking up her medications from the pharmacy; she did not remember which day she had contacted him. -She did not document her phone call to Resident #6's family to request a refill of omeprazole. -She did not tell the DRC about Resident #6 being out of omeprazole because she had contacted the family member instead. -It was the responsibility of all the MAs and the DRC to ensure that all medications were available on the medication cart for administration. Telephone interview with Resident #6's family member on 08/31/23 at 11:45am revealed: -He had received a phone call several days prior regarding Resident #6 being out of a few of her medications. -He was not responsible for reordering, refilling,	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
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{D 358}	Continued From page 32 or picking up any of Resident #6's prescriptions. -He did sometimes offer to pick up Resident #6's prescriptions if she ran out because he did not want her to miss any doses of her medications. -Resident #6's pharmacy was able to deliver her medications to the facility free of charge and he had asked the staff to request refills of her medications from the pharmacy directly. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed he was not aware that Resident #6 had ran out of omeprazole 20mg. Telephone interview with Resident #6's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #6 was prescribed omeprazole to treat heartburn. -Not receiving omeprazole as ordered could result in Resident #6 having some symptoms of acid reflux or heartburn. -She expected the facility staff to reorder medications prior to them running out. -If a new prescription was needed, she wanted to be notified 7 days prior to the medication running out. -She expected the MAs to administer Resident #6's omeprazole as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She had been notified by the DRC after the morning medication pass on 08/30/23 that Resident #6 had not received omeprazole as ordered. -Resident #6's omeprazole running low should have been caught during a medication cart audit and refilled prior to it running out. Refer to the telephone interview with the Director	{D 358}			

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{D 358}	Continued From page 33 of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. c. Review of Resident #6's current FL2 dated 06/07/23 revealed there was an order for Tylenol 500mg (used to treat pain) take 1 tablet daily. Observation of the morning medication pass on 08/30/23 at 8:15am revealed: -The medication aide (MA) removed 6 oral medications from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The MA said there were four medications she was missing and not able to administer after looking for the medications in the medication cart. -The MA handed a plastic medication cup to Resident #6 with a cup of water and Resident #6 asked the MA where the rest of her pills were. -Resident #6 was advised by the MA that she needed to reorder the rest of her medication, because they had ran out. -The MA observed Resident #6 taking and swallowing her medications. -The MA did not administer Tylenol 500mg, because it was not available in the medication cart for administration. Review of Resident #6's August 2023 MAR revealed: -There was an entry for Tylenol 500mg take 1 tablet daily scheduled at 8:00am. -There was documentation Tylenol 500mg was not administered on 08/30/23 at 8:00am. Observation of medication on hand for Resident #6 on 08/30/23 at 12:03pm revealed there was no	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
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{D 358}	Continued From page 34 Tylenol 500mg tablets available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/30/23 at 12:20pm revealed: -Resident #6 did not have a current medication order on file at the pharmacy for Tylenol 500mg daily. -The pharmacy had not dispensed Tylenol 500mg tablets to the facility for Resident #6. -She did not see an FL2 on file for Resident #6 dated 06/07/23. Interview with Resident #6 on 08/30/23 at 11:55am revealed: -She noticed she was missing some of her pills in her medication cup earlier that morning. -She thought she had received all of her medications yesterday on 08/29/23. -She was not experiencing any symptoms of pain. Interview with the MA on 08/30/23 at 3:05pm revealed: -She reordered medications that were running low when the quantity was down to 12 doses. -If a medication did not arrive from the pharmacy within 3 days, the MAs were supposed to notify the Director of Resident Care (DRC). -She did not normally work on Resident #6's hall during the 8:00am medication pass often so she was not familiar with Resident #6's medications and she did not know if the other MAs had requested a refill for Resident #6's Tylenol or not. -The facility did not use house stock supply of medications for residents such as Tylenol. -Resident #6 had not complained about having pain during her shift on 08/30/23. Telephone interview with the DRC on 08/31/23 at	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/31/2023
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FOREST HEIGHTS SENIOR LIVING COMMUNIT **2500 POLO RIDGE COURT**
WINSTON SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 35 12:25pm revealed he was not aware that Resident #6 had ran out of Tylenol 500mg tablets. Telephone interview with Resident #6's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #6 was prescribed scheduled Tylenol 500mg daily to treat generalized aches and pains. -There would be no harm for Resident #6 missing a dose of Tylenol. -She expected the facility staff to reorder medications prior to them running out. -If a new prescription was needed, she wanted to be notified 7 days prior to the medication running out. -She expected the MAs to administer Resident #6's Tylenol as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She had been notified by the DRC after the morning medication pass on 08/30/23 that Resident #6 had not received Tylenol as ordered. -Resident #6's Tylenol running low should have been caught during a medication cart audit and reordered prior to it running out. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. d. Review of Resident #6's current FL2 dated 06/07/23 revealed there was an order for Systane (lubricating eye drops used to treat dry eyes) 0.6% eye drops, instill 1 drop in each eye four times daily. Observation of the morning medication pass on	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
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{D 358}	Continued From page 36 08/30/23 at 8:15am revealed: -The medication aide (MA) removed 6 oral medications from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -No eye drops were removed from the medication cart. -The MA said there were 4 medications she was missing and not able to administer after looking for the medications in the medication cart. -The MA handed a plastic medication cup to Resident #6 with a cup of water and Resident #6 asked the MA where the rest of her pills were. -Resident #6 was advised by the MA that she needed to reorder the rest of her medication because they had ran out. -The MA did not administer Systane eye drops, because it was not available in the medication cart for administration. Review of Resident #6's August 2023 MAR revealed: -There was an entry for Systane 0.6% eye drops instill 1 drop in both eyes four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation Systane eye drops were administered on 08/30/23 at 8:00am; the documentation space on the MAR was blank. Observation of medication on hand for Resident #6 on 08/30/23 at 12:03pm revealed there was no Systane 0.6% eye drops available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/30/23 at 12:20pm revealed: -Resident #6 had an order for Systane 0.6% eye	{D 358}			

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NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 37 drops instill one drop into each eye four times daily. -The pharmacy last dispensed Systane eye drops for Resident #6 on 03/24/22. -Systane 0.6% eye drops were also sold over-the-counter. Interview with Resident #6 on 08/30/23 at 11:55am revealed: -She usually received eye drops with her morning medication pass and she had received them during the morning medication pass the previous day, on 08/29/23. -If she did not receive her eye drops, her eyes sometimes became dry and blurry. -Her eyes felt a little dry. Interview with the MA on 08/30/23 at 3:05pm revealed: -She did not normally work on Resident #6's hall during the 8:00am medication pass often so she was not familiar with Resident #6's morning medications and did not know if the other MAs had requested a refill for Resident #6's Systane eye drops or not. -Sometimes it was hard to know when eye drops were low and needed to be refilled. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed he was not aware that Resident #6 had ran out of Systane 0.6% eye drops. Telephone interview with Resident #6's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #6 was prescribed scheduled Systane 0.6% eye drops four times daily to treat dry eyes. -Missing a dose of Systane eye drops could cause Resident #6's eyes to feel dry while	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 358}	Continued From page 38 blinking. -She expected the facility staff to reorder medications prior to them running out. -If a new prescription was needed, she wanted to be notified 7 days prior to the medication running out. -She expected the MAs to administer Resident #6's Systane eye drops as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed she had been notified by the DRC after the morning medication pass on 08/30/23 that Resident #6 had not received Systane eye drops as ordered. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 3. Review of Resident #7's current FL2 dated 05/01/23 revealed: -Diagnoses included gastroesophageal reflux disease (GERD). -There was an order for famotidine (an antacid medication used to treat GERD) 20mg take 1 tablet twice daily. Observation of the morning medication pass on 08/30/23 at 8:30am revealed: -The medication aide (MA) removed 9 oral medications from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -The MA handed a plastic medication cup to Resident #7 containing 9 tablets with a cup of water. -The MA observed Resident #7 taking his	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 39 medication. -The MA did not administer famotidine 20mg, because it was not available in the medication cart for administration. Review of Resident #7's August 2023 MAR revealed: -There was an entry for famotidine 20mg, take 1 tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation famotidine had been administered at 8:00am on 08/30/23. Observation of medication on hand for Resident #7 on 08/30/23 at 12:00pm revealed there was an empty medication bottle for famotidine 20mg with a dispensed date of 03/17/23 and a dispensed quantity of 120 tablets. Interview with the MA on 08/30/23 at 3:05pm revealed: -During the medication pass she had overlooked Resident #7's famotidine, because he was on another acid reflux medication as well that she administered. -She had not noticed she had not administered famotidine to Resident #7 or that she documented she administered the medication that morning on 08/30/23. Interview with Resident #7 on 08/30/23 at 3:45pm revealed: -He was not familiar with which medications he had ordered, he just took whatever medications the MA gave him. -He did not have any symptoms of heartburn that day. -He had not recently experienced symptoms of heartburn.	{D 358}			

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{D 358}	Continued From page 40 Telephone interview with a MA on 08/31/23 at 11:10am revealed: -Resident #7 had been out of famotidine the last time she administered his medications on 08/27/23. -She had not requested a refill for Resident #7's famotidine, but she notified the oncoming second-shift MA that it needed to be reordered. -She did not know if Resident #7's famotidine had been reordered and received by the facility. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed he was not aware that Resident #7 had ran out of famotidine 20mg tablets. Telephone interview with Resident #7's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #6 was prescribed famotidine 20mg treat symptoms of acid reflux. -Missing a dose of famotidine could cause Resident #7 to experience heart burn. -She expected the facility staff to reorder medications prior to them running out. -If a new prescription was needed, she wanted to be notified 7 days prior to the medication running out. -She expected the MAs to administer Resident #7's famotidine twice daily as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed she had not been made aware that Resident #7 had ran out of famotidine. Attempted telephone interview with a representative from Resident #7's pharmacy on 08/30/23 at 12:27pm was unsuccessful.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 41 Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 4. Review of Resident #8's current FL2 dated 07/30/22 revealed: -Diagnoses included muscle weakness, type 2 diabetes, and chronic kidney disease. -There was an order for Diclofenac 1% gel (a topical pain relief medication) apply 1 gram topically to painful areas twice daily. Observation of the morning medication pass on 08/30/23 at 8:45am revealed: -The medication aide (MA) removed 6 oral medications from the medication cart and compared each medication bottle label to the medications due on the medication administration record (MAR). -There were no topical medications removed from the medication cart. -The MA handed a plastic medication cup to Resident #8 containing 6 medications with a cup of water. -The MA observed Resident #8 taking her medication. -The MA did not apply Diclofenac 1% gel. Review of Resident #8's August 2023 MAR revealed: -There was an entry Diclofenac 1% gel, apply 1 gram topically to painful areas twice daily scheduled at 8:00am and 8:00pm. -There was no documentation Diclofenac 1% gel had been applied at 8:00am on 08/30/23; the documentation space on the MAR was blank. Observation of medication on hand for Resident	{D 358}			

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{D 358}	Continued From page 42 #8 on 08/30/23 at 12:03pm revealed there was one 100-gram tube of Diclofenac 1% gel with a dispensed date of 08/03/23 and the tube was unopened. Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:00pm revealed: -Resident #8 had an order for Diclofenac 1% gel to be applied twice daily to painful areas. -The pharmacy last dispensed Diclofenac 1% gel to the facility for Resident #8 on 08/03/23 for a quantity of 100 grams which was a 50-day supply. -Prior to 08/03/23, the pharmacy dispensed Diclofenac 1% gel for Resident #8 in February 2022. -Diclofenac 1% gel was also available over-the-counter. Interview with the MA on 08/30/23 at 3:05pm revealed: -During her medication passes, she usually administered all of the oral medications first, then went back around to all of the residents to administer their treatments or topical medications. -She had planned to go back to Resident #8 to apply her Diclofenac gel, but she forgot to. Interview with Resident #8 on 08/30/23 at 3:40pm revealed: -She did not remember the last time a MA applied a pain relief gel to her ankles or other areas of her body. -She did not have any pain. Telephone interview with Resident #8's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #8 was prescribed Diclofenac 1% gel to	{D 358}		

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{D 358}	Continued From page 43 treat ankle pain due to a history of having an ankle fracture. -Not receiving the Diclofenac 1% gel could result in Resident #8 having pain to her ankle. -She expected the MAs to administer Diclofenac 1% gel to Resident #8 as ordered. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -She was not aware that Resident #8 did not receive Diclofenac 1% gel during the morning medication pass on 08/30/23. -She expected the MAs to review each page of each resident's MAR so that medications were not missed during the medication pass. -She expected medications to be administered as ordered. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 5. Review of Resident #5's current FL2 dated 08/02/23 revealed: -Diagnoses included history of urinary tract infection, type 2 diabetes, and kidney disease. -There was an order for Nystatin (a cream used to treat yeast or fungal skin infections) 100,000 unit/gram cream apply to penis where irritated or red two times daily for 14 days from 07/24/23 through 08/07/23. Review of Resident #5's August 2023 medication administration record (MAR) revealed: -There was an entry for Nystatin 100,000 unit/gram cream apply to tip of penis twice daily for 14 days scheduled at 8:00am and 8:00pm. -There was documentation Resident #5 was out	{D 358}		

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{D 358}	Continued From page 44 of the facility from 08/01/23 through 08/04/23. -There was documentation Nystatin cream was not applied for 6 out of 6 opportunities from 8:00pm on 08/04/23 through 8:00am on 08/07/23; there was no documented reason why the medication was not applied. Observation of medication on hand for Resident #5 on 08/29/23 at 4:00pm revealed there was one unopened 30-gram tube of Nystatin 100,000 unit/gram cream with a dispensed date of 08/07/23. Interview with Resident #5 on 08/30/23 at 2:58pm revealed: -He had been in a rehabilitation facility from mid-July 2023 through 08/04/23. -While at the rehabilitation facility, he had a condom catheter in place which caused irritation to the skin on his penis. -After he returned to the facility, the medication aides (MA) never applied Nystatin cream to his affected area. -He had mentioned having skin irritation to his penis a couple of times and the MAs applied some type of ointment, but he did not know what it was and he could not remember which MA he told. -He no longer had any irritation to the skin on his penis. Interview with a MA on 08/30/23 at 3:05pm revealed: -She was not aware of Resident #5's order for Nystatin cream. -She had never applied Nystatin cream to Resident #5, because she had not worked on the days from 08/04/23 through 08/07/23. -She saw the tube of Nystatin cream in the medication cart and had asked the facility's	{D 358}			

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{D 358}	Continued From page 45 previous Director of Resident Care (DRC) about it. The DRC told her she would clarify with the doctor if the order should be extended since the Nystatin cream was received at the facility the day the order ended on 08/07/23. -The DRC had not followed up with her about whether she needed to apply the Nystatin cream to Resident #5. -She had not asked the facility's new DRC about Resident #5's Nystatin order and she had not asked Resident #5 about whether or not he still had symptoms and needed the Nystatin cream. -Resident #5 never complained to her about skin pain or irritation to his penis. Telephone interview with Resident #5's primary care provider (PCP) on 08/31/23 at 1:10pm revealed: -Resident #5 was ordered Nystatin cream while at the rehabilitation facility due to skin irritation from his condom catheter. -She was not aware the Nystatin cream had never been applied. -There was no negative outcome to Resident #5 missing his Nystatin cream because he reported his skin had healed, but not receiving the Nystatin could have resulted in his skin condition worsening. -The facility's previous DRC had not contacted her about extending the dates of the order for applying Nystatin cream. Telephone interview with the DRC on 08/31/23 at 12:25pm revealed that since starting his position as DRC one week prior, he had not been made aware of Resident #5's Nystatin order. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed:	{D 358}			

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{D 358}	Continued From page 46 -She was not aware of Resident #5 Nystatin order or that it had not been applied. -She expected the MAs who worked on the days that the Nystatin was due, to contact the pharmacy to have the Nystatin cream delivered so it could be applied as ordered. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 6. Review of Resident #4's FL2 dated 07/30/22 revealed diagnoses included diabetes, hypertension, and history of cerebrovascular accident (CVA). Review of Resident #4's signed physician's order dated 05/04/23 revealed an order for ferrous sulfate 325mg (used to treat low iron levels) daily at bedtime. Review of Resident #4's July 2023 Medication Administration Record (MAR) from 07/03/23 to 07/31/23 revealed: -There was an entry for ferrous sulfate 325mg tablet take 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation ferrous sulfate 325mg tablet was administered from 07/03/23 to 07/31/23. Review of Resident #4's August 2023 MAR revealed: -There was an entry for ferrous sulfate 325mg tablet take 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation ferrous sulfate 325mg tablet was not administered from 08/16/23 to	{D 358}			

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{D 358}	Continued From page 47 08/29/23. -There was documentation ferrous sulfate 325mg was not administered and the reason documented as the medication was "on order" on 08/16/23, 08/17/23, 08/19/23, 08/22/23, 08/26/23, 08/27/23 and 08/29/23. Observation of Resident #4's medications on hand on 08/30/23 at 3:20pm revealed there were no ferrous sulfate 325mg tablets available for administration. Telephone interview with a representative from Resident #4's pharmacy on 08/30/23 at 1:20pm revealed: -There was an active order on file for ferrous sulfate 325mg tablet daily. -The pharmacy last dispensed 30 ferrous sulfate tablets on 07/03/23 which was a 30-day supply. Telephone interview with Resident #4's primary care provider (PCP) on 08/31/23 at 1:45pm revealed: -She was not aware and was not contacted about Resident #4 missing doses of ferrous sulfate. -The indication for ferrous sulfate for Resident #4 was to prevent anemia as she was also ordered a long term anticoagulant due to a history of CVA. -A potential outcome of missing about three weeks of ferrous sulfate was anemia. -Resident #4's iron levels were within the normal limits the last time they were checked in July 2023. Telephone interview with a medication aide (MA) on 08/31/23 at 11:06am revealed: -She was not aware there was no ferrous sulfate available for administration on the medication cart on 08/30/23. -If a medication had ran out when she checked	{D 358}			

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{D 358}	Continued From page 48 the medication cart, she reordered the medication by faxing the pharmacy. -All medications were individually reordered at the facility. Telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm revealed he did not know there was no ferrous sulfate on the medication cart available for administration for Resident #4. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed she was not aware there was no ferrous sulfate on the medication cart available for administration for Resident #4. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm. 7. Review of Resident #3's FL2 dated 07/30/22 revealed: -Diagnoses included benign prostatic hyperplasia (BPH) and dementia. -There was an order for finasteride 5mg daily (used to treat BPH). Review of Resident #4's signed physician's order dated 08/03/23 revealed there was an order for finasteride 5mg daily. Review of Resident #3's July 2023 Medication Administration Record (MAR) from 07/03/23 to 07/31/23 revealed: -There was an entry for finasteride 5mg take 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation finasteride 5mg was	{D 358}			

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NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{D 358}	Continued From page 49 administered from 07/03/23 to 07/31/23. Review of Resident #3's August 2023 MAR revealed: -There was an entry for finasteride 5mg take 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation that finasteride 5mg was administered from 08/01/23 to 08/28/23. Observation of Resident #3's medications on hand on 08/30/23 at 12:40pm revealed there was no finasteride 5mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/30/23 at 1:20pm revealed: -There was an active order on file for Resident #3 for finasteride 5mg take one tablet at bedtime. -The pharmacy last dispensed finasteride 5mg for Resident #3 on 07/21/23 for a quantity of 30 tablets which was a 30-day supply. -The medication had not been requested for reorder as of 08/30/23. Telephone interview with Resident #3's PCP on 08/31/23 at 1:46pm revealed: -She was not aware and was not contacted about Resident #3 missing doses of finasteride. -The indication for finasteride for Resident #3 was to help with urinary symptoms and frequency. -A potential side effect of Resident #3 missing about one week of finasteride was urinary frequency. Interview with a medication aide (MA) on 08/30/23 at 12:51pm revealed: -She was not aware that finasteride was not available for administration on the medication cart for Resident #3.	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/31/2023
NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106		
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{D 358}	Continued From page 50 -She administered medications to Resident #3 on 08/30/23. -She had not reordered and she did not know if anyone else had tried to reorder Resident #3's finasteride. -There were times when she worked the medication cart and medications were not available. -MAs faxed medication orders to the pharmacy and contacted the pharmacy to reorder medications. -If a resident ran out of a medication, MAs were supposed to fill out a reorder form and fax the form to the pharmacy. -The residents' medications had to be reordered individually as they ran low. -She tried to reorder medications when there were 7 doses left. Interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm revealed he was not aware finasteride was not available for administration on the medication cart for Resident #3. Interview with the Administrator on 08/31/23 at 2:20pm revealed she was not aware finasteride was not available for administration on the medication cart for Resident #3. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to the telephone interview with the Director of Resident Care (DRC) on 08/31/23 at 12:25pm. Refer to the telephone interview with the Administrator on 08/31/23 at 2:20pm.	{D 358}			

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NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106			
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{D 358}	Continued From page 51 Telephone interview with the DRC on 08/31/23 at 12:25pm revealed: -He was not aware of any medications being out and not available for administration on the medication cart. -The MAs were expected to request medication refills prior to the medications running out when the medication was down to a 7-day supply. -The facility's contracted pharmacy requested that medication refills be sent one week in advance to ensure the refill arrived prior to the medication running out. -If a medication ran out, the MA was responsible for contacting the pharmacy for a refill that same day. -Since starting the position of DRC one week prior, he had not had the opportunity to audit the medication carts yet. Telephone interview with the Administrator on 08/31/23 at 2:20pm revealed: -The residents' medication were "on demand," meaning that they had to be reordered individually. -MAs were expected to reorder medications when there was a 7-day supply remaining by calling or faxing the pharmacy. -MAs were also expected to follow-up with the pharmacy via phone call to ensure that faxes were received and to call the pharmacy a second time if the medication was not received the next day. -The facility's previous DRC had been responsible for completing medication cart audits every week. -The last medication cart audit would have been completed one-and-a-half to two weeks prior by the previous DRC. -During the medication cart audits, the previous DRC had been checking that all the orders on the	{D 358}			

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NAME OF PROVIDER OR SUPPLIER FOREST HEIGHTS SENIOR LIVING COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 POLO RIDGE COURT WINSTON SALEM, NC 27106			
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{D 358}	Continued From page 52 medication cards matched the order entry on the MAR, and that all ordered medications were available on the medication cart. -The DRC was responsible for faxing medication refill requests to the pharmacy if she noticed a medication that had ran out or was running low during her medication cart audit. -The MAs were expected to administer medications as they were ordered. <u>The facility failed to ensure medications were administered as ordered for 4 of 4 residents during the medication pass including a resident who received the incorrect dose of diuretic medication which placed her at risk for dehydration, and did not receive an antidepressant which could result in an increase in symptoms of depression (#9), and a resident who did not receive two pain medications and an acid reflux medication which placed her at risk for uncontrolled pain and heartburn, and did not receive eye drops resulting in the resident experiencing dry eyes (#6); a resident did not receive an anti-acid which placed the resident at risk for acid reflux and heart burn (#7); and a resident who did not receive a topical pain medication which placed the resident at risk for increased pain (#8); and for 3 of 5 residents for record review including a resident who did not receive a topical treatment for skin irritation placing him at risk for a worsening skin condition (#5); a resident who did not receive an iron supplement placing her at risk for anemia (#4); and a resident who did not receive a medication for an enlarged prostate which placed the resident at risk for urinary frequency (#3). This failure was detrimental to the health and safety of the residents and constitutes an Unabated Type B Violation.</u>	{D 358}			

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{D 358}	Continued From page 53 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/30/23 for this violation.	{D 358}			