STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515083	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundale Nursing Home	800 J D Anderson Drive Morgantown, WV 26505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to document voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and maintain evidence of the result of all grievances for no less than 3 years from the date the grievance decision was issued. This has the potential to affect, more than a limited number of Residents. Facility census: 85. Findings Included: Record review of the facility's policy titled, Resident and Family Grievances, showed: --The grievance official is responsible for overseeing the grievance process: receiving and tracking grievances through their conclusion. --Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision. A grievance log will be maintained for each calendar year. a) Grievance Process A record review on 01/08/25 of grievances revealed no grievance forms or logs were filled out for the last two years. During an interview with the Social Services Director (SSD) on 01/08/25 at 2:22 PM SSD states that the facility has not had any grievances in the last two years, and they do not keep a list of concerns. She continued to say that the facility lets each department take care of any complaint made at that department. During an interview with the Administrator on 01/08/25 at approximately 2:50 PM, she stated that the residents or representative has to say they want to file a formal grievance before they would write the concern / grievance on a formal grievance form. She stated that she feels that care, treatment, medication issues, lost personal items or perceived rudeness is just an informal complaint, and the facility does not log them or consider them a grievance.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to provide evidence that the long-term care Ombudsman was sent a copy of the written Notice of Transfer for acute hospital transfers. This was true for two (2) out of two (2) residents reviewed for hospitalizations during the long-term care survey process. Resident identifiers: #28 and #4. Facility census: 85. Findings included: a) Resident #28 A record review, completed on 01/14/25 at 9:26 AM, revealed that Resident #28 had been transferred to the hospital on [DATE]. Although the Notice of Transfer/Discharge was given to the resident at the time of transfer, there was no evidence that the facility had sent a copy of the notice to the long-term care Ombudsman. During an interview on 01/14/25 at 11:19 AM, the Director of Social Services stated that she had not yet sent a notification to the long-term care Ombudsman. She stated, We do a log, I am way behind on my log. We try to do it no less than yearly. b) Resident 4 Medical Record review on 01/14/25 revealed resident #4 was discharged to the hospital on [DATE] and 11/30/24. Subsequent review of Resident #4's medical record showed it did not contain documentation that the Notice of Transfer or Discharge was provided to the Ombudsman. On 01/14/25 at 11:26 AM during an interview the Social Worker verified, there was no evidence that the Notice of Transfer or Discharge was sent to the Ombudsmen for the discharges on 09/29/24 or 11/30/24. She stated that she was behind on the Transfer or Discharge log.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interviews, the facility failed to identify Major Depressive disorder on Preadmission Screening and Resident Review (PASARR). This was found true for one (1) of three (3) residents reviewed during the long-term care survey process. Resident identifier: Resident #53. Facility Census: 85 Findings included: a) Resident #53 A record review conducted on 01/07/25, at approximately 11:45 AM for Resident #53 revealed that the PASARR completed on 03/18/24 did not include any diagnoses of Mental Disorder (MD) or Intellectual Disability (ID). Record reviews also indicated that Resident #53 had been diagnosed with Major Depressive Disorder (MDD) on 11/26/24. Further record review revealed no updated PASARR that captured the MDD diagnosis. During an interview, with the Director of Nursing (DON), on 01/09/24 at approximately 10:55 AM, she confirmed that the PASARR did not reflect the new diagnosis of Major Depressive Disorder. She further stated that she would notify Social Services of the deficiency. On 01/13/24 at approximately 12:12 PM, during an interview with the Director of Social Services (DSS) #15, she confirmed that the PASARR and Care Plan had not been updated to reflect the new diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to ensure that the Resident had a person-centered, comprehensive care plan, developed and implemented to meet his / her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. This practice affected one (1) of nine (9) residents' care plans reviewed during the Long-Term Care Survey Process (LTCSP). This failure to ensure that the comprehensive care plan was developed to ensure the residents' highest practicable well-being placed the resident at risk of not receiving services that would meet their desires or needs. Resident Identifier: Resident #53. Facility Census: 85. Findings included: a) Resident #53 During a review of Resident #53's current diagnoses performed on 01/07/25 at approximately 11:45 AM, revealed that the resident had been diagnosed with Major Depressive Disorder (MDD) on 11/26/24. Continued review revealed the resident's current care plan did reflect specific interventions to address the symptoms and management of MDD. The care plan, however, did address interventions for the management of the symptoms of the medications prescribed for MDD. The review of Resident #53's Care Plan on 01/07/25 revealed the following: PSYCHOTROPIC - (Resident name) is at risk for side effects/complications from psychotropic medication use. Ordered trazodone for MDD, Seroquel for psychosis, and Depakote for psychosis. Has tearfulness, difficulty sleeping, hallucinations, paranoia, delusions, agitation, etc. She is a hospice patient with terminal dx (diagnosis) of HTN (high blood pressure), Heart Disease with HF (heart failure). Date Initiated: 01/17/2024 Revision on: 11/26/2024 On 01/09/25 at 2:06 PM, the Director of Nursing (DON) confirmed the care plan addressed the side effects and complications of the psychotropic medications prescribed for MDD, but did not specifically address the needs of a resident with MDD. She stated that Social Services would know more about the diagnosis. During an interview with the Director of Social Services (DSS) #15, on 01/13/25 at approximately 12:12 PM, she confirmed that the Care Plan had not been updated to reflect and address the diagnosis of MDD.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, and staff interview, the facility failed to follow physician orders related to administration of pain medication. This was true for one (1) of three (3) residents reviewed for pain during the annual long-term care survey process. Resident identifier: #2. Facility census: 85. Findings included: a) Resident #2 A record review was completed on 01/08/25 at 7:00 PM. The record review demonstrated that Resident #2 had the following physician order: Hydrocodone-Acetaminaphen oral tablet 5-325 MG. Give 1 tablet by mouth every 6 hours as needed for pain related to pain, for severe pain (7-10). Review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed the following dates the medication was administered outside the physician's parameters for severe pain. December 2024 -12/10/24 Pain Level of 6 -12/11/24 Pain Level of 3 -12/25/24 Pain Level of 3 January 2025 -12/06/26 Pain Level of 3 During an interview on 01/09/25 at 8:56 AM, the Director of Nursing (DON) acknowledged the medication was administered outside of the parameters set in the physician's order for severe pain ranked 7 - 10. She recognized it was the same nurse who had made the error and stated that the nurse would be re-educated and disciplined.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and staff interview, the facility failed to ensure accurate weights were obtained for three (3) out of three (3) residents sampled for weight loss. Failure to monitor and investigate significant changes in resident's weight status places the residents at risk for an incorrect assessment or diagnosis of impaired nutrition or hydration status. Further, this failed practice potentially prevented the interdisciplinary team from accurately developing and implementing interventions to stabilize or improve the resident's nutritional status before complications arose. Resident Identifiers: Residents #24, #53 and #78. Facility Census:85. The findings included: a) Resident #24 During a review of Resident #24's weights on 01/09/25 at approximately 9:18 AM, the following values were revealed: 10/1/2024 21:28 175.9 Lbs 11/1/2024 23:28 175.9 Lbs 12/1/2024 20:35 177.2 Lbs 1/8/2025 19:29 160.4 Lbs Based on these records, the resident experienced a weight loss of 16.8 pounds, (9.4% of body weight), over a period of 37 days, between 12/01/24 and 01/08/25. A review of Resident #24's care plan revealed the following: PROBLEM: [Resident] has the potential for decreased fluid status, AEB constipation, hx of UTI, and intake less than 75%. Limited fluid preferences. Family provides beverage of choice (Mountain Dew) Date initiated: 11/13/2018 Revision: 09/19/2024 APPROACHES/TASKS: Encourage the resident to drink fluids of choice with and between meals (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date initiated: 11/13/2018 Revision: 09/10/2020 Monitor/document/report PRN any s/sx of dehydration: decreased or no urine output. Concentrated urine. Strong odor. Tenting skin. Cracked lips. Furrowed tongue. New onset confusion. Dizziness. Fever. Thirst. Recent/sudden weight loss. Dry/sunken eyes. Date initiated: 03/18/2021 Offer fluids when giving medication Date initiated: 11/13/2018 Provide supplements as ordered by MD Date initiated: 04/09/2024 Record review on 01/13/25 at 11:35 AM revealed no documentation that the nurse was aware of the weight loss. b) Resident #53 During the record review of Resident #53's weights on 01/07/25 at approximately 3:15 PM, the following values were seen: 3/1/2024 06:33 208.1 Lbs 3/12/2024 18:23 202.6 Lbs 4/1/2024 06:12 217.3 Lbs 4/2/2024 15:07 213.5 Lbs This record shows that Resident #53 experienced a weight loss of 5.5 pounds in 11 days, between 03/01/24 and 03/12/24. In addition, the resident also experienced a significant weight gain of 14.7 pounds (6.76% of body weight), over a period of 19 days, between 03/12/24 and 04/01/24 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ongoing record review revealed a nutritional assessment and dietitian note on 03/29/24 that stated the following: Resident's significant change nutritional assessment completed. NKFA. Weight reflects significant weight gain over past one month. Resident was admitted to hospice. Resident has her own teeth was some missing. She eats all meals in her room per her request. Diuretic therapy; weight fluctuations may occur with diuretic therapy. The record review showed that the resident was prescribed Spironolactone once daily. However, there was no documentation that the weight gain was investigated, or that the physician was notified. Further, clinical evidence has shown that dehydration and weight loss, not weight gain, are associated with diuretic therapy. c) Resident #78 Record review on 01/07/25 at approximately 1:45 PM revealed the following: 12/23/2024 06:29 147.8 Lbs 12/24/2024 06:13 147.4 Lbs 12/25/2024 11:49 161.0 Lbs 12/26/2024 06:03 161.0 Lbs This weight record revealed that Resident #78 gained 13.6 pounds (9.22% of her body weight), in one (1) day, between 12/24/24 and 12/25/24. Record review also reveals that the resident lost 11.8 pounds (7.39% of her body weight) in one (1) day between 12/22/24 and 12/23/24. Further record review revealed a dietitian's note on 01/02/25 which stated the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident's] plan of care reviewed and updated. CW is 161.7 lbs. with a BMI of 26.9. CW reflects significant weight loss of 6.9% over past 1 month, 8.0% over past 3 months and weight gain of 10.2% over past 6 months. Will alert MD of significant weight changes via weight change stamp. Diet is Regular with PO intakes over past week as noted: 2 meals @ 0-25%, 9 meals @ 26-50%, 5 meals @ 51-75%, 3 meals @ 76-100%. She eats breakfast and supper in her room and in fine dining for lunch and supper. Dietary is providing 3780 cc which exceeds her estimated fluid needs of 2059 cc, calculated using his adjusted weight of 151 lbs. @ 30 cc/kg. Dx. of Depression may affect PO intakes. Dx. of Edema. Will continue with current goals and approaches, review plan of care quarterly. On 01/13/25 at approximately 1:54 PM, Registered Nurse (RN) #80 and Nursing Assistant (NA) #24 were observed weighing Resident #78 with the aid of a Hoyer lift. The resident was seated in a wheelchair with a blue sling underneath her. RN #80 first zeroed the scale on the Hoyer lift, and then lowered it so that NA #24 could attach the sling to the lift bar. Once the sling was securely attached, the resident was hoisted up and moved away from the wheelchair, ensuring that her extremities were protected during the process. Once hoisted, the resident was weighed, and her weight was recorded as 164.6 pounds. She was then carefully transferred and lowered into her bed. The sling was removed, and the resident was made comfortable. When questioned about the resident's weight, RN #80 explained that she would deduct the weight of the blue sling from the recorded weight to determine the resident's actual weight. Upon being asked about the sling's weight, RN #80 stated it was 2.2 pounds. She mentioned that she had found this information in the manufacturer's manual. The Centers for Medicare Services (CMS) interpretative guidelines suggest the following parameters for evaluating the significance of unplanned and undesired weight loss: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10% Greater than 10% On 01/08/25 at 1:15 PM, the Quality Assurance Trainer (QA Trainer) #104 presented the facility's protocols for staff training, including weight monitoring. A review of the training protocol revealed that if weights varied by five (5) pounds from a previous weight, the nurse was to be notified. During an interview with QA Trainer #104 on 01/14/25 at 10:55 AM, he stated that the staff were required to notify the nurse on duty of a weight change of five (5) pounds or over. The Director of Nursing (DON) was interviewed on 01/13/25 at 10:45 AM and notified of the significant weight changes. DON confirmed that the significant and severe changes in weight were due to the staff's inaccurate weighing of residents. She further stated that the residents should have been re-weighed when the discrepancies were noted. The QA Trainer #104 stated during the interview on 01/14/25 at 10:55 AM that all the scales were checked monthly to ensure all facility scales were calibrated correctly. In addition, he stated that he did not think the problem of having inconsistent weights was with the scales but with the weighing techniques of the staff. He further stated that based on the survey findings, he was creating a training program for the staff to ensure that they weighed residents accurately.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on record review and interview, the facility failed to notify the physician of a resident's significant change in weight, and failed to ensure that the physician conducted a medical evaluation of a resident with a sudden significant change in weight. As a result, the residents were not evaluated to determine the cause for the sudden change in body weight. This placed the resident at risk for serious harm or death. Resident Identifiers: Resident #24, #53, and #78. Facility Census: 85. Findings Included: a) Resident #24 During a review of Resident #24's weights on 01/09/25 at approximately 9:18 AM, the following values were revealed: -10/1/2024 21:28 175.9 Lbs -11/1/2024 23:28 175.9 Lbs -12/1/2024 20:35 177.2 Lbs -01/8/2025 19:29 160.4 Lbs Based on these records, the resident experienced a weight loss of 16.8 pounds, (9.4% of body weight), over a period of 37 days, between 12/01/24 and 01/08/25. A review of Resident #24's care plan revealed the following: PROBLEM: [Resident] has the potential for decreased fluid status, AEB constipation, hx of UTI, and intake less than 75%. Limited fluid preferences. Family provides beverage of choice (Mountain Dew) Date initiated: 11/13/2018 Revision: 09/19/2024 APPROACHES/TASKS: -Encourage the resident to drink fluids of choice with and between meals Date initiated: 11/13/2018 (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revision: 09/10/2020 -Monitor/document/report PRN any s/sx of dehydration: decreased or no urine output. Concentrated urine. Strong odor. Tenting skin. Cracked lips. Furrowed tongue. New onset confusion. Dizziness. Fever. Thirst. Recent/sudden weight loss. Dry/sunken eyes. Date initiated: 03/18/2021 Offer fluids when giving medication Date initiated: 11/13/2018 Provide supplements as ordered by MD Date initiated: 04/09/2024 Record review on 01/13/25 at 11:35 AM revealed no documentation that the nurse was aware of the weight loss, or that the physician had been notified. b) Resident #53 During the record review of Resident #53's weights on 01/07/25 at approximately 3:15 PM, the following values were seen: -03/01/2024 06:33 208.1 Lbs -3/12/2024 18:23 202.6 Lbs -04/01/2024 06:12 217.3 Lbs -04/02/2024 15:07 213.5 Lbs This record shows that Resident #53 experienced a weight loss of 5.5 pounds in 11 days, between 03/01/24 and 03/12/24. In addition, the resident also experienced a significant weight gain of 14.7 pounds (6.76% of body weight), over a period of 19 days, between 03/12/24 and 04/01/24 Ongoing record review revealed a nutritional assessment and dietitian note on 03/29/24 that stated the following: (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident's significant change nutritional assessment completed. NKFA (No known food allergies). Weight reflects significant weight gain over past one month. Resident was admitted to hospice. Resident has her own teeth was some missing. She eats all meals in her room per her request. Diuretic therapy; weight fluctuations may occur with diuretic therapy. The record review showed that the resident was prescribed Spironolactone once daily. However, clinical evidence has shown that dehydration and weight loss, not weight gain, are associated with diuretic therapy. Record review revealed no documentation that the weight gain was investigated, or that the physician was notified. c) Resident #78 Record review on 01/07/25 at approximately 1:45 PM revealed the following: 12/23/2024 06:29 147.8 Lbs 12/24/2024 06:13 147.4 Lbs 12/25/2024 11:49 161.0 Lbs 12/26/2024 06:03 161.0 Lbs This weight record revealed that Resident #78 gained 13.6 pounds (9.22% of her body weight), in one (1) day, between 12/24/24 and 12/25/24. Record review also reveals that the resident lost 11.8 pounds (7.39% of her body weight) in one (1) day between 12/22/24 and 12/23/24. Further record review revealed a dietitian's note on 01/02/25 which stated the following: [Resident's] plan of care reviewed and updated. CW is 161.7 lbs. with a BMI of 26.9. CW reflects significant weight loss of 6.9% over past 1 month, 8.0% over past 3 months and weight gain of 10.2% over past 6 months. Will alert MD of significant weight changes via weight change stamp. Diet is Regular with PO intakes over past week as noted: 2 meals @ 0-25%, 9 meals @ 26-50%, 5 meals @ 51-75%, 3 meals @ 76-100%. She eats breakfast and supper in her room and in fine dining for lunch and supper. Dietary is providing 3780 cc which exceeds her estimated fluid needs of 2059 cc, calculated using his adjusted weight of 151 lbs. @ 30 cc/kg. Dx. of Depression may affect PO intakes. Dx. of Edema. Will continue with current goals and approaches, review plan of care quarterly. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Once again, record review revealed no documentation that the physician was notified of the sudden changes in body weight. The Centers for Medicare Services (CMS) interpretative guidelines suggest the following parameters for evaluating the significance of unplanned and undesired weight loss: Interval Significant Loss Severe Loss 1 month 5% Greater than 5% 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10% On 01/08/25 at 1:15 PM, the Quality Assurance Trainer (QA Trainer) #104 presented the facility's protocols for staff training, including weight monitoring. A review of the training protocol revealed that if weights varied by five (5) pounds from a previous weight, the nurse was to be notified. During an interview with QA Trainer #104 on 01/14/25, at 10:55 AM, he stated that staff were required to notify the on-duty nurse of any weight change of five pounds or more. The Director of Nursing (DON) was interviewed on 01/13/25 at 10:45 AM and notified of the significant weight changes. DON confirmed that the significant and severe changes in weight were due to the staff's inaccurate weighing of residents. She further stated that the residents should have been re-weighed when the discrepancies were noted. The QA Trainer #104 stated during the interview on 01/14/25 at 10:55 AM that all the scales were checked monthly to ensure all facility scales were calibrated correctly. In addition, he stated that he did not think the problem of having inconsistent weights was with the scales but with the weighing techniques of the staff. He further stated that based on the survey findings, he was creating a training program for the staff to ensure that they weighed residents accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515083	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundale Nursing Home	800 J D Anderson Drive Morgantown, WV 26505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to store food in a safe sanitary manner in regard to storing medical ice packs in the freezer in the residents pantry. This has the potential to affect a limited number of residents. Facility census: 85. Findings Included: a) Two South Resident Pantry During the tour on 01/08/25 at 9:20 AM to the Resident pantry, two (2) medical Ice packs were observed stored in resident freezer. An interview, on 01/08/25 at 9:20 AM, with the Dietary Manager confirmed the medical ice packs should not be stored with resident food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515083	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to complete a comprehensive social services assessment in its entirety for Resident #35. This was a random opportunity for discovery. Resident identifier: #35. Facility census: 85. Findings included: a) Resident #35 During a record review, on 01/13/25 at 11:29 AM, it was identified that the following questions were left unanswered on the comprehensive social services assessment, dated 06/25/24. Question 12: Date capacity determined by MD Question 13: Competency (Guardian, Conservator, or Both) Question 14: Current Pain Medications Further record review revealed: -The most recent physician determination of capacity was on 05/22/24 -Resident #35 had both a court appointed legal guardian and a conservator effective 01/28/13 -Resident #35 was ordered Tramadol pain medication, an order that began on 07/20/23. During an interview, on 01/13/25 at 2:15 PM, the Director of Social Services acknowledged the questions were left blank and were unanswered.