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 _____	R 02/26/2025

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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 02/25/25 to 02/26/25.	{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: The Type B Violation was abated. Deficient practice continues. Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents (#3) related to an order for a physical therapy (PT)/occupational therapy (OT) evaluation and treatment. The findings are: Review of Resident #3's current FL2 dated 09/24/24 revealed: -Diagnoses included Alzheimer's disease with early onset, essential hypertension, major depression, glaucoma, and anxiety disorder. -The resident required assistance with bathing and toileting. -The resident was semi-ambulatory and used a walker. -The resident was documented as being constantly disoriented. Review of Resident #3's current assessment and care plan dated 12/17/24 revealed:	{D 273}		

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{D 273}	Continued From page 1	{D 273}		

-The resident was semi-ambulatory and used a wheelchair.
-The resident was disoriented.
-The resident required extensive assistance by staff with bathing, dressing, and grooming.
-The resident required supervision by staff with eating.
-The resident required limited assistance by staff with toileting, ambulation, and transferring.

Review of Resident #3's accident / incident (A/I) report dated 01/06/25 at 11:25am revealed:
-The resident had an unwitnessed fall with injury while trying to make it to her restroom with a skin tear on his head.
-The resident exhibited a small skin tear injury on her lower right arm related to this fall.
-The resident complained of her head hurting related to this fall.
-The resident's guardian requested for Resident #3 not be sent to the emergency room (ER) after the emergency medical services (EMS) evaluated her.
-The resident was to follow-up with her primary care provider (PCP).
-The resident was to be monitored for 72 hours for any change in condition and as a fall precaution intervention.

Review of Resident #3's A/I report dated 01/14/25 at 7:15am revealed:
-The resident had an unwitnessed fall when she attempted to ambulate without assistance in the common area of the special care unit (SCU).
-The resident exhibited a skin tear injury on the right side of her head related to this fall.
-The resident was transported by EMS to the hospital ER.
-The resident was admitted to the local hospital on 01/14/25.

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{D 273}	Continued From page 2 Review of Resident #3's hospital discharge summary dated 01/16/25 revealed Physical therapy (PT)/occupational therapy (OT) services were ordered to evaluate and treat Resident #3's repeated falls and poor vision. Review of Resident #3's A/I report dated 01/20/25 at 6:15am revealed: -The resident had an unwitnessed fall without injury while sitting in the common area of the SCU. -The resident did not exhibit or complain of pain and/or injury related to this fall. -The resident was not sent to the ER. -The resident was to follow-up with her PCP. Review of Resident #3's A/I report dated 01/23/25 at 4:00am revealed: -The resident had an unwitnessed fall without injury while trying to make it to her restroom. -The resident did not exhibit or complain of pain and/or injury related to this fall. -The resident was not sent to the emergency ER. -The resident was to follow-up with her PCP. Review of Resident #3's provider visit notes and progress notes dated January 2025 - February 2025 revealed no documentation of the resident being seen for PT/OT therapy. Observation of Resident #3 on 02/26/25 at 7:55am revealed she used a wheelchair and required staff assistance for ambulation into the dining room. Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable.	{D 273}		

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{D 273}	Continued From page 3 Telephone interview with Resident #3's guardian on 02/26/25 at 12:30pm revealed: -He was aware of Resident #3's falls within the month of January and Resident #3's 01/14/25 hospital visit related to a fall. -He was not aware of an order for home health therapy from the 01/16/25 local hospital discharge instructions. -He was not aware of any recent assistance from a physical or occupational therapist for Resident #3 recently but Resident #3 had received home health therapy previously in December 2024. Interview with a personal care aide (PCA) on 02/26/25 at 12:40pm revealed she was not aware if Resident #3 had received any PT/OT therapy recently. Interview with a medication aide (MA) on 02/26/25 at 12:55pm revealed: -She was aware of Resident #3's increased falls within January 2025. -She was not aware of any updates or any additional interventions recently for PT/OT therapy for Resident #3. -The Resident Care Coordinator (RCC) and Administrator were responsible for reviewing any orders related to residents' hospital discharge summaries. Interview with Resident #3's PCP on 02/26/25 at 1:35pm revealed: -She was the PCP for Resident #3 who resided in the SCU. -She was aware of Resident #3's increased falls from January 2025 and had suggested increased monitoring to the staff. -She was not aware of a referral for Resident #3's PT/OT home health therapy services from 01/16/25 and the facility staff had not	{D 273}		

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{D 273}	Continued From page 4	{D 273}		

communicated to her about the hospital discharge summary instructions.
-She expected the facility to communicate with her related to PT/OT home health therapy services for Resident #3 on 01/16/25.

Interview with the RCC on 02/26/25 at 3:45pm revealed:
-She was aware Resident #3's increased falls.
-She and the Health and Wellness Director (HWD) were responsible for reviewing residents' hospital discharge visit summary recommendations and ensuring follow-up for referrals to home health agencies.
-The HWD no longer worked at the facility with leaving in early February 2025.
-She and the Administrator assumed the HWD duties when the HWD left until a replacement was hired.
-She and the Administrator were responsible for reviewing residents' hospital discharge visit summary recommendations and for ensuring referrals for home health therapy services including PT/OT were scheduled for residents.
-MAs, the RCC, and the Administrator are expected to follow the facility's order-tracking-form process to complete hospital discharge summary recommendations for a PT/OT referral in a timely manner.
-She was not aware of the PT/OT referral from the 01/16/25 hospital discharge summary instructions for Resident #3 until today on 02/26/25 due to the notes being in the former HWD's office.

Interview with the Administrator on 02/26/25 at 4:15pm revealed:
-He was aware of Resident #3's increased falls in January 2025.
-The RCC and the HWD were responsible for

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{D 273}	Continued From page 5 reviewing residents' hospital discharge visit summary recommendations and ensuring follow-up for PT/OT referrals to home health agencies. -The HWD no longer worked at the facility with leaving in early February 2025. -He and the RCC assumed the HWD duties when the HWD left until a replacement was hired. -He and the RCC were responsible were responsible for reviewing residents' hospital discharge visit summary recommendations and ensuring follow-up for PT/OT referrals to home health agencies. -He expected the staff and the RCC to follow the facility's order-tracking-form process to complete hospital discharge summary recommendations for a PT/OT referral in a timely manner. -He was not aware of the referral for PT/OT from the 01/16/25 hospital discharge summary recommendations for Resident #3 until today on 02/26/25 due to the notes being in a folder within the former HWD's office.	{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, interviews, and records reviews, the facility failed to ensure implementation of physician's orders for 1 of 5	D 276		

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sampled residents (#1) who had an order for an antibiotic and an order for a topical steroid cream (#1) that were never started.

The findings are:

Review of Resident #1's record revealed a current FL-2 dated 01/18/25 revealed diagnoses included unspecified encephalopathy, phimosis, benign prostatic hyperplasia with lower urinary tract symptoms, other retention of urine, chronic kidney disease, and unspecified heart failure.

Review of Resident #1's resident register revealed he was admitted to the facility on 01/31/25.

a. Review of Resident #1's physician's order dated 01/29/25 revealed an order to administer Bactrim (a medication used to treat bacterial infection) 800-160mg once daily every 12 hours for bacterial infection for 7 days.

Review of Resident #1's January electronic medication administration record (eMAR) from 01/31/25 and February 2025 eMAR from 02/01/25 through 02/24/25 revealed there were no entries for Bactrim 800-160mg daily.

Review of Resident #1's provider visit notes and progress notes dated January 2025 - February 2025 revealed there were no entries for Resident #1's Bactrim 800-160mg daily.

Observation of Resident #1's medications on hand on 02/26/25 at 12:30pm revealed there was no Bactrim available for administration.

Interview with Resident #1 on 02/26/25 at 12:45pm revealed he did not know if he was

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prescribed an antibiotic or not when he was admitted to the facility.

Telephone interview with a representative from the facility's contracted pharmacy on 02/26/25 at 11:05am revealed the pharmacy did not have a current or previous order for Bactrim for Resident #1.

Interview with a medication aide (MA) on 02/26/25 at 12:40pm revealed:
-She was not aware any new or previous medications for Resident #1 other than those entered on Resident #1's current eMAR.
-The Resident Care Coordinator (RCC) and Administrator were responsible for reviewing physicians' orders and for recording the entries into the eMAR.

Interview with Resident #1's primary care provider (PCP) on 02/26/25 at 1:35pm revealed:
-She was the PCP for Resident #1 only for the first initial visit on 02/05/25 after his admission to the facility.
-She referred Resident #1 to hospice care for his primary care needs on 02/05/25.
-She was not aware of Resident #1's physicians' orders from 01/29/25 for Bactrim.
-She expected the facility to communicate with her related to Resident #1's previous physicians' orders to start his medications in a timely manner upon admission to the facility.

Telephone interview with Resident #1's hospice nurse on 02/26/25 at 4:00pm revealed:
-Resident #1 was admitted as a hospice patient on 02/07/25.
-She was not aware of Resident #1's physicians' orders from 01/29/25 for Bactrim.
-She expected the facility to communicate with

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her related to Resident #1's previous physicians' orders to start his medications in a timely manner.

Refer to interview with the RCC on 02/26/25 at 3:45pm.

Refer to interview with the Administrator on 02/26/25 at 4:15pm.

b. Review of Resident #1's physician's order dated 01/29/25 revealed an order to apply hydrocortisone cream (a medication used to treat bacterial infection) 1% to a penile lesion every day and at evening shift for 1 week.

Review of Resident #1's January eMAR from 01/31/25 and February 2025 eMAR from 02/01/25 through 02/24/25 revealed there were no entries for hydrocortisone cream 1% every day and evening.

Review of Resident #1's provider visit notes and progress notes dated January 2025 - February 2025 revealed there were no entries for Resident #1's hydrocortisone cream 1% every day and evening.

Observation of Resident #1's medications on hand on 02/26/25 at 12:30pm revealed there was no hydrocortisone cream available for administration.

Interview with Resident #1 on 02/26/25 at 12:45pm revealed he did not know if he was prescribed a cream or not when he was admitted to the facility.

Telephone interview with a representative from the facility's contracted pharmacy on 02/26/25 at

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D 276	Continued From page 9 11:05am revealed the pharmacy did not have a current or previous order for hydrocortisone cream for Resident #1. Interview with a MA on 02/26/25 at 12:40pm revealed: -She was not aware of any new or previous medications for Resident #1 other than those entered on Resident #1's current eMAR. -The Resident Care Coordinator (RCC) and Administrator were responsible for reviewing physicians' orders and for recording the entries into the eMAR. Interview with Resident #1's PCP on 02/26/25 at 1:35pm revealed: -She was the PCP for Resident #1 only for the first initial visit on 02/05/25 after his admission to the facility. -She referred Resident #1 to hospice care for his primary care needs on 02/05/25. -She was not aware of Resident #1's physicians' orders from 01/29/25 for hydrocortisone cream. -She expected the facility to communicate with her related to Resident #1's previous physicians' orders to start his medications in a timely manner upon admission to the facility. Telephone interview with Resident #1's hospice nurse on 02/26/25 at 4:00pm revealed: -Resident #1 was admitted as a hospice patient on 02/07/25. -She was not aware of Resident #1's physicians' orders from 01/29/25 for hydrocortisone cream. -She expected the facility to communicate with her related to Resident #1's previous physicians' orders to start his medications in a timely manner. Refer to interview with the RCC on 02/26/25 at	D 276		

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D 276	Continued From page 10 3:45pm. Refer to interview with the Administrator on 02/26/25 at 4:15pm. _____ ____ Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 3:45pm revealed: -She and the former Health and Wellness Director (HWD) were responsible for reviewing residents' FL2's and physicians' orders upon admission to the facility. -The HWD no longer worked at the facility with leaving in early February 2025. -She and the Administrator assumed the HWD duties when the HWD left until a replacement was hired. -She and the Administrator were responsible for reviewing FL2's and physicians' orders upon admission to the facility since the former HWD had left. -MAs, the RCC, and the Administrator are expected to follow the facility's order-tracking-form process to start physicians' orders in a timely manner. -She was not aware of the physicians' orders from 01/29/25 for Resident #1's Bactrim and hydrocortisone cream due to only reviewing Resident #1's FL2. Interview with the Administrator on 02/26/25 at 4:15pm revealed: -The RCC and the former HWD were responsible for reviewing residents' FL2's and physicians' orders upon admission to the facility. -The HWD no longer worked at the facility with leaving in early February 2025. -He and the RCC assumed the HWD duties when the HWD left until a replacement was hired. -He and the RCC were responsible were	D 276		

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D 276	Continued From page 11 responsible for reviewing FL2's and physicians' orders upon admission to the facility since the former HWD had left. -He expected the staff and the RCC to follow the facility's order-tracking-form process to start physicians' orders in a timely manner -He was not aware of the physicians' orders from 01/29/25 for Resident #1's Bactrim and hydrocortisone cream. .	D 276		
{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: Deficient practice continues. Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets as ordered by the provider for 1 of 3 sampled special care unit (SCU) residents (#6) with therapeutic diet orders for a finger food (FF) diet. The findings are: Review of Resident #6's current FL2 dated 05/08/24 revealed diagnoses including mild cognitive impairment, unspecified osteoarthritis, and dementia. Review of Resident #6's diet order form dated	{D 310}		

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{D 310}	Continued From page 12 05/08/24 revealed an order for a FF diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #6 was to be served a FF diet. Review of the FF menu for the lunch meal service on 02/25/25 revealed Resident #6 was to be served potato bacon soup, four ounces of finger bite chicken meatballs, finger bite zucchini tempura, sweet potato bites, and strawberries. Observation of Resident #6's lunch meal service on 02/25/25 between 12:00pm and 1:00pm revealed: -Resident #6 was served potato bacon soup, a finger bite chicken sandwich, finger bite zucchini tempura, French fries, and a half cup of strawberry parfait. -Resident #6 ate 65% of her meal and consumed 100% of her beverages without difficulty. -Resident #6 was not supposed to have been served a half cup of strawberry parfait and should have been served strawberries. Review of the FF menu for the breakfast meal service on 02/26/25 revealed Resident #6 was to be served a waffle, syrup, egg bites, and ham bites. Observation of Resident #6's breakfast meal service on 02/26/25 between 8:00am and 8:30am revealed: -Resident #6 was served waffle bites, syrup, egg bites, a two slices of ham. -Resident #6 ate 75% of her meal and consumed 100% of her beverages without difficulty. -Resident #6 was not supposed to have been served two slices of ham and should have been served ham bites.	{D 310}		

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{D 310}	Continued From page 13 Based on observations, interviews and record review, it was determined Resident #6 was not interviewable. Interview with Resident #6's primary care provider (PCP) on 02/26/25 at 1:35pm revealed: -She ordered a FF diet for Resident #6 due to Resident #6's dementia and osteoarthritis. -She did not know Resident #6 was not served a FF diet according to the menu on 02/25/25 and 02/26/25. -She expected the facility to serve diets as ordered for all residents. Interview with a personal care aide (PCA) from the SCU unit on 02/26/25 at 8:30am revealed: -She assisted in the SCU dining room during meals. -She was aware Resident #6 was on a FF diet. -She was aware Resident #6 was served strawberry parfait at the lunch meal on 02/25/25 and was served ham slices at the breakfast meal on 02/26/25. -She was not aware Resident # 6 should have been served strawberries at the lunch meal on 02/25/25 and should have been served ham bites at the breakfast meal on 02/26/25. -She relied on dietary staff to provide meals for residents at mealtimes. Interview with a second PCA from the SCU unit on 02/26/25 at 8:40am revealed: -She assisted in the SCU dining room during meals. -She was aware Resident #6 was on a FF diet. -She was not aware Resident #6 was served strawberry parfait at the lunch meal on 02/25/25 because she had not worked that day. -She was aware Resident #6 was served ham	{D 310}		

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	HAL034087	A. BUILDING: _____ B. WING _____	R 02/26/2025

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 310}	Continued From page 14	{D 310}		

slices at the breakfast meal on 02/26/25 but she was not aware Resident #6 should have been served ham bites.
-She relied on dietary staff to provide meals for residents at mealtimes.

Interview with medication aide (MA) on 02/26/25 at 8:50am revealed:
-She assisted in the SCU unit dining room during breakfast and lunch.
-She was aware Resident #6 was on a FF diet.
-She was aware Resident #6 was served strawberry parfait at the lunch meal on 02/25/25 and was served ham slices at the breakfast meal on 02/26/25.
-She was not aware Resident # 6 should have been served strawberries at the lunch meal on 02/25/25 and should have been served ham bites at the breakfast meal on 02/26/25.
-She relied on dietary staff to provide meals for residents at mealtimes.

Interview with a dietary aide on 02/26/25 at 9:15am revealed:
-The cook or Dietary Manager (DM) plated the food for the residents at meals.
-She brought the meals that were plated by the cook or the DM to the SCU for the PCA's to serve to the SCU residents for every meal.

Interview with a cook on 02/26/25 at 9:20am revealed:
-She or the DM prepared each meal for the residents.
-She was aware Resident #6 was on a FF diet.
-She prepared Resident #6's lunch meal on 02/25/25 and breakfast meal on 02/26/25.
-She prepared Resident #6 a strawberry parfait at the lunch meal on 02/25/25.
-She knew Resident #6 should have been served

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{D 310}	Continued From page 15	{D 310}		

strawberries but was rushed in preparing food and had not paid attention.
-She prepared Resident #6 ham slices at the breakfast meal on 02/26/25.
-She knew Resident #6 should have been prepared ham bites but was rushed and did not pay attention.
-She and the DM were responsible for preparing residents' meals according to the therapeutic menus and serving residents' diets as ordered.

Interview with the DM on 02/26/25 at 3:15pm revealed:
-He or the cook prepared each meal for the residents.
-He was aware Resident #6 was on a FF diet.
-The cook prepared Resident #6's lunch meal on 02/25/25 and the breakfast meal on 02/26/25..
-He was not aware Resident #6 was served strawberry parfait at the lunch meal on 02/25/25 and was served ham slices at the breakfast meal on 02/26/25.
-He and the cook were responsible for preparing residents' meals according to the therapeutic menus and serving residents' diets as ordered.
-He expected meals to be served according to the residents' diets as ordered.

Interview with the Special Care Unit Coordinator (SCUC) on 02/26/25 at 9:05am revealed:
-Resident #6 was ordered a FF diet due to Resident #6's dementia and osteoarthritis.
-Dietary staff were responsible for plating the food at meals and serving food to the residents.
-She did not know Resident #6 was not served according to her FF diet at the lunch mealtime on 02/25/25 and at the breakfast mealtime on 02/26/25.
-The DM and the cook were responsible for ensuring residents' diets were served as ordered.

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{D 310}	Continued From page 16 -She expected meals to be served according to the residents' diets as ordered. Interview with the Administrator on 02/26/25 at 9:35am revealed: -He did not know Resident #6 was not served according to her FF diet at the lunch mealtime on 02/25/25 and at the breakfast mealtime on 02/26/25. -The DM and the cook were responsible to serve diets as ordered to the residents. -He expected meals to be served according to the residents' diets as ordered.	{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: FOLLOW UP TO THE TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to an anti-anxiety	{D 358}		

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{D 358}	Continued From page 17 medication. The findings are: Review of Resident #5's current FL2 dated 05/21/24 revealed: -Diagnoses including major depressive disorder and obstructive sleep apnea. -There was an order for clonazepam (medication to treat anxiety) 0.5mg every 24 hours Review of Resident #5's signed physicians order sheet dated 01/06/25 revealed there was an order for clonazepam 0.5mg take 1 two times a day. Review of Resident #5's February 2025 electronic medication administration record (eMAR) 02/01/25-02/25/25 revealed: -There was an entry for clonazepam 0.5mg take 1 two times a day scheduled at 9:00am and 9:pm. -There were 6 opportunities clonazepam was documented as "other, see progress note": 02/18/25 and 02/19/25 and 02/20/25 and 02/21/25 at 9:00am and 9:00pm. Review of Resident #5's control substance count sheets from 02/02/25 to 02/25/25 revealed there were no clonazepam 0.5mg signed out from 02/17/25 at 9:00am to 02/21/25 at 9:00pm for a total of 10 missed doses. Review of Resident #5's electronic progress notes from 02/01/25 to 02/25/25 revealed clonazepam 0.5mg was not administered due to needing a new order on 02/28/25 at 9:00pm, 02/29/25 at 9:00pm, 02/20/25 at 9:00am, 02/20/25 at 9:00pm, 02/21/25 at 9:00am and 02/21/25 at 9:00pm.	{D 358}		

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{D 358}	Continued From page 18 Observation of Resident #5's medications on hand for administration on 02/25/25 at 3:45pm revealed: -There were 53 clonazepam remaining in 2 bubble cards of 30 (23 in first card and 30 in second card), each from the contracted pharmacy dispensed for 60 tablets on 02/21/25 with instructions for one tablet twice a day for anxiety. Interview with Resident #5 on 02/25/25 at 3:40pm revealed: -She took clonazepam to help her sleep and for anxiety. -The facility staff waited too long to reorder her clonazepam and she ran out last week for 4 days or so. -She had difficulty sleeping for the past 4 days and believed it was because she didn't have her clonazepam those days previous. -She had it for 3 days now and did not have any increased anxiety or panic attacks. Interview with a medication aide (MA) on 02/25/25 at 3:45pm revealed: -Resident #5 had run out of clonazepam last week. -The Resident Care Coordinator (RCC) obtained new orders for controlled substances. -She did not inform the RCC or Administrator because she worked from 3:00pm to 11:00pm and clonazepam was due at 9:00pm when they are not in the facility. -There was a note from the prior shift that she needed a new order so she thought it was taken care of. -Resident #5 had not complained of anxiety or panic attacks within the last week. Interview with a second MA on 02/25/25 at	{D 358}		

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{D 358}	Continued From page 19 8:10am revealed: -Resident #5 had run out of clonazepam last week, around 02/19/25. -The RCC contacted providers for new orders and she was not sure which provider ordered Resident #5's clonazepam. -When she returned to work the clonazepam was in the medication cart. -Resident #5 had not complained of anxiety or panic attacks in the past 2 weeks. Telephone interview with Resident #5's psychiatric provider on 02/26/25 at 9:55am revealed: -Resident #5 was ordered clonazepam 0.5mg 2 times a day for panic disorder. -There was no request from the facility for a new order until 02/21/25 directly to him or via triage on-call providers. -Resident #5 could have increased anxiety, panic attacks or withdrawal if she was not administered clonazepam for a long period of time. -He received no report of anxiety or panic attacks and he saw her 02/24/25 in person and her only report was trouble sleeping, which is normal for her. -He expected the facility to contact him for a new clonazepam order before residents run out of medication and to administer medications as ordered. Interview with the Resident Care Coordinator (RCC) on 02/26/25 at 3:50pm revealed: -The RCC or the Administrator were now responsible for obtaining new orders for controlled substances from resident's providers. -The previous Health and Wellness Director (HWD) was responsible for auditing medication carts and eMAR orders but he was no longer employed after 02/10/25.	{D 358}		

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{D 358}	Continued From page 20 -She was on vacation from 02/17/25 to 02/21/25 and so did not audit medications on the cart. -In her absence, she expected MAs to send an electronic request to providers for a new order or to notify the Administrator before medications run out. -She expected MAs to administer medications as ordered. Interview with the Administrator on 02/26/25 at 4:15pm revealed: -He and the RCC were now responsible for obtaining new orders for controlled substances from resident's providers. -The previous Health and Wellness Director (HWD) was responsible for auditing medication carts and eMAR orders until 02/10/25. -He did not audit medications of the cart the week of 02/17/25 to 02/21/25. -A MA asked him how to obtain a new order 02/17/25-02/21/25, but he could not remember which day. -He instructed the MA to request a new order from the provider electronically. -If he or the RCC were not available, he expected MAs to send an electronic request to providers for needed orders before medications run out. -He expected MAs to administer medications as ordered. .	{D 358}		