STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366479	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberland Ridge Nursing & Rehabilitation	3558 Ridgewood Road Fairlawn, OH 44333

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and review of the facility policy, the facility failed to ensure Resident #37's care planned interventions were implemented and skin impairments were identified and treated timely. This affected one (Resident's #37) of four residents reviewed for skin integrity. The facility census was 67.Findings include:Review of Resident #37's medical record revealed an admission date of 10/03/25 and diagnoses included non-infective gastroenteritis and colitis and cerebral palsy.Review of Resident #37's admission Skin assessment dated [DATE] revealed Resident #37 had a stage I pressure ulcer (skin is intact but shows damage from prolonged pressure, appearing as a persistent red, reddish-blue, or purplish area that doesn't turn white (blanch) when pressed), the skin was intact, non-blanchable, and there was erythema (reddening of the skin caused by inflammation).Review of Resident #37's physician orders revealed on 10/04/25, an order to apply house moisture barrier ointment to peri area, buttocks, coccyx after incontinent episodes and as needed. On 10/06/25, an order to complete head to toe skin check to be completed every day shift every Monday, Thursday for skin.Review of Resident #37's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had severe cognitive impairment. Resident #37 had impairment on both sides of upper and lower extremities, was dependent on staff for toileting hygiene, bathing, dressing and personal hygiene. Resident #37 required substantial to maximal assistance to roll to the left and right sides and return to lying on his back on the bed. Resident #37 had an indwelling catheter and was always incontinent of bowel. Resident #37 did not have moisture associated skin damage (MASD). Resident #37 did not reject care during the seven-day assessment look-back period. Review of Resident #37's Wound Care notes written by Wound Nurse Practitioner (WNP) #306 and dated 11/05/25 included Resident #37's sacrum Stage I pressure injury showed complete epithelialization with no signs of infection or inflammation. Healing was complete and the wound was now fully closed. Review of Resident #37's care plan dated 11/14/25 included Resident #37 had an alteration in elimination and was incontinent of bowel and bladder. Resident #37 would be clean, dry and odor free. Interventions included to monitor for skin redness and irritation and notify nursing; provide incontinence care as needed.Review of Resident #37's Wound Care notes written by WNP #306 and dated 11/26/25 did not reveal evidence Resident #37's sacrum was evaluated.Review of Resident #37's progress notes dated 11/26/25 through 12/02/25 did not reveal evidence Resident #37 had skin impairment of the lower back, buttocks, hips, and sacral area.Review of Resident #37's Treatment Administration Record (TAR) dated 12/01/25 revealed a head to toe skin check completed every day shift every Monday and Thursday was checked off it was completed on 12/01/25 by Licensed Practical Nurse (LPN) #262. On 12/01/25 apply house moisture barrier ointment to peri area, buttocks, coccyx after incontinent episode and as needed every shift for preventative was checked off it was completed on day shift (no time was documented) by LPN #262. On 12/01/25 cleanse sacrum with soap and water and apply Triad paste every shift for wounds for prevention was checked off it was completed on day shift (no time was documented) by LPN #262. Observation on 12/02/25 at 9:55 A.M. of Resident #37 revealed Certified Nursing Assistant (CNA) #242 was preparing to provide incontinence care for Resident #37. Resident #37 was lying on his back in bed and he was lying on a low air loss mattress. The low air loss mattress pump revealed a red light was showing the pump had a low pressure, and there was no alarm sounding. CNA #242 confirmed the low air loss mattress pump had a low pressure reading. CNA #242 began providing incontinence care and when she removed Resident #37's incontinence brief and had him turn onto his right side multiple long, dark, red marks about three to four inches long and a half inch wide were seen on his left hip and upper outer area of his left thigh. CNA #242 stated she usually worked on another nursing unit and was not familiar with Resident #37 and did not know if he had the marks previously. Resident #37's lower back had a very large reddened area covering both sides of his lower back and there were many, scattered open areas, and many of the scattered open areas had a small amount of fresh blood draining from them. Resident #37's buttocks were very reddened, raw and had scattered open areas draining a small amount of fresh blood. CNA #242 stated the reddened areas on Resident #37's lower back and buttocks did not look like new areas. Resident #37 grimaced when asked if his bottom hurt, and CNA #242 stated Resident #37's lower back and buttocks looks really bad. Resident #37 had a moderate amount of formed, brown stool in his incontinence brief and when CNA #242 cleaned his buttocks the area was very red, with open areas that were bleeding. The surveyor asked LPN #262 to come into Resident #37's room

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of the facility policy, the facility failed to ensure Resident #13's care planned interventions were implemented and failed to ensure Resident #13 had a comprehensive fall evaluation completed timely. This affected one (Resident #13) out of three residents reviewed for falls. The facility census was 67.Findings include:Review of Resident #13's medical record revealed an admission date of 09/04/25. Diagnoses included sepsis, obesity, and type two diabetes mellitus with diabetic neuropathy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had no impairment of the upper and lower extremities and required substantial to maximal assistance for bathing and was dependent for toileting and personal hygiene. Resident #13 required substantial to maximal assistance for the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed. Resident #13 did not reject care during the seven-day assessment look-back period.Review of Resident #13's Fall Risk Evaluation dated 10/28/25 revealed Resident #13 was at risk for falls.Review of Resident #13's care plan dated 11/14/25 revealed Resident #13 was at risk for falls related to muscle weakness, obesity, shortness of breath and other diagnoses. Resident #13 would minimize potential risk factors related to falls. Interventions included to educate Resident #13 on proper hand placement during sit-to-stand transfers to promote safety; encourage Resident #13 to use assistive devices properly; transfer and change positions slowly; provide rest periods. Interview on 12/01/25 at 5:20 P.M. with the Director of Nursing (DON) revealed when a resident had a fall the nurse would assess the resident for an injury, would check vital signs, would check to see if the resident hit their head and initiate neuro checks if indicated. The nurse would ask if the resident had pain, and if they had difficulty moving an extremity etcetera. IDON #308 stated if the resident had pain there should be something documented about it. The physician or nurse practitioner would be notified. If the resident had a severe injury they would be sent to the hospital for evaluation. The investigation would be completed in risk management with the details of the fall. There should be a fall assessment and a pain assessment completed, and a physical assessment completed in the progress notes. The DON stated the facility charted by exception, meaning charting is done if there were concerns but otherwise no charting was required to be done. Charting might not be done post fall if there were no issues. There was no template for a post fall assessment. Review of Resident #13's Fall report dated 12/02/25 at 4:00 P.M. revealed Resident #13 was being transferred via sit-to-stand and during the transfer she began to slide out of the lift. Certified Nursing Assistant (CNA) #241 lowered Resident #13 to the floor and made Licensed Practical Nurse (LPN) #233 aware of the situation. Resident #14 was placed in bed via a mechanical lift. No injuries were noted. Resident #13's responsible party and Nurse Practitioner (NP) #309 were notified. Resident #13's level of pain was documented as a zero on a pain scale of zero being no pain and ten being the worst pain, and Resident #13 was oriented to person, situation, place and time.Observation on 12/02/25 at 4:33 P.M. of Resident #13 revealed she was lying in bed with the head of her bed elevated, was pleasant and had an anxious look on her face. Resident #13 stated she was shook up because she just had a fall from a sit-to-stand lift about a half hour ago. Resident #13 indicated she told CNA #241 she did not have a good grip on the sit-to-stand with her hands but CNA #241 was impatient and kept going without checking to make sure her hands had correct placement. Resident #13 stated she could feel her hands giving out and she was telling CNA #241 I am falling, I am falling but CNA #241 just kept going. Resident #13 indicated she could feel the belt around her chest was not tight, she could feel it slipping and she slipped out of the holster, slid down, and slammed her right knee into the sit-to-stand lift then plopped on the floor kind of hard on her back and butt. Observation of Resident #13's right leg revealed about a three inch circular, reddened area by Resident #13's right knee. Resident #13 stated after it happened the aides and nurses did not pay attention, CNA #241 told me you did not fall, you slipped out, and my vital signs including my blood pressure were not checked. Resident #13 stated no one asked me if I had pain and her back and butt were hurting and she was sore all over. Resident #13 stated her pain level after the fall was a six out of ten, on a pain scale of zero (no pain) to 10 (most severe pain). Resident #13 stated she had high anxiety and after she fell and was on the floor she was worried staff would hurt her when they assisted her off the floor. Resident #13 insisted she wanted Assistant Director of Nursing (ADON) #290 to come to the room to help, and fought with them for ten minutes and they finally got him. ADON #290 indicated a mechanical lift had to be used to assist Resident #13 to bed

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of the facility policy, the facility failed to ensure the residents received timely and appropriate incontinence care. This affected one (Resident's #31) of four residents reviewed for skin integrity. The facility census was 67.Findings include:Review of Resident #31's medical record revealed an initial admission date of 06/10/25 and a re-entry date of 09/03/25. Diagnoses included urinary tract infection, diabetes mellitus without complications, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had moderate cognitive impairment. Resident #31 required substantial to maximal assistance with toileting hygiene, bathing, and personal hygiene and was frequently incontinent of urine and bowel.Review of Resident #31's care plan dated 09/14/25 revealed Resident #31 had an alteration in elimination and was frequently incontinent of bowel and bladder. Resident #31 would be clean, dry and odor free. Interventions included to provide incontinence care as needed. Observation on 12/02/25 at 10:33 A.M. revealed Certified Nursing Assistant (CNA) #242 was providing Resident #31's incontinence care. Resident #31 had two incontinence briefs on and both were saturated with urine and Resident #31 had a bowel movement. A folded blanket under Resident #31, used as a reusable chux pad (an absorbent waterproof pad) was wet with urine and the urine was dried around the edges. CNA #242 removed Resident #31's two briefs, the wet chux pad and threw them on the floor without using a plastic bag. Resident #31 had a moderate, formed brown bowel movement, and when CNA #242 cleansed his buttocks and sacral area redness was noted. CNA #242 stated it looked like Resident #31 had not had his brief changed in a long time. CNA #242 finished providing incontinence care, she did not remove her soiled gloves and touched Resident #31's closet door and took items out of his closet with soiled gloves. With soiled gloves on CNA #242 touched Resident #31's clean bed linens, his pillow and the door handle to his room. CNA #242 left the room and removed her soiled gloves after leaving and put them in a trash container. CNA #242 confirmed she had soiled gloves on when she touched furniture, bed linens and door handles while in Resident #31's room.Interview on 12/02/25 at 10:45 A.M. with the Director of Nursing (DON) revealed CNA #242 told her Resident #31 was wearing two incontinence briefs and she touched Resident #31's closet door, clean bed linens, his pillow and the door handle to his room while wearing soiled gloves. The DON confirmed Resident #31 should not have been wearing two incontinence briefs.Review of the facility policy titled Skin Incontinence Care Protocol revised 09/2017 revealed the facility would provide incontinence care for the resident to assist in maintaining skin integrity, preventing skin breakdown, controlling odor and providing comfort and self-esteem for the resident. After each incontinent episode perform proper hand hygiene and wear gloves when providing incontinence care. This deficiency represents non-compliance investigated under Complaint Number 2625673.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, pharmacy interview, and record review, the facility failed to ensure Resident #13's physician orders were followed and her medication was available for administration. This affected one (Resident #13) of five reviewed for medication administration. The facility census was 67. Findings include:Review of Resident #13's medical record revealed an admission date of 09/04/25. Diagnoses included obesity - class III and type two diabetes mellitus (DM) with diabetic neuropathy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact and did not reject care during the seven-day assessment look-back period.Review of Resident #13's physician orders dated 11/05/25 revealed Zepbound subcutaneous solution 2.5 milligrams (mg) per 0.5 milliliter (ml), inject one pen needle subcutaneously one time a day every Tuesday for DM. Last week of injection, please notify the Nurse Practitioner (NP).The care plan dated 11/14/25 included Resident #13 had the potential for alteration in nutrition related to diagnoses. Resident #13 was on the medication Zepbound for weight loss. Interventions included to administer medications as ordered.The Medication Administration Record (MAR) dated 12/02/25 revealed Zepbound subcutaneous solution 2.5 mg per 0.5 ml, inject one pen needle subcutaneously one time a day every Tuesday for DM was not administered at lunchtime as ordered. The progress note dated 12/02/25 at 2:55 P.M. revealed Zepbound was on order.Interview on 12/02/25 at 4:33 P.M. with Resident #13 revealed she was on a weight loss shot and she should have received it between 11:00 A.M. and 1:00 P.M. today. Resident #13 stated she asked Licensed Practical Nurse (LPN) #233 where her shot was and was told it was not at the facility and was on order. Interview on 12/03/25 at 8:19 A.M. with Assistant Director of Nursing (ADON) #290 revealed Resident #13's Zepbound medication was expensive and the Administrator had to give his approval for it to be filled and delivered to the facility by the pharmacy.Interview on 12/03/25 at 10:05 A.M. with the Administrator revealed he received a call yesterday (12/02/25) from the pharmacy and they needed approval because Resident #13's prior authorization did not go through. The Administrator stated he approved Resident #13's Zepbound on 12/02/25 and he did not know who should have made sure the Zepbound was available for administration. The Administrator stated going forward, Resident #13's Zepbound would be ordered on Mondays and it would be administered to Resident #13 on Wednesdays. The Administrator stated the ADON would be responsible to make sure Resident #13's Zepbound was available for administration.Interview on 12/04/25 at 11:13 A.M. with Pharmacy Representative #310 revealed the pharmacy received a refill request on 12/02/25 through the electronic system for Resident #13's Zepbound. When the pharmacy processed the request, it was not covered by Resident #13's insurance, the facility was contacted and the Administrator authorized the pharmacy to send one Zepbound pen.This deficiency represents non-compliance investigated under Complaint Number 2643181.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of a manufacturer insert, staff interviews, record review, and facility policy review, the facility failed to ensure a medication error rate of less than five percent (%). Three errors were observed in 25 opportunities resulting in a 12% error rate. This affected three (Resident #14, #17 and #31) of three residents observed for medication administration. The facility census was 62. Findings include:1. Record review for Resident #14 revealed an admission date of 09/25/20. Diagnoses included type two diabetes mellitus with hyperglycemia.Review of the care plan dated 10/06/20 revealed Resident #14 was at risk for hypo/hyperglycemia episodes. Interventions included insulin as ordered.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact and had diabetes mellitus.Review of the physician order for Resident #14 revealed an order with a start date 09/01/22 for Novolog FlexPen solution pen injector 100 units per milliliter (ml), inject as per sliding scale: If 151 to 200 give two units.Observation on 01/21/26 at 12:04 P.M. of medication administration with Licensed Practical Nurse (LPN) #307 revealed LPN #307 confirmed Resident #14's blood sugar was 151. LPN #307 removed Resident #14's Novolog FlexPen from the medication cart, placed a needle on the Novolog FlexPen then dialed in two units of insulin. Observation revealed LPN #307 then administered the two units of insulin to Resident #14. LPN #307 confirmed she never primed the Novolog FlexPen before administering the insulin and revealed she never primed insulin pens because they were preset when dialed in.Interview on 01/21/26 at 12:16 P.M. with the Director of Nursing (DON) revealed nurses need to prime the insulin pen prior to dialing up the amount to be administered. Review of the NovoLog insulin insert provided by the facility titled How to use your NovoLog FlexPen revealed take the cover cap off the syringe, screw the needle on the FlexPen, dial two units, hold the syringe with needle pointing up and tap reservoir gently to move air bubbles to top of needle. Press the push button on your syringe as far as it will go until a drop of insulin appears. Make sure your dose selector is set at zero, dial the number of units you need to inject.2. Record review for Resident #31 revealed an admission date of 04/23/24. Diagnoses included acute respiratory failure, muscle weakness, acute and chronic congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD) with acute exacerbation.Review of the care plan dated 03/03/25 revealed Resident #31 had respiratory deficiencies or abnormalities of pulmonary function related to COPD, CHF, and respiratory failure. Interventions included to administer aerosol treatments as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had moderate cognitive impairment. Resident #31 had debility and cardiorespiratory conditions.Review of the physician orders for Resident #31 revealed an order with a start date of 12/26/25 for breztri aerosphere inhalation aerosol (triple combination inhaler designed for long-term maintenance treatment of COPD) 160-9-4.8 micrograms (mcg)/ACT, two puffs inhale orally two times a day related to COPD with acute exacerbation, administer with spacer, rinse mouth after use with water, do not swallow. Breztri was scheduled to be administered rise (6:00 A.M. to 9:00 A.M.) and bedtime (7:00 P.M. to 10:00 P.M.)Review of the medication administration record for January 2026 revealed Resident #31 missed one dose of breztri aerosphere inhalation aerosol on 01/21/26 for the morning administration (6:00 A.M. to 9:00 A.M). Observation on 01/21/26 at 8:18 A.M. of medication administration revealed Licensed Practical Nurse (LPN) #323 did not have breztri aerosphere inhaler to administer to Resident #31. LPN #323 confirmed the medication was not available and she would need to reorder it from the pharmacy.Interview on 01/22/26 at 12:30 P.M. with Respiratory Therapist (RT) #299 confirmed she worked with Resident #31 and revealed the medication breztri is a bronchodilator, and it opens up the airways and it should be administered to the resident as ordered.3. Record review for Resident #17 revealed an admission date of 04/29/23. Diagnosed included Alzheimer's disease and muscle weakness.Review of the care plan dated 10/25/24 revealed Resident #17 was at risk for alteration in comfort, generalized pain and comorbidities. Intervention included medications as ordered to manage pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was severely cognitively impaired. Resident #17 received a scheduled pain medication program. Review of the physician orders for Resident #17 revealed an order with a start date of 08/19/25 for capsaicin external cream 0.1% (used to relieve nerve pain in the joints, applied to both knees) apply to joints topically every shift for pain. Capsaicin external cream was scheduled to be administered twice a day, 6:00 A.M. to 9:00 A.M. and 7:00 P.M. to 10:00 P.M.Review of the medication administration record for January 2026 revealed Resident #17 missed one

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff interviews, pharmacist interview, and review of the facility policy, the facility failed to ensure Resident #101 was free from significant medication errors. This affected one (Resident #101) of five residents reviewed for medication administration. The facility census was 67. Findings include:Review of Resident #101's medical record revealed an admission date of 10/08/25. Diagnoses included Parkinson's Disease without dyskinesia and anxiety. Resident #101 was discharged from the facility on 10/12/25.Review of Resident #101's admission assessment and Baseline Care Plan dated 10/08/25 included Resident #101 was confused and disoriented and unaware of safety needs. Resident #101 was anxious and received antianxiety medication. Review of Resident #101's physician orders dated 10/08/25 revealed alprazolam (Xanax) oral tablet 0.25 milligrams (mg), give one table by mouth every 12 hours as needed for anxiety.Review of Resident #101's Medication Administration Record dated 10/08/25, 10/09/25, 10/10/25, 10/11/25 and 10/12/25 did not reveal alprazolam 0.25 mg, give one tablet by mouth every 12 hours as needed for anxiety was administered to Resident #101.The progress notes dated 10/12/25 at 11:46 A.M. included a girl and a guy visited Resident #101. They were not Resident #101's Power of Attorney (POA) and they were filming (with their cell phones) and arguing with the aides. Resident #101 was asked if she felt abused, and she stated no and if she felt safe and the answer was yes. Resident #13's physician was contacted and notified she needed anxiety medication and a prescription was needed. The police were called and were present in the facility. Resident #101's family was present and stated they wanted to sign Resident #13 out of the facility against medical advice (AMA). The Director of Nursing (DON) and Resident #13's physician were notified. Review of Resident #101's late entry progress note dated 10/12/25 at 6:54 P. M. revealed on 10/11/25 at 6:50 P.M., the family requested anxiety medication be administered to Resident #101. Resident #101 was noted to be fidgeting with her fingers only and had observable signs of anxiety. Resident #13's physician was notified that Resident #13 needed a prescription for Xanax 0.25 mg, one tablet every 12 hours as needed. Per the physician (unidentified), have pharmacy call for a verbal. The facility pharmacy was contacted and notified they needed to call the physician for a prescription. Interview on 12/01/25 at 3:53 P.M. with Pharmacist #311 revealed Resident #101's alprazolam (Xanax) was never filled because the pharmacy never got a valid prescription. Pharmacist #311 stated the pharmacy followed up three times and sent three communications to Resident #101's physician and one of them on 10/12/25 was marked urgent. Pharmacist #311 indicated the pharmacy never received a response from Resident #101's physician. Pharmacist #311 stated there were no notes in the pharmacy records indicating nurse's from the facility called about Resident #101's Xanax. Pharmacist #311 stated on 10/12/25 the pharmacy stopped the follow up for Resident #101's alprazolam because they received an order to discontinue Resident #101's medications because Resident #101 left the facility AMA. Pharmacist #311 stated Resident #101's alprazolam order was first received on 10/11/25 and the communications started on 10/11/15. Pharmacist #311 could not say why the pharmacy did not receive Resident #101's order for alprazolam on 10/08/25 when it was ordered. Interview on 12/01/25 at 4:05 P.M. with the Director of Nursing (DON) revealed alprazolam 0.25 mg was kept in the facility starter supply area, the physician could call or fax the order in, and as soon as that was done the facility could get authorization to administer alprazolam to Resident #101. The DON stated she was not employed at the facility when Resident #101 resided there and she could not speak to why Resident #101's alprazolam was not filled on 10/08/25 when it was ordered.Interview on 12/01/25 at 4:29 P.M. with Licensed Practical Nurse (LPN) #281 revealed Resident #101's husband was her POA. LPN #281 stated she admitted Resident #101 to the facility, and she started Resident #101's admission and the night shift nurse was supposed to finish it. LPN #281 stated she did not know what happened after she left and did not know if Resident #101's alprazolam was ordered and filled. Resident #101 had visitors while she resided in the facility and they asked many questions that the facility staff could not answer because they were not her POA. The visitors would get upset when their questions would not get answered. LPN #281 stated 10/11/25 and 10/12/25 were days close to a holiday and the nurses could not reach the nurse practitioner or the physicians. Neither the nurse practitioner or the physicians responded to faxes and telephone calls relating to the residents. LPN #281 stated it was a really weird weekend and it was unusual not to be able to contact nurse practitioners or physicians. LPN #281 indicated a meeting was held after that weekend because they could not get the physicians to respond to their faxes and telephone calls. LPN #281 stated she thought the problem was because the facility did not have a schedule stating which