STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	11/08/2024

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 11/06/24 to 11/08/24.	D 000		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure follow-up with a physician for 1 of 5 sampled residents who had blood pressure checks for routine monitoring and blood pressure checks with parameters (Resident #5). The findings are: Review of Resident #5's current FL2 dated 06/06/24 revealed diagnoses including hypertension, syncope and collapse, and orthostatic syncope. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 06/10/24. Review of Resident#5's progress notes revealed Resident #5 had an unwitnessed fall on 09/16/24 and was sent to a local emergency department (ED) for evaluation for possible head injury. Review of Resident #5's electronic triage note revealed: -On 09/27/24, a medication aide (MA) contacted	D 273		

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the triage team related to elevated blood pressure (200/77).
-The teletriage team called back requesting a second BP check.
-Resident #5's BP on recheck was 194/159 documented on the electronic triage note.
-The teletriage team recommended Resident #5 be sent to emergency department (ER) for evaluation and follow-up with primary care provider (PCP) upon return.
-Resident #5 was sent out to a local hospital for treatment.

a. Review of Resident #5's PCP progress notes dated 09/18/24 revealed:
-Resident #5 was seen by the facility and resident's PCP on 09/18/24 after a fall in her room and hospital emergency department visit to rule out head injury.
-Resident #5's "blood pressure (BP) was noted to be elevated prior to the visit".
-The PCP ordered for BP to be measured in the morning and evening for next 14 days. Notify triage/provider if systolic was less than 90 or greater than 180, or diastolic was less than 60 or greater than 100.

Interview with a morning MA on 11/08/24 at 2:45pm revealed:
-On 09/27/24 in the evening, Resident #5 complained to her she was not feeling well.
-The MA took Resident #5's BP and it was elevated but did not document the BP reading.
-The MA called the PCP's office to leave a message with the teletriage team.
-The triage team requested a second BP, which was still elevated, and advised the MA send Resident #5 out to a local emergency department (ED) for evaluation.
-She did not know Resident #5 had an order to

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check BP in the morning and the evening for 14 days starting on 09/18/24.

Review of Resident #5's September 2024 medication administration record (MAR) revealed:
-There was no entry for BP to be measured in the morning and evening for the next 14 days. Notify triage/provider if systolic BP was less than 90 or greater than 180, or diastolic BP was less than 60 or greater than 100.
-There was no documentation for BP values obtained from 09/18/24 to 09/30/24 available for review.

Interview with Resident #5's PCP on 11/08/24 at 10:10am revealed:
-The PCP ordered for BP to be measured in the morning and evening for the next 14 days. Notify triage/provider if systolic BP was less than 90 or greater than 180, or diastolic BP was less than 60 or greater than 100 after a fall in her room and hospital ED visit to rule out head injury on 09/16/24.
-Resident # 5 was being treated for hypertension and had some elevated BP reading on previous PCP visits.
-She wanted to monitor Resident #5's BP to adjust medications to lower her BP.
-She did not know the facility had failed to take BP readings as ordered because she was not notified for the facility failing to monitor Resident #5's BP as ordered from 09/18/24 to 09/27/24.
-The facility did not always provide the current MAR for her to review when she saw the resident.
-Not controlling Resident #5's elevated systolic BP placed the resident at increased risk of damage to her kidneys, vessels in her eyes, and could increase risk for a stroke.
-Resident #5 had not been experiencing falls previously.

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Second interview with the same MA on 11/08/24 at 11:15am revealed:
-The former facility Nurse had processed all orders from Resident #5's PCP prior to the end of September 2024.
-She had not seen Resident #5's orders for checking BPs in the morning and evening dated 09/18/24.
-If the BP was supposed to be checked in the morning and evening for Resident #5, there should be a blood pressure/heart rate (BP/HR) sheet, used by the facility to document values obtained, in the resident's record for review.
-She had not routinely taken Resident #5 BP when she worked from 09/18/24 to 09/27/24 when Resident #5 was sent to the local ED for elevated BP.

Interview with the Resident Care Coordinator (RCC) on 11/07/24 at 1:15pm revealed:
-The MAR did not have a space to document BP values large enough for the values to be legible, so the facility used an auxiliary BP/HR log to document the values.
-The facility Nurse routinely processed PCP orders when the orders were transcribed and faxed or emailed to the facility following the PCP visits.
-The facility Nurse reviewed the orders and usually highlighted any orders that were listed on the transcribed notes.
-The PCP routinely generated hard copy orders for medications.
-If the facility Nurse was not present when the PCP finished seeing residents, the MA working when the PCP completed her visit was responsible to process orders from the PCP visit.
-The facility Nurse was responsible to ensure that orders for treatments like blood pressure checks

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were completed and providers notified if orders were not completed, when the facility Nurse was still working at the facility.
-The RCC was responsible for ensuring orders were completed or providers notified if not completed since the facility Nurse position was vacant as of late September 2024.
-Resident #5 had no BP/HR log created and available for review for September 2024.
-The RCC did not know Resident #5's blood pressures ordered in the morning and evening were not completed or the provider notified for missed blood pressure checks.

Interview with Resident #5 on 11/08/24 at 1:50pm revealed:
-She did not know all her medications or if her blood pressure medications had changed recently.
-She thought the facility took her blood pressure every day but she did not recall having her blood pressure taken multiple times each day.

Refer to the interview with the Corporate Nurse on 11/08/24 at 11:50am.

Refer to the interview with the Administrator on 11/08/24 at 12:00pm.

b. Review of Resident #5's Progress notes dated 10/02/24 revealed there was an order for BP to be measured every 8 hours at least one hour after scheduled BP medications. Notify triage or provider if systolic is less than 90 or greater than 180.

Review of Resident #5's BP/HR log for October 2024 revealed:
-There were 93 opportunities for BP readings from 10/01/24 to 10/31/24.

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-There were no BP readings documented for 10/01/24 or 10/02/24.
-There were 47 BP readings documented beginning on 10/03/24 at 5:30am to 4:00pm on 10/31/24.
-There were days with one BP readings documented, there were days with 2 BP readings documented and only 10/08/24 had 3 BP values documented.
-There were 5 of 47 documented opportunities when the systolic BP reading was greater than 180 documented from 10/03/24 to 10/31/24.
-Systolic BP readings ranged from 126 to 197.

Review of Resident #5's October 2024 MAR revealed:
-There was a handwritten entry for check BP every 8 hours and administer BP medication for systolic number greater than 170.
-There was no entry for BP checks every 8 hours and notify triage or provider if systolic was less than 90 or greater than 180.

Review of Resident #5's October 2024 BP/HR log revealed there were 5 opportunities for systolic BP readings documented were more than 180 as follows:
-On 10/06/24 at 4:30pm, Resident #5's BP was documented as 187/67; there was no documentation Resident #5's provider was contacted.
-On 10/14/24 at 8:00pm, Resident #5's BP was documented as 190/65; there was no documentation Resident #5's provider was contacted.
-On 10/21/24 at 7:00pm, Resident #5's BP was documented as 180/62; there was no documentation Resident #5's provider was contacted.
-On 10/26/24 at 8:00am, Resident #5's BP was

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documented as 197/61; there was no documentation Resident #5's provider was contacted.
-On 10/26/24 at 12:00pm, Resident #5's BP was documented as 185/66; there was no documentation Resident #5's provider was contacted.

Review of Resident #5's November 2024 BP/HR log revealed there was 1 opportunity for systolic BP reading documented more than 180 as follows: On 10/26/24 at 12:00pm, Resident #5's BP was documented for 185/66 on the BP/HR log; there was no documentation Resident #5's provider was contacted.

Interview with Resident #5's PCP on 11/08/24 at 10:10am revealed:
-She wanted to monitor Resident #5's BP to adjust medications to lower her BP.
-She had no documentation the facility notified her for Resident #5's systolic BP over 180 as ordered from 10/04/24 to 11/07/24.
-The facility did not always provide the current MAR for her to review when she saw the resident.
-Not controlling Resident #5's elevated systolic BP placed the resident at increased risk of damage to her kidneys, vessels in her eyes, and could increase risk for a stroke.

Interview with a MA on 11/08/24 at 11:15am revealed:
-The former facility Nurse had processed all orders from the PCP prior to the end of September 2024.
-The RCC processed the orders for PCP since October 2024.
-If the BP was supposed to be checked in the morning and evening for Resident #5, there should be a BP/HR sheet, used by the facility to

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document values obtained, in the resident's record for review.
-She had not routinely taken Resident #5's BP or notified Resident #5's PCP if a BP was over 180 when she worked from 10/03/24 to 11/07/24.

Interview with the RCC on 11/07/24 at 1:15pm revealed:
-The facility Nurse routinely processed PCP orders when the orders were transcribed and faxed or emailed to the facility following the PCP visits.
-The facility Nurse reviewed the orders/progress notes and usually highlighted any orders that were listed on the transcribed notes.
-The PCP routinely generated hard copy orders for medications, but the treatment orders did not always have a separate order.
-The facility Nurse was responsible to ensure that orders for treatments like BP checks were completed and providers notified if orders were not completed, when the facility Nurse was still working at the facility.
-The RCC was responsible for ensuring orders were completed or providers notified if not completed since the facility Nurse position was vacant as of late September 2024.
-She did not have a system in place to routinely audit residents' records for provider notification for BP parameters.
-The RCC did not know Resident #5's PCP had not been notified for systolic BP readings greater than 180.

Interview with Resident #5 on 11/08/24 at 1:50pm revealed:
-She thought the facility staff took her BP every day but she did not recall having her BP taken multiple times each day.
-She could not tell if her BP was high because

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D 273	Continued From page 8 she did not feel any symptoms like dizziness or headache. Refer to the interview with the Corporate Nurse on 11/08/24 at 11:50am. Refer to the interview with the Administrator on 11/08/24 at 12:00pm. _____ Interview with the Corporate Nurse on 11/08/24 at 11:50am revealed: -Resident record audits were conducted by a Corporate Nurse routinely every 3 months for a sample of residents but not all residents. -The facility Nurse position was currently vacant and the RCC was responsible for ensuring that treatment/medications were administered as ordered until the position was filled. Interview with the Administrator on 11/08/24 at 12:00pm revealed: -He had been assisting the RCC with managing residents' medication orders when needed. -The facility Nurse was responsible for auditing residents' medication orders for accuracy and completeness. -Due to staffing turnover, medication orders compared to MAR entries had not been routinely audited since September 2024. _____ The facility failed to follow-up with a physician for 1 of 5 sampled residents with a diagnosis if hypertension and who had blood BP checks for routine monitoring and BP checks with parameters and BP checks were not done or the PCP notified for systolic BP readings greater than 180 placing the resident at increased risk for kidney damage and stroke (#5). The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare	D 273		

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D 273	Continued From page 9 of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/07/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 23, 2024.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for food service guidance for 1 of 4 sampled residents (#4) with physician's orders for a finger food (FF) diet. The findings are: Review of Resident #4's current FL2 dated 09/26/24 revealed: -Diagnoses included vascular dementia. -There was an order for a FF diet listed.	D 296		

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D 296	Continued From page 10 Review of Resident #4's therapeutic diet orders dated 10/23/24 revealed an order for a FF diet. Review of the diet order manual in the kitchen revealed Resident #4 was to be served a FF diet. Review of the facility's therapeutic menus revealed there was no FF menu available. Review of the facility's week-at-a-glance menu for the lunch meal on 11/06/24, for regular diets, revealed Tuscan white bean soup, BBQ chicken quarters, homemade sweet potato chips, cranberry apple coleslaw, sweet dinner roll, butter, peach crisp, 2% milk, and coffee were to be served. Observation of the Special Care Unit (SCU) lunch meal service on 11/06/24 between 12:05pm and 1:05pm revealed: -Resident #4 was served BBQ chicken wings, homemade sweet potato chips, honey graham crackers, milk, and strawberry vitamin water. -Resident #4 consumed 100% of the meal with no difficulty. -It could not be determined if Resident #4 was served the correct therapeutic diet due to a FF menu was not available for staff guidance. Review of the facility's week-at-a-glance menu for the lunch meal on 11/07/24, for regular diets, revealed broccoli cheese soup, french bread pizza, steak fries, peas with fresh dill, butter, apple pie, 2% milk, and coffee were to be served. Observation of the SCU lunch meal service on 11/07/24 between 12:25pm and 1:10pm revealed: -Resident #4 was served french bread pizza bites, large cut steak fries, peas, and 2 whole	D 296		

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sugar cookies.
-Resident #4 consumed 100% of the meal with no difficulty.
-It could not be determined if Resident #4 was served the correct therapeutic diet due to a FF menu was not available for staff guidance.

Interview with a PCA from the SCU unit on 11/07/24 at 12:30pm revealed:
-She assisted in the SCU dining room during meals.
-The PCAs used the therapeutic diet list provided by the kitchen staff to serve residents according to their meals.
-She was not aware Resident #4 was on a FF diet.
-She relied on the kitchen staff to provide the meals according to the therapeutic diet list to serve residents according to their diet orders.

Interview with a second PCA from the SCU unit on 11/07/24 at 12:40pm revealed:
-She assisted in the SCU dining room during meals.
-The PCAs used the therapeutic diet list provided by the kitchen staff to serve residents according to their meals.
-She was aware Resident #4 was on a FF diet.
-She relied on the kitchen staff to provide the meals according to the therapeutic diet list to serve residents according to their diet orders.

Interview with the Special Care Unit Coordinator (SCUC) on 11/07/24 at 1:45pm revealed:
-The Dietary Manager (DM) was responsible for ensuring that the kitchen was supposed to have therapeutic diet menus to match each therapeutic diet offered by the facility.
-She was not aware the kitchen did not have a therapeutic menu to match a FF diet.

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-She was aware Resident #4 was ordered a FF diet.
-She expected the kitchen to have a therapeutic menu to match each therapeutic diet offered at the facility.

Interview with Resident #4's primary care provider (PCP) on 11/08/24 at 10:35am revealed:
-Resident #4 had an order for a FF diet because the resident chose not to use silverware and due to his dementia.
-She expected Resident #4 to be served meals according to the therapeutic diet menu for a FF diet.

Interview with the Dietary Manager (DM) on 11/08/24 at 10:22am revealed:
-There were no therapeutic diet menus available for a FF diet.
-He did not know he needed a menu for a FF diet.
-He thought he could use the regular menus and cut the meals into small pieces.
-He used the regular menus along with referencing the diet orders manual in the kitchen to prepare Resident #4's FF diet meal.

Interview with the Resident Care Coordinator (RCC) on 11/08/24 at 1:45pm revealed:
-She did not know there were menus not available for all therapeutic diets.
-She updated diet order sheets and provided them to the dietary staff, but she did not know about menus.
-The DM was responsible for ensuring menus were available for dietary staff for guidance in food preparation for therapeutic diets.

Interview with the Administrator on 11/08/24 at 2:20pm revealed:
-He knew the facility needed therapeutic diet

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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 296	Continued From page 13 menus available for staff guidance each therapeutic diet ordered for residents in the facility. -The facility had therapeutic diet menus available, but he did not know the therapeutic menus did not include a FF diet. -The DM was responsible for ensuring a therapeutic menu was available for residents diets ordered by a physician. -He expected the facility to have a therapeutic menu to match all residents diets ordered by a physician. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable.	D 296		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure water was served at each meal for residents in the Special Care Unit (SCU) in addition to other beverages. The findings are:	D 306		

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D 306	Continued From page 14 Review of the facility's census revealed a census of 22 residents in SCU. Observation of the lunch meal service on 11/06/24 for the SCU between 12:15pm and 1:15pm revealed: -There were 20 residents present for the lunch meal service. -The beverages were served by the personal care aides (PCAs) from a beverage cart. -Beverages included lemonade, milk, tea, and water. -The PCAs poured lemonade for all the SCU residents and water was not offered to each SCU resident. -Twelve SCU residents were served water, and all the other residents were served other beverages. -Eight residents were not served water. Observation of the breakfast meal service on 11/07/24 for the SCU unit between 8:00am and 8:35am revealed: -There were 20 residents present for the lunch meal service. -The beverages were served by the PCAs from a beverage cart. -Beverages included milk, orange juice, cranberry juice coffee, and water. -The PCAs poured orange juice and cranberry juice for all the SCU residents, and no water was offered to each SCU resident. -None of the 20 residents were served water, and all the residents were served other beverages. Interview with a PCA from the SCU unit on 11/07/24 at 12:30pm revealed: -She assisted in the SCU dining room during meals. -She relied on dietary staff to provide beverages for residents at mealtimes.	D 306		

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-A few residents were served water, but the other residents were served a mixture of other beverages.
-She was aware water should have been served to all residents with each meal. (If she knew this then why was water not served?)

Interview with a second PCA from the SCU unit on 11/07/24 at 12:40pm revealed:
-She assisted in the SCU dining room during meals.
-Beverages were prepared by the dietary staff on beverage carts and then carted to the SCU for the PCAs to serve the SCU residents.
-She served the residents beverages from the beverage cart.
-A few residents were served water, but the other residents were served tea and juice.
-She did not know water should have been served to all residents with each meal.

Interview with medication aide (MA) on 11/07/24 at 1:00pm revealed:
-She assisted in the SCU unit dining room during breakfast and lunch.
-She was aware residents should have been served water with each meal.
-She was not aware the SCU residents had not been served water with each meal.

Interview with the Special Care Unit Coordinator (SCUC) on 11/07/24 at 1:45pm revealed:
-She was aware water should have been served with each meal to residents in the SCU.
-She was not aware water was not served to 8 SCU residents with the lunch meal service on 11/06/24 or with the breakfast meal service on 11/07/24 for 20 SCU residents.
-She expected water to served, and not just offered to the residents by the PCAs in the SCU

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D 306	Continued From page 16 during each meal. Interview with a dietary staff on 11/07/24 at 2:25pm revealed: -Beverages were prepared and placed on a beverage cart by the dietary staff before mealtimes. -Water was always available as a beverage for the SCU residents. -The PCAs and MAs were responsible for serving beverages to the SCU residents from the beverage cart. -She was not aware water was not served with the lunch meal service on 11/06/24 for 8 SCU residents or with the lunch meal service on 11/07/24 for 20 SCU residents. -She was not aware water should have been served to all residents with each meal. Interview with the Dietary Manager (DM) on 11/07/24 at 3:45pm revealed: -He was aware water should have been served daily to all SCU residents with each meal. -Beverages were prepared by the dietary staff on beverage trays and then carted to the SCU before every meal. -Water was always available as a beverage for the SCU residents. -He was not aware water was not served with the lunch meal service on 11/06/24 for 8 SCU residents or with the lunch meal service on 11/07/24 for 20 SCU residents. -He expected water to be served to the SCU residents during every meal according to nutritional requirements. Interview with the Resident Care Coordinator (RCC) on 11/08/24 at 1:45pm revealed: -She did not know SCU residents were not served water with each meal.	D 306		

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D 306	Continued From page 17 -She knew residents were to be served water daily with each meal. -There should be no issues for SCU residents to be served water during each meal. -She expected water to be served to the SCU residents during every meal according to nutritional requirements and regulations. Interview with the Administrator on 11/08/24 at 2:20pm revealed: -He did not know SCU residents were not served water with each meal. -He knew residents were to be served water daily with each meal. -There should be no issues for SCU residents to be served water during each meal. -He expected water to be served to the SCU residents during every meal according to nutritional requirements and regulations.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets as ordered by the provider for 1 of 4 sampled residents (#3) with therapeutic diet orders for a consistent carbohydrate controlled (CCHO) diet (#3). The findings are:	D 310		

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D 310	Continued From page 18 Review of Resident #3's current FL2 dated 05/08/24 revealed hypothyroidism, type 2 diabetes and late-onset Alzheimer's disease. Review of Resident #3's diet order form dated 05/08/24 revealed an order for a CCHO diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a CCHO diet. Review of the CCHO menu for the lunch meal service on 11/06/24 revealed Resident #3 was to be served Tuscan white bean soup, three ounces of BBQ chicken quarter, homemade sweet potato chips, and two ounces (a half-serving) of peach crisp. Observation of Resident #3's lunch meal service on 11/06/24 between 12:22pm and 1:15pm revealed: -Resident #3 was served Tuscan white bean soup, six ounces of BBQ chicken quarter, homemade sweet potato chips, and two ounces (a half-serving) of peach crisp, water, and cranberry juice. -Resident #3 ate 50% of her meal and consumed 100% of her beverages without difficulty. -Resident #3 was not supposed to have been served six ounces of BBQ chicken quarter and should have been served three ounces of BBQ chicken quarter. Review of the CCHO menu for the lunch meal service on 11/07/24 revealed Resident #3 was to be served broccoli cheese soup, a half-slice of French bread pizza, steak fries, and a half slice of apple pie.	D 310		

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D 310	Continued From page 19 Observation of Resident #3's lunch meal service on 11/07/24 between 12:16pm and 1:02pm revealed: -Resident #3 was served broccoli cheese soup, a full slice of French bread pizza, French fries, a half slice of apple pie, water, and cranberry juice. -Resident #3 ate 75% of her broccoli cheese soup, 0% of her French bread pizza, 100% of her French fries, and a half slice of apple pie. Resident #3 was not supposed to be served a full slice of French bread pizza and should have been served a half slice. Based on observations, interviews and record review, it was determined Resident #3 was not interviewable. Interview with a dietary aide on 11/07/24 at 3:25pm revealed: -The cook or Dietary Manager (DM) plated the food for the residents at meals. -The residents sat in the same seating arrangements at each meal. -She brought the residents their meals that were plated by the DM. Interview with the DM on 11/07/24 at 3:30pm revealed: -He or the cook prepared each meal for the residents. -He prepared Resident #3's meal on 11/06/24 and 11/07/24. -He served Resident #3 a full serving of BBQ chicken thigh at the lunch meal on 11/06/24 and did not know Resident #3 should have been served a half portion of BBQ chicken thigh. -He served Resident #3 a full serving a French bread pizza at the lunch meal on 11/07/24 and did not know Resident #3 should have been served a half slice of French bread pizza.	D 310		

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-He knew therapeutic menus must be used to prepare desserts for residents with special diets but was not aware therapeutic menus and diets must be served as ordered for all other menus items.
-He was responsible for preparing residents' meals according to the therapeutic menus and serving residents' diets as ordered.

Telephone interview with Resident #3's primary care provider (PCP) on 11/08/24 at 10:20am revealed:
-She ordered a CCHO diet for Resident #3 due to Resident #3's diabetes.
-She did not know Resident #3 was not served a CCHO diet according to the menu on 11/06/24 and 11/07/24.
-She last saw Resident #3 on 11/06/24.
-She expected the facility to serve diets as ordered for all residents and to let her know if a resident was refusing an ordered diet.

Interview with the Resident Care Coordinator (RCC) on 11/08/24 at 2:45pm revealed:
-Resident #3 was ordered a CCHO diet due to Resident #3's diabetes.
-Dietary staff were responsible for plating the food at meals and serving food to the residents.
-She did not know Resident #3 was not served according to her CCHO diet at the lunch mealtime on 11/06/24 and 11/07/24.
-The DM was responsible for ensuring residents' diets were served as ordered.

Interview with the Administrator on 10/30/24 at 9:45am revealed:
-He did not know Resident #3 was not served according to her CCHO diet at the lunch mealtime on 11/06/24 and 11/07/24.
-The DM was responsible to serve diets as

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D 310	Continued From page 21 ordered to the residents.	D 310		
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 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#2, #3 and #5) related to an anti-hypertensive medication scheduled and with parameters for administration (#5), a resident with orders for an iron supplement and vitamin D3 (#2), and a resident with an order for a dietary supplement (#3). The findings are: 1. Review of Resident #5's current FL2 dated 06/06/24 revealed diagnoses including hypertension, syncope and collapse, and orthostatic syncope. Review of Resident #5's electronic triage notes revealed: -On 09/27/24, a medication aide (MA) contacted the triage team related to elevated blood pressure	D 358		

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(BP) reading of 200/77.
-Recheck of Resident #5's BP was requested with a result of 222/74.
-Resident #5 was sent out to a local hospital for treatment.

Review of Resident #5's hospital discharge summary dated 09/30/24 revealed:
-Resident #5 received orders for 2 scheduled BP medications.
-Resident #5 received an order for hydralazine 25mg every 8 hours as needed for systolic BP greater than 170.

Review of Resident #5's after visit summary with the PA at an outside provider's office dated 10/07/24 revealed:
-Resident #5 saw the outside provider as a follow-up for recent hospital visit.
-Resident #5 BP reading at the visit was 173/54.
-The medications to be administered listed on the after-visit summary included hydralazine 25mg every 8 hours as needed for systolic BP greater than 170.

Review of a facility fax from the PA at an outside provider's office dated 10/09/24 revealed:
-There was a subsequent order to administer hydralazine 25mg 3 times a day.
-There was no documentation to discontinue hydralazine 25mg every 8 hours as needed.

Review of Resident #5's October 2024 medication administration record (MAR) and October 2024 BP/HR log revealed:
-There was a handwritten entry for hydralazine 25mg one tablet every 8 hours as needed for systolic BP greater than 170 sustained on the MAR.
-Systolic BP readings ranged from 126 to 197.

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-There were 4 opportunities for systolic BP readings documented were more than 170 as follows:
-On 10/14/24 at 8:00pm, Resident #5's BP reading was documented as 190/65 on the BP/HR log and no hydralazine 25mg was documented as administered on the MAR.
-On 10/21/24 at 7:00pm, Resident #5's BP reading was documented as 180/62 on the BP/HR log and no hydralazine 25mg was documented as administered on the MAR.
-On 10/26/24 at 8:00am, Resident #5's BP reading was documented as 197/61 on the BP/HR log and no hydralazine 25mg was documented as administered on the MAR.
-On 10/26/24 at 12:00pm, Resident #5's BP reading was documented as 185/66 on the BP/HR log and no hydralazine 25mg was documented as administered on the MAR.
-There were 47 opportunities for BP readings not documented from 10/01/24 to 10/31/24 when it could not be determined if Resident #5 should have received hydralazine 25mg as ordered for systolic BP greater than 170.

Review of Resident #5's November 2024 BP/HR log from 11/01/24 to 11/07/24 revealed:
-There were 21 opportunities for BP readings ordered 3 times a day from 11/01/24 to 11/07/24.
-There were 4 documented BP values.

Review of Resident #5's November 2024 MAR from 11/10/24 to 11/07/24 revealed

Review of Resident #5's November 2024 MAR from 11/01/24 to 11/07/24 compared to BP readings documented on the resident's November 2024 BP/HR log from 11/01/24 to 11/07/24 revealed:
-There was no entry for hydralazine 25mg one

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D 358	Continued From page 24 tablet every 8 hours as needed for systolic BP greater than 170 sustained. -On 11/01/24 at 5:00pm, Resident #5's BP was documented as 186/51 on the BP/HR log and no hydralazine 25mg was documented as administered on the MAR. -On 11/08/24 at 9:25am, Resident #5's BP reading was 176/77 and hydralazine 25mg was administered.. Observation of Resident #5's medications on hand for administration on 11/08/24 at 12:00pm revealed: -There were 19 tablets of hydralazine in 2 partial bingo cards from the contracted pharmacy dispensed for 90 tablets on 09/30/24 with instructions for one tablet every 8 hours as needed for systolic BP greater than 170. -There were 83 tablets of hydralazine 25mg dispensed on 10/27/24 from an outside pharmacy on 10/27/24 with instructions for one tablet (25mg) 3 times a day. Interview with a medication aide (MA) on 11/08/24 at 1:30pm revealed: -The facility had separate BP/HR log sheets used with the MAR for documenting BP readings if ordered for residents. -The former facility Nurse monitored the documentation of BP/HR logs before she left at the end of September 2024. -The Resident Care Coordinator (RCC) and Administrator had assumed duties of the facility Nurse until a new nurse was hired. -Resident #5's order for BP checks 3 times a day and hydralazine 25mg one tablet every 8 hours was listed on the MAR but in the as needed section of the MAR. -The MAs could have overlooked the order since hydralazine 25mg was ordered as needed.	D 358		

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D 358	Continued From page 25 Interview with Resident #5 on 11/08/24 at 1:50pm revealed: -The facility provided transportation to her appointments with outside providers. -The transportation staff stayed with her at her appointments and was given the paperwork provided at the outside provider visits. -She had a follow-up appointment scheduled with her family medical physician's assistant (PA) after a recent hospital visit. -She was then scheduled for an appointment 2 weeks after the first visit to her family medical physician's assistant (PA). -Sometimes a friend would take her to the pharmacy she used before moving into the facility in June 2024 for medication pick-up. -She did not know all her medications or if her BP medications had changed recently. Interview with a second MA on 11/08/24 at 2:40pm revealed: -She knew Resident #5 had an order for BP checks 3 times a day and administer hydralazine 25mg for systolic BP greater than 170. -The facility did not have working blood pressure devices on all the medication carts or floors of the building. -She borrowed a BP device from another area of the building to check Resident #5's BP when she worked. -If MAs were not documenting BP values on the BP/HR log, then most likely they were not checking the BP. -The former facility Nurse brought a manual BP device to each cart however all manual BP devices were missing parts and did not work (no specific time frame given). -The facility Nurse did not fix the BP devices before she left in September 2024.	D 358		

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D 358	Continued From page 26 Telephone interview with a nurse at Resident #5's outside provider's office on 11/08/24 at 9:05am revealed: -Resident #5 was seen at the clinic on 10/07/24. -There was no order to discontinue hydralazine 25mg as needed for systolic BP greater than 170. -There was documentation for an order for hydralazine 25mg 3 times a day scheduled was electronically sent to an outside pharmacy. Interview with Resident #5's primary care provider (PCP) on 11/08/24 at 10:10am revealed: -Resident #5 frequently had very high systolic BP readings. -Not controlling Resident #5's elevated systolic BP placed the resident at increased risk of damage to her kidneys, vessels in her eyes, and could increase risk for a stroke. Interview with the Resident Care Coordinator (RCC) on 11/08/24 at 11:30am revealed: -The RCC or the MA was responsible to process orders received by reviewing all documents, preparing a medication tracking form for any orders, and faxing orders to the contracted pharmacy. -Resident #5 had an order to check BP every 8 hours and administer hydralazine 25mg for systolic BP greater than 170. -The MAs were supposed to administer medications as ordered on the MAR. -The former facility Nurse had been responsible for auditing MARs to ensure medications were administered as ordered. -She was responsible to ensure medications and treatments were administered as ordered since the facility Nurse left in late September 2024. -She did not have a system in place to routinely audit residents MARs and ensure medications	D 358		

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were administered as ordered.
-She did not know Resident #5's hydralazine 25mg was not administered as ordered according to the parameters.

Interview with the Corporate Nurse on 11/08/24 at 11:50am revealed:
-Medication audits were conducted by a Corporate Nurse routinely every 3 months for a sample of residents but not all residents.
-The facility Nurse position was currently vacant and the RCC was responsible for ensuring that medications were administered as ordered until the position was filled.

Interview with the Administrator on 11/08/24 at 12:00pm revealed:
-He had been assisting the RCC with managing residents' medication orders when needed.
-The facility Nurse was responsible for auditing residents' medication orders for accuracy and completeness.
-Due to staffing turnover, medication orders compared to MAR entries had not been routinely audited since September 2024.

b. Review of Resident #5's after visit summary with the physician's assistant (PA) at an outside provider dated 10/07/24 revealed:
-Resident #5's blood pressure on visit was 173/54.
-Resident #2 was scheduled a follow-up appointment on 10/21/24 (2 weeks later).

Review of the facility's transportation log on 11/08/24 revealed that Resident #5 was transported to the follow-up appointment on 10/21/24.

Telephone interview with a nurse at Resident #5's

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outside provider's office on 11/08/24 at 9:05am revealed:
-Resident #5 was seen at the clinic on 10/21/24.
-Resident #5 had an order for hydralazine 50mg 3 times a day written on 10/21/24.
-There was documentation that the order for hydralazine 50mg 3 times a day was electronically sent to an outside pharmacy.
-The office routinely provided a copy of the visit's summary to the resident or resident's representative at the end of the visit.
-There was no documentation the facility had contacted the clinic since the visit on 10/21/24.

Review of Resident #5's October 2024 MAR revealed:
-There was no entry for hydralazine 50mg one tablet 3 times a day ordered on 10/21/24.
-There was no documentation for administration of hydralazine 50mg ordered 3 times a day.

Review of Resident #5's November 2024 MAR revealed:
-There was no entry for hydralazine 50mg one tablet 3 times a day ordered on 10/21/24.
-There was no documentation for administration of hydralazine 50mg ordered 3 times a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/08/24 at 10:45am revealed:
-The facility was supposed to send all medication orders to the pharmacy for tracking residents' medications.
-The pharmacy received an order dated 09/30/24 for hydralazine 25mg every 8 hours as needed for systolic BP greater than 170.
-The contracted pharmacy dispensed 90 hydralazine 25mg with instruction one tablet every 8 hours as needed for systolic BP greater than

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170 on 09/30/24.
-On 10/09/24, the contracted pharmacy received an order for hydralazine 25mg 3 times a day but did not dispense any medication because the resident's insurance denied another dispensing for refill too soon.
-There were no additional orders for hydralazine 25mg or 50mg received by the facility's contracted pharmacy

Observation of Resident #5's medications on hand for administration on 11/08/24 at 12:00pm revealed:
-There were 83 tablets of hydralazine 25mg dispensed on 10/27/24 from an outside pharmacy on 10/27/24 with instructions for one tablet (25mg) 3 times a day.
-There were 19 tablets of hydralazine in 2 partial bingo cards from the contracted pharmacy dispensed for 90 tablets on 09/30/24 with instructions for one tablet every 8 hours as needed for systolic BP greater than 170.
-There was no hydralazine 50mg on hand for administration.

Interview with the RCC on 11/08/24 at 11:30am revealed:
-The facility had a transportation staff assigned to take residents to appointments scheduled with providers outside the facility.
-The facility's transportation staff had a calendar he/she used to track transportation to scheduled appointments.
-The facility Nurse routinely reviewed all paperwork received from providers either in the facility or outside the facility.
-The facility Nurse position had been vacant since late September 2024.
-If the transportation staff transported a resident to an outside appointment any orders, visit

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summaries or paperwork issued at the visit were to be given to the transportation staff for the facility Nurse or MA on duty to review and fax to the contracted pharmacy.
-The RCC or the medication aide (MA) on duty when the transportation staff returned the resident to the facility were responsible to review all paperwork from resident's visits to outside providers.
-The RCC or the MA was responsible to process orders received by reviewing all documents, preparing a medication tracking form for any orders, and faxing orders to the contracted pharmacy.

Interview with Resident #5's facility PCP on 11/08/24 at 10:10am revealed:
-Resident #5 frequently had very high systolic BP readings.
-She had a visit with Resident #5 on 10/02/24 after the resident was sent to a local ED for elevated systolic BP.
-The facility should be providing any documents from Resident #5's hospital visits or appointments with outside providers for her review.
-She did not know Resident #5 had appointments with an outside provider on 10/08/24 and 10/21/24.
-She did not know Resident #5's hydralazine was increased to 50mg 3 times a day on 10/21/24 by a different provider.
-The facility did not always provide the current MAR for her to review when she saw the resident.
-Not controlling Resident #5's elevated systolic BP placed the resident at increased risk of damage to her kidneys, vessels in her eyes, and could increase risk for a stroke.

Interview with a MA on 11/08/24 at 11:15am revealed:

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-The MA on duty when a resident returned to the facility from an appointment with a provider outside of the facility.
-She was responsible to check with the transportation staff for any documents or orders sent back to the facility from the provider.
-If the transportation staff had not presented the information to the facility Nurse or RCC, the MA was responsible to review the documentation provided and process any medication orders by hand writing the medication or treatment on the resident's MAR, filling out a new order tracking form, faxing the information to the contracted pharmacy, and place the documentation in a designated folder for the facility Nurse or RCC to review for accuracy of the MAR and completing of the order.
-She had not seen Resident #5's paperwork or orders from an outside provider's visit on 10/21/24.

Second interview with the RCC on 11/08/24 at 11:45am revealed:
-There was no information available at the facility for Resident #5's visit to the appointment on 10/21/24.
-Currently since the facility Nurse position was vacant, the transportation staff should ensure all information regarding a resident's appointment with an outside provider was delivered to the RCC.
-If the RCC was not present in the building, the documents from the residents' outside provider visit should be delivered to the lead MA working in the area that the resident resided.
-The RCC or MA would process any orders by reviewing the order, handwriting the order on the MAR, start an order tracking form, and fax the order to the contracted pharmacy.
-Orders entered by MAs were placed in a

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dedicated holder for the facility Nurse or the RCC to review for completeness and accuracy of MAR entry.
-When the contracted pharmacy received the medication orders, the residents' MARs were corrected and the next month's MAR should reflect changes made throughout each month to replace handwritten MAR entries.
-The facility should notify the contracted pharmacy for any MAR corrections needed.
-The facility Nurse was responsible for auditing residents' physician's orders compared to the MARs to ensure medications were administered as ordered.
-The former facility Nurse left at the end of September 2024 and the position was currently vacant.
-There currently was no system in place to routinely audit for medications administered as ordered.

Interview with the Corporate Nurse on 11/08/24 at 11:50am revealed:
-Medication audits were conducted by a Corporate Nurse routinely every 3 months for a sample of residents but not all residents.
-The facility Nurse position was currently vacant and the RCC was responsible for ensuring that medications were administered as ordered until the position was filled.

Interview with the Administrator on 11/08/24 at 12:00pm revealed:
-He was had been assisting the RCC with managing residents' medication orders when needed.
-The facility Nurse was responsible for auditing residents' medication orders for accuracy and completeness.
-Due to staffing turnover, medication orders

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compared to MAR entries had not been routinely audited since September 2024.

Interview with Resident #5 on 11/08/24 at 1:50pm revealed:
-The facility provided transportation to her appointments with outside providers.
-The transportation staff stayed with her at her appointments and was given the paperwork provided at the outside provider visits.
-She had a follow-up appointment scheduled with her family medical physician's assistant (PA) after a recent hospital visit.
-She was then scheduled for an appointment 2 weeks after the first visit to her family medical physician's assistant (PA).
-Sometimes a friend would take her to the pharmacy she used before moving into the facility in June 2024 for medication pick-up.
-She did not know all her medications or if her blood pressure medications had changed recently.

2. Review of Resident #2's FL2 dated 03/01/24 revealed diagnoses included mild anemia.

Review of Resident #2's signed physician order dated 04/12/24 revealed an order to self-administer her medications.

a. Review of Resident #2's signed physician order dated 05/02/24 revealed there was an order for ferrous sulfate (an iron supplement used to treat anemia) 325mg tablet take one tablet daily.

Review of Resident #2's September 2024 medication administration record (MAR) revealed:
-There was an entry for ferrous sulfate 325mg take one tablet daily.
-There was no documentation from 09/01/24 to

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D 358	Continued From page 34 09/30/24 that ferrous sulfate was administered. Review of Resident #2's October 2024 MAR revealed: -There was an entry for ferrous sulfate 325mg take one tablet daily. -There was no documentation from 10/01/24 to 10/31/24 that ferrous sulfate was administered. Review of Resident #2's November 2024 MAR revealed: -There was an entry for ferrous sulfate 325mg take one tablet daily. -There was no documentation from 11/01/24 to 11/06/24 that ferrous sulfate was administered. Observation of Resident #2's medications on hand on 11/08/24 at 9:00am revealed: -Resident #2 stored her medications in a lockbox in her room. -There was no ferrous sulfate available for administration in Resident #2's medication lockbox or on the medication cart. Telephone interview with the facility's contracted pharmacy on 11/08/24 at 9:41am revealed: -There was a current order on file for Resident #2 for ferrous sulfate 325mg take one tablet daily. -Ferrous sulfate was currently in process to be dispensed. -The most recent dispense date for Resident #2's ferrous sulfate was on 08/27/24 for a quantity of 30 tablets which was a one-month supply. Telephone interview with Resident #2's primary care provider (PCP) on 11/08/24 at 10:20am revealed: -She did not know Resident #2 was not administered her ferrous sulfate for about five weeks.	D 358		

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-She was concerned about Resident #2 not being administered her ferrous sulfate because of Resident #2's mild anemia diagnosis.
-Potential side effects or outcomes of Resident #2 not being administered ferrous sulfate were fatigue, headaches and weakness.

Interview with Resident #2 on 11/08/24 at 9:02am revealed:
-She self-administered most of her medications.
-Before she ran out of ferrous sulfate, staff brought a medication card with a month's supply of ferrous sulfate from the medication cart.
-She told two or three different staff she had run out of ferrous sulfate and staff told her they would order more ferrous sulfate from the pharmacy.
-She had been taking ferrous sulfate since May 2024.
-She had been out of ferrous sulfate for four or five weeks.

Second interview with Resident #2 on 11/08/24 at 11:12am revealed she had not experienced any weakness, fatigue or headaches since she had run out of ferrous sulfate.

Interview with a medication aide (MA) on 11/08/24 at 11:00am revealed:
-She did not know Resident #2 was out of ferrous sulfate until 11/07/24.
-If a resident ran out of medication, MAs were supposed to call the pharmacy and find out if the pharmacy received a refill order.
-The MAs were supposed to reorder medication that was running low when there were five doses remaining.

Interview with the Resident Care Coordinator (RCC) on 11/08/24 at 1:45pm revealed:
-She and the Administrator noticed Resident #2

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was out of ferrous sulfate on 10/23/24 when the Administrator completed Resident #2's updated self-medication management evaluation.
-She thought Resident #2's ferrous sulfate was reordered on 10/23/24 and the medication was available to be administered until a MA told her the ferrous sulfate was not available on the morning of 11/08/24.
-Resident medications should be reordered five to seven days before a medication ran out.
-Staff ordered Resident #2's medications from the pharmacy and gave Resident #2 her medications to store in her lockbox in Resident #2's room.
-She expected MAs to ask Resident #2 weekly if the resident was low on medication or needed more medication.

Interview with the Administrator on 11/08/24 at 2:25pm revealed:
-He completed Resident #2's updated self-medication management evaluation on 10/23/24.
-Resident #2 told him she was out of ferrous sulfate on 10/23/24 and Resident #2 also told him Resident #2 had let the MA know she was out of ferrous sulfate.
-He let the RCC know Resident #2 was out of ferrous sulfate on 10/23/24 and the RCC had called the pharmacy on 10/23/24.
-He did not know Resident #2 was out of and was not administered ferrous sulfate for five weeks.
-The MAs and the RCC were responsible to order medications before they ran out.

b. Review of Resident #2's signed physician order dated 05/02/24 revealed there was an order for vitamin D3 (a supplement used to treat vitamin D deficiency) 50 mcg (2000 units) capsule take one capsule daily.

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Review of Resident #2's September 2024 medication administration record (MAR) revealed:
-There was an entry for vitamin D3 50mcg capsule take one capsule daily.
-There was no documentation from 09/01/24 to 09/30/24 that Vitamin D3 was administered.

Review of Resident #2's October 2024 MAR revealed:
-There was an entry for vitamin D3 50mcg capsule take one capsule daily.
-There was no documentation from 10/01/24 to 10/31/24 that Vitamin D3 was administered.

Review of Resident #2's November 2024 MAR revealed:
-There was an entry for vitamin D3 50mcg capsule take one capsule daily.
-There was no documentation from 11/01/24 to 11/06/24 that Vitamin D3 was administered.

Observation of Resident #2's medications on hand on 11/08/24 at 9:00am revealed:
-Resident #2 stored her medications in a lockbox in her room.
-There was no vitamin D3 available for administration in Resident #2's medication lockbox or on the medication cart.

Telephone interview with the facility's contracted pharmacy on 11/08/24 at 9:41am revealed:
-There was a current order on file for Resident #2 for vitamin D3 50mcg take one capsule daily.
-Vitamin D3 was currently in the process to be dispensed.
-The most recent dispense date for Resident #2's vitamin D3 was 08/27/24 for a quantity of 30 capsules which was a one-month supply.

Telephone interview with Resident #2's primary

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care provider (PCP) on 11/08/24 at 10:20am revealed:
-She did not know Resident #2 was not administered her vitamin D3 for about five weeks.
-She would not anticipate any side effects or outcomes for Resident #2 not being administered her vitamin D3.
-She expected staff to ensure Resident #2 had her medication available to administer.

Interview with a medication aide (MA) on 11/08/24 at 11:00am revealed:
-She did not know Resident #2 was out of vitamin D3 until 11/07/24.
-If a resident ran out of medication, MAs were supposed to call the pharmacy and find out if the pharmacy received a refill order.
-MAs were supposed to reorder medication that was running low when there were five doses remaining.

Interview with the RCC on 11/08/24 at 1:45pm revealed:
-She and the Administrator noticed Resident #2 was out of vitamin D3 on 10/23/24 when the Administrator completed Resident #2's updated self-medication management evaluation.
-She thought Resident #2's vitamin D3 was reordered on 10/23/24 and the medication was available to be administered until a MA told her the vitamin D3 was not available on the morning of 11/08/24.
-She expected MAs to ask Resident #2 weekly if Resident #2 was low on medication or needed more medication.

Interview with the Administrator on 11/08/24 at 2:25pm revealed:
-Resident #2 told him she was out of vitamin D3 on 10/23/24 and Resident #2 also told him that

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST HEIGHTS SENIOR LIVING COMMUNITY	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 39	D 358		

she had let the MA know she was out of vitamin D3.
-He had let the RCC know Resident #2 was out of vitamin D3 on 10/23/24 and the RCC had called the pharmacy on 10/23/24.
-He did not know Resident #2 was out of and was not administered vitamin D3 for five weeks.
-The MAs and the RCC were responsible to ensure Resident #2's medications were available to be self-administered.

3. Review of Resident #3's FL2 dated 05/08/24 revealed:
-Diagnoses included hypothyroidism and late onset Alzheimer's disease.
-There was an order for metamucil (a supplement used to prevent constipation) 0.4gm take one capsule daily.

Review of Resident #3's signed physician's order dated 08/08/24 revealed there was a discontinue order for metamucil 0.4gm.

Review of Resident #3's September 2024 medication administration record (MAR) revealed:
-There was an entry for metamucil 0.4gm take one capsule daily scheduled for administration at 8:00am.
-There was documentation metamucil 0.4gm was administered from 09/01/24 to 09/30/24 after it was discontinued on 08/08/24.

Review of Resident #3's October 2024 MAR revealed:
-There was an entry for metamucil 0.4gm take one capsule daily scheduled for administration at 8:00am.
-There was documentation metamucil 0.4gm was administered from 10/01/24 to 10/31/24 after it was discontinued on 08/08/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HEIGHTS SENIOR LIVING COMMUNITY	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 358	Continued From page 40 Review of Resident #3's November 2024 MAR revealed: -There was an entry for metamucil 0.4gm take one capsule daily scheduled for administration at 8:00am. -There was documentation metamucil 0.4gm was administered from 11/01/24 to 11/06/24 after it was discontinued on 08/08/24. Observation of Resident #3's medications on hand on 11/07/24 at 2:15pm revealed there were 22 of 30 metamucil capsules available for administration on the medication cart with a dispensed date of 10/16/24. Telephone interview with the facility's contracted pharmacy on 11/08/24 at 9:41am revealed: -There was a current order on file for Resident #3 for metamucil 0.4gm capsule daily. -The most recent dispense dates for Resident #3's metamucil were 10/16/24 for a quantity of 30 capsules, 09/16/24 for a quantity of 30 capsules and 08/17/24 for a quantity of 30 capsules which was each a one-month supply. Telephone interview with Resident #3's primary care provider (PCP) on 11/08/24 at 10:20am revealed: -She did not know Resident #3 was administered metamucil from 09/01/24 to 11/06/24 after it was discontinued on 08/08/24. -She would not anticipate any side effects of Resident #3 being administered metamucil after it was discontinued. -She expected staff to administer medications as ordered. Based on observations, interviews and record review, it was determined Resident #3 was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034087	A. BUILDING: _____ B. WING _____	11/08/2024

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D 358	Continued From page 41 interviewable. Interview with a medication aide (MA) on 11/08/24 at 11:00am revealed: -She thought Resident #3's metamucil was still an active order and did not know it was discontinued in August 2024. -The pharmacy printed MARs. -MAs checked new MARs for resident order accuracy and the Resident Care Coordinator (RCC) checked the MARs a second time. Interview with the RCC on 11/08/24 at 1:45pm revealed: -She did not know Resident #3 was administered metamucil after it was discontinued from 09/01/24 to 11/06/24. -MAs initially looked at orders when they were written. -There should have been a follow-up completed to determine Resident #3's metamucil was discontinued. -She was currently responsible for following up on new orders and discontinue orders for residents. Interview with the Administrator on 11/08/24 at 2:25pm revealed: -He did not know Resident #3 was administered metamucil after it was discontinued from 09/01/24 to 11/06/24. -The MAs and the RCC were responsible to administer medications as ordered. _____ The facility failed to administer medications as ordered for 3 of 5 residents (#2, #3, #5) related to not administering a blood pressure (BP) medication for elevated systolic BP placing the resident at increased risk for kidney damage and stroke (#5) and a resident was not administered an iron supplement for five weeks placing her at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 42 risk for weakness, headaches, and fatigue (#2). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 23, 2024.	D 358		