STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036047	A. BUILDING: _____ B. WING _____	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 an annual survey on 01/18/23 - 01/20/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 7 exit doors that were accessible to residents with known disorientation and wandering behaviors, were equipped with sounding devices when the exit doors were opened to alert staff. The findings are: Observation of the facility's entrance/exit doors on 01/18/23, 01/19/23 and 01/20/23 revealed: -There was no audible sounding device heard when the front exterior and interior entrance/ exit doors were opened. -There was no audible sounding device heard when the side door, the residents used to go out smoking, on the 100 hall was opened.	D 067	Somerset Court of Goldsboro shall ensure that each exit door accessible by residents is equipped with a sounding device that is activated when the door is opened, and is of sufficient volume that it can be heard by staff. Maintenance Tech ensured that all door alarms were activated to sound anytime the exit doors are opened. Maintenance Tech also installed secondary sounding alarms to all exit doors accessible by residents, and ensured volume sufficient to be heard throughout the facility. 1/23/23 Executive Director (ED) re-educated staff on the elopement policy, and completed an elopement drill with facility staff to ensure all staff understood the importance of resident supervision and safety, as well as knowing what to do in the case of a missing resident. 2/8/23 ED will ensure all staff notify the Maintenance Tech and/or ED anytime the door alarms are noted to not be functioning properly, or functioning but can't be heard throughout the facility. Facility staff will also ensure doors are shut securely behind them, and that no resident is following when staff is departing from the facility. 3/6/23 Maintenance Tech will check the functionality of the door alarms based on an established monitoring schedule. Any noted concerns will be repaired immediately and discussed with the ED. 3/6/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristen Lynn TITLE: ED (X6) DATE: 3/3/23

Kristen Lynn ED 3/6/23

Reviewed and Acknowledged
03/13/23 WW

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D 067	Continued From page 1 -There was no audible sounding device heard when the side door, the residents used to go out smoking, on the 200 hall was opened. a. Review of Resident #2's current FL-2 dated 10/25/22 revealed diagnoses included dysphagia, hypokalemia, and a history of cerebral vascular accident. Review of Resident #2's resident register dated 10/26/22 revealed the resident was admitted on 10/26/22. Review of Resident #2's care plan dated 12/14/22 revealed the residents was sometimes disoriented. Review of Resident #2's incident and accident report dated 10/29/22 revealed: -The resident eloped from the facility on 10/28/22. -The resident was placed on 15-minute checks for 72 hours. -The resident was educated on when leaving the facility, sign in and out. Interview with the Lead Supervisor on 01/20/22 at 10:29am revealed: -She was not aware of the door Resident #2 used when he left the facility. -Resident #2 left the facility because he wanted some cigarettes. -Resident #2 had not attempted to leave the facility since 10/28/22. Refer to interview with the Lead Supervisor on 01/20/22 at 10:29am. Refer to interview with the Administrator on 01/20/23 at 9:46am.	D 067	ED will follow-up on the functional status of door alarms daily in management meeting with the maintenance tech, as well as follow-up on any concerns voiced from the remainder of the management team. Interventions will be put in place for any noted concerns promptly.	3/6/23

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D 067	Continued From page 2 b. Review of Resident #4's current FL-2 dated 07/05/22 revealed: -Diagnoses of dementia, hypertension, and anemia. -The resident was documented as ambulatory and intermittently disoriented. Review of Resident #4's Resident Register revealed: -The resident was admitted to the facility on 06/10/19. -The resident was documented as forgetful and needed reminders. -The resident was documented as "sometimes" having significant memory loss and must be directed. Review of Resident #4's current assessment and care plan dated 04/27/22 revealed: -The resident was documented as ambulatory and having wandering behaviors. -The resident was documented as always disoriented. -The resident was documented as having significant memory loss and must be directed. Review of Resident #4's Independent Assessment for Personal Care dated 05/04/22 revealed: -The resident was an elopement risk due to wandering and confusion. -The resident had exit-seeking behavior and he was on one-hour checks for safety. -The resident could be redirected verbally. -The resident was ambulatory without devices and steady. Observation of Resident #4 on 01/18/23 from 3:31pm - 3:37pm revealed: -Resident #4 walked from his room and exited the	D 067		

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D 067	Continued From page 3 side exit door at the end of the hall at 3:31pm. -The exit door alarm did not sound when the door was opened and their was no staff with the resident or in view of the resident. -The resident sat on the side porch and smoked a cigarette and then came back inside and went to his room. -No door alarms sound and no staff were present. Interview with a medication aide (MA) on 01/20/23 at 10:48am revealed: -Resident #4 would tell staff before he tried to leave the facility. -Resident #4 would go out the front door to the parking lot then turned around and came back inside the facility while staff watched him. -She was not aware of the resident leaving the premises. -Resident #4 would go outside to smoke and he had not tried to leave while smoking to her knowledge. -The door alarms on the exit doors at the end of the hallways were turned off during the day so residents could go outside to smoke. -Resident #4 went out the unalarmed exit doors to smoke and staff was not required to go outside with the resident when he smoked. Interview with the Lead Supervisor on 01/20/23 at 11:25am revealed: -Sometime between August 2022 and November 2022, Resident #4 left the facility and walked to a nearby bank. -She went with another staff member and they found the resident standing outside of the bank and brought him back to the facility. -The resident had not left the facility again to her knowledge. -They did not document the resident leaving and going to the bank to her knowledge.	D 067		

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D 067	Continued From page 4 -She told the Resident Care Coordinator (RCC) about it and staff monitored the resident every 15 minutes for 72 hours after the incident. -Resident #4 would go outside the end exit door to smoke on his own. -The resident had not tried to leave again on his own to her knowledge. Interview with the RCC on 0/20/23 at 11:43am revealed: -Most of Resident #4's confusion was about him wanting to go to social services or to the bank to get a check or money. -The resident would sign out and start walking out in the parking lot toward the road but staff would watch him and redirect him to come back inside the facility. -She assessed Resident #4 as safe to smoke on his own based on observing him light and smoke his cigarettes safely. -She did not think about with the door alarms being turned off during the day, staff would not know when Resident #4 went outside. -Resident #4 had always come back in on his own when he went outside to smoke to her knowledge. Interview with the Administrator on 01/20/23 at 1:24pm revealed: -She did not know when Resident #4 had left the facility and was found by staff at the bank because it was before she started working at the facility. -Resident #4's cognitive orientation changed from day to day and my not be able to find his way back to the facility if he left. -The door alarms would be turned back on during the day to alert staff when residents, including Resident #4 exited the facility.	D 067		

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D 067	Continued From page 5 Refer to interview with the Lead Supervisor on 01/20/22 at 10:29am. Refer to interview with the Administrator on 01/20/23 at 9:46am. c. Review of Resident #5's current FL-2 dated 10/18/22 revealed: -Diagnoses included depression, chronic kidney disease, and hypokalemia. -The resident was intermittently disoriented. Refer to interview with the Lead Supervisor on 01/20/22 at 10:29am. Refer to interview with the Administrator on 01/20/23 at 9:46am. Interview with the Lead Supervisor on 01/20/22 at 10:29am revealed: -The 2 doors residents used to go outside to smoke, and the front entrance door were not alarmed. - She was not aware of the reason for the doors not being alarmed during the day. -The 2-hour checks staff were to complete would allow the facility to know if a resident had eloped. Interview with the Administrator on 01/20/23 at 9:46am revealed: -The front door and the 2 doors used by residents to go outside, and smoke had not been alarmed since she started 2 months ago. -She did not know why the doors did not to have a sounding device when opened. -Staff were expected to complete 2-hour checks of the residents in the facility.	D 067		

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D 338	Continued From page 6	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338	Somerset Court of Goldsboro shall ensure that the rights of all Residents guaranteed under the Declaration of Resident Rights, are maintained and may be exercised without hindrance.	
	10A NCAC 13F .0909 Resident Rights			
	An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the rights for 1 of 6 sampled residents (#9) were maintained related to the resident being treated with respect, dignity, and her right to privacy. The findings are: Review of the facility's Policy and Procedures Manual dated September 2021 revealed the Executive Director and staff would make sure every effort to assist residents in exercising their Declaration of Residents' Rights. Review of Resident #9's current FL-2 dated 12/12/22 revealed diagnoses included essential hypertension. Review of Resident #9's Resident Register revealed: -The resident was admitted to the facility on 05/06/19. -The resident was documented as forgetful and needed reminders. Review of Resident #9's current assessment and care plan dated 01/09/23 revealed: -The resident was documented as sometimes disoriented, forgetful, and needed reminders. -The resident required supervision by staff with ambulation and transferring.		ED will complete Resident Rights in-service with all staff. 3/6/23 ED removed master key from Resident # 8 posession, and replaced with single key specific to his room only. 1/18/23 ED checked all extra keys to ensure no other master keys located within Resident room keys. 1/21/23 ED and Maintenance Tech will ensure that all new admission Residents receive a key specific to their room only, and are not inadvertantly given a master key at any time. 3/6/23 Life Enrichment Coordinator (LEC) will ensure Resident Council meetings are held on a monthly basis, with the date clearly posted for the knowledge of all Residents. LEC will review Resident Rights as a part of the meeting to ensure Residents are made aware of their rights, and will allow time for Residents to voice any concerns of violations of their Rights in a safe environment. Any concerns voiced will be reviewed with the ED upon completion of the meeting to allow for prompt follow-up and appropriate intervention. This follow-up will include the respective Department Head as well. KL 3/6/23 3/6/23 ED/RCC will round in the facility no less than twice daily to ensure Residents' needs are met, and no concerns are voiced. 3/6/23	

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D 338	Continued From page 7 -The resident required limited staff assistance with eating, toileting, bathing, dressing, and grooming. Observation during tour of the facility on 01/18/23 at 9:35am revealed: -Surveyor knocked on the locked door of Resident #9's room but there was no answer. -Resident #8 came out of his room from across the hallway three doors down from Resident #9's room. -Resident #8 took a key in his possession and unlocked Resident #9's room door. Interview with Resident #8 on 01/18/23 at 9:35am revealed: -He had a key to Resident #9's room and he had it for "a good while". -He got the key from a former maintenance staff person who no longer worked at the facility. -He used the key to unlock Resident #9's door because Resident #9 was hard of hearing and he did not want the resident to miss going to the dining room for meals. -He also used the key to unlock residents' doors if they locked themselves out of their rooms. Observation on 01/18/23 at 9:37am revealed Resident #9 used the key to unlock a vacant resident room door next to his room to show the key worked on any of the doors. Interview with the Administrator/Executive Director on 01/18/23 at 11:36am revealed: -Residents' room keys were supposed to be specific to their own personal room. -She was not aware Resident #8 had a key that opened other residents' rooms. -Resident #8 should not have a master key that opened all resident room doors.	D 338		

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D 338	Continued From page 8 Interview with a medication aide (MA) on 01/20/23 at 10:48am revealed: -She was not aware Resident #8 had a key to Resident #9's room. -She had observed Resident #8 going in and out of Resident #9's room but she had not noticed Resident #8 unlocking Resident #9's door. -She did not think Resident #8 should have a key to Resident #9's room because both residents had "cognitive issues". -She had never seen any inappropriate behavior between the two residents. -Resident #9 had not complained to her about Resident #8 going into her room. Interview with the Lead Supervisor on 01/20/23 at 11:25am revealed: -Resident #8 was always checking on Resident #9. -She was aware Resident #8 had a master key to all of the residents' rooms in the facility. -She reported it during a stand-up meeting about a month ago. -She thought the Resident Care Coordinator (RCC), the Business Office Manager (BOM), and the Administrator were all in the meeting. -Resident #8 would say he was going in Resident #9's room to get the resident up. -She had never seen Resident #8 unlock Resident #9's room with a key but staff (could not recall who) told her about it. -She could not recall the exact date she was told about the key but it had been at least 2 years that the resident had a key to Resident #9's room. Interview with the RCC on 0/20/23 at 11:43am revealed: -She was not sure how long Resident #8 had a master key to the rooms in the facility.	D 338		

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D 338	Continued From page 9 -One of the Lead Supervisors said she reported Resident #8 had a key to Resident #9's room during a stand up staff meeting (not sure of date). -She did not remember hearing that information at the meeting. -If she had heard that information, she would gotten the key from Resident #8 at that time. -Resident #9's room was usually locked. -She had not seen Resident #8 go in or out of Resident #9's room. -The MAs had master keys to the residents' rooms in case a resident locked themselves out or in case of an emergency. -The personal care aides (PCAs) had one master key they shared while on duty. -She, the Administrator, and the maintenance staff person also had master keys to the rooms in the facility. -Resident #9 had not complained about anyone going in her room and she had not reported that Resident #8 had a key to her room. -She had not observed any inappropriate behavior between Resident #8 and Resident #9. -She was concerned that a resident had a master key that unlocked all residents' rooms due to privacy and safety. Interview with Resident #9 on 01/20/23 at 9:49am revealed: -She had a key to her room and she usually locked the door to her room when she left the room. -She usually left the door unlocked when she was in the room except she usually locked the door at night. -Staff knew that Resident #8 had a key to her room. -Resident #8 came in her room to check on her "all the time". -Resident #8 came in her room some mornings	D 338		

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D 338	Continued From page 10 and tried to wake her up. -Resident #8 would wake her up to remind her to go to breakfast. -Resident #8 came into her room quietly but she could hear him sometimes as he was coming in the room. -Resident #8 came in one morning (could not recall when) while she was in the bathroom combing her hair. -She did not hear him come in so when he tapped her on the shoulder, "I jumped". -Resident #8 sometimes knocked before he used the key to unlock the door and sometimes he did not. -She had not told anyone that Resident #8 had a key to her room because she was "scared" if she said something Resident #8 would get mad with her. -A few years ago when she first met Resident #8, he tried to kiss her but she told him she just wanted to be friends. -Resident #8 had not tried kiss her anymore; he was her friend. -Resident #8 was not touching her or doing anything wrong; she would have told someone if he was doing anything wrong in that way. -She did not want Resident #8 to have a key to her room. -She was "glad" Resident #8 no longer had a key to her room so he could not "just pop in" anytime. A second interview with the Administrator/Executive Director on 01/20/23 at 1:24pm revealed: -Resident #9 had not reported Resident #8 was coming in her room or any other concerns. -She was concerned with the master key that Resident #8 could enter any resident's room and violate their privacy. -Resident #8's master key was switched on	D 338		

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D 338	Continued From page 11 Wednesday, 01/18/23, and now his key only opened his room.	D 338		
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 residents (#2, #6, #7) observed during the medication pass including errors with insulin (#6), ear wax removal drops (#7), a medication for acid reflux (#2), and a potassium supplement (#2). The findings are: The medication error rate was 15% as evidenced by 4 errors out of 26 opportunities during the 7:00am - 8:00am medication pass on 01/19/23. a. Review of Resident #6's current FL-2 dated 11/30/22 revealed: -Diagnoses included diabetes mellitus type 2 and primary hypertension. -There was an order for Novolog Flexpen Inject 14 units 3 times a day before meals, hold for blood sugar less than (<) 130. (Novolog is rapid-acting insulin used to lower blood sugar.	D 358	Somerset Court of Goldsboro shall ensure that the preparation and administration of medications and treatments by staff are according to Provider's orders, which are maintained in the Resident's record; as well as according to the facility's policies and procedures, and rule area .1004(a). Area Clinical Director (ACD) will perform random med pass observations at a minimum of 3 observations per month. Observations will be reviewed with the med tech for educational feedback, the Care Manager, and the ED who will then file in the employee's education folder. 3/6/23 Resident Care Coordinator (RCC) will ensure "Do Not Crush" list is available on each medication cart for Med Tech use. 3/6/23 RCC will ensure accuracy when approving orders, making sure to follow all directions given. RCC will be sure to seek order clarification for any unclear orders or orders with variables received. 3/6/23 RCC and ED will conduct monthly Med Tech meetings to provide ongoing education related to medication administration including Diabetic education. RCC will ensure Med Techs understand the importance of wasting 2 units of insulin prior to dialing the ordered dose when administering insulin via an insulin pen. 3/6/23 RCC will pull EMAR compliance reports daily and review for accuracy and compliance of administration. The report will be discussed with the ED daily in management meeting for any needed follow-up. 3/6/23	

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D 358	Continued From page 12 According to the manufacturer, Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.) Review of Resident #6's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flexpen inject 14 units 3 times a day before meals, hold for blood sugar < 130. -Novolog Flexpen was scheduled for 8:00am, 12:00pm, and 5:00pm and documented as administered from 01/01/23 - 01/19/23. -The resident's blood sugar ranged from 82 - 452 from 01/01/23 - 01/19/23. Observation of the 8:00am medication pass on 01/19/23 revealed: -Resident #6's blood sugar was 335 at 7:31am. -The MA dialed the Novolog Flexpen to 14 units, then put the pen needle on the end of the pen. -The MA administered 14 units of Novolog insulin into Resident #6's left abdomen at 7:33am. -The MA did not put the pen needle on first and the MA did not perform a 2-unit air shot prior to dialing the insulin pen to 14 units to ensure no air bubbles were present and insulin was flowing from the pen. Interview with Resident #6 on 01/19/23 at 10:28am revealed: -She usually received insulin every day. -She usually got "woozy" and her stomach hurt when her blood sugar was too low. -She felt like her blood sugar was too high at times, but she could not describe the symptoms she felt when it was high. -She denied any current symptoms of high or low blood sugar.	D 358	RCC will complete cart audits weekly for overall QA of the medication cart to ensure the cart is stocked with appropriate and accurate medications. RCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. ED will review completed chart audits for verification.	3/6/23 3/6/23

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D 358	Continued From page 13 Interview with the MA on 01/19/23 at 10:50am revealed: -She had training on the use of insulin pens by a nurse but she could not recall when. -She was not aware she needed to put the pen needle on the insulin pen prior to dialing up any insulin. -She did not usually do an air shot prior to dialing up the ordered dose of insulin. -She thought maybe she was supposed to dial up one extra unit and do an air shot but she was not sure. Interview with the Resident Care Coordinator (RCC) on 01/19/23 at 11:07am revealed: -The MAs had been trained on proper technique for use of insulin pens upon hire by a nurse and during annual training. -The MAs had been instructed on putting the pen needle on the insulin pen and performing an air shot prior to dialing the ordered dose. -She could not recall how many units should be dialed to prime the insulin pens but she thought it was 2 units. Interview with the Administrator on 01/19/23 at 11:40am revealed: -The facility's licensed health professional support nurse usually trained the MAs on how to administer insulin. -The MAs should use proper technique when administering insulin with insulin pens, including a 2-unit air shot. Interview with Resident #6's primary care provider (PCP) on 01/20/23 at 1:04pm revealed: -The MAs needed to administer Resident #6's insulin pen correctly. -Leaving air in the insulin pen could cause	D 358		

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D 358	Continued From page 14 increased burning and pain at the injection site and prevent the full dose from being administered. b. Review of Resident #2's current FL-2 dated 10/25/22 revealed diagnoses included dysphagia, hypokalemia (low potassium), and history of stroke. Review of Resident #2's physician's order dated 10/26/22 revealed an order for Pantoprazole 40mg DR (delayed-release) take 1 tablet twice daily. (Pantoprazole is used to treat acid reflux. Pantoprazole DR is a delayed-release tablet and should not be crushed. Crushing a delayed-release tablet may result in the medication being released too early and being destroyed by stomach acid.) Review of Resident #2's standing orders dated 11/02/22 revealed an order for all medications may be given by mouth and/or crushed (CHECK DO NOT CRUSH LIST) and placed in applesauce or pudding UNLESS otherwise noted. Observation of the 8:00am medication pass on 01/19/23 revealed: -The medication aide (MA) prepared morning medications for Resident #2, including one Pantoprazole 40mg DR tablet. -The MA crushed all of Resident #2's oral medications, including the Pantoprazole 40mg DR tablet, mixed them in pudding and administered the medications to the resident at 8:10am. Observation of Resident #2's medications on hand on 01/19/23 at 10:47am revealed: -There was a multidose pack (MDP) with a pharmacy label dated 01/13/23.	D 358		

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D 358	Continued From page 15 -The MDP included Pantoprazole 40mg DR tablet in the morning and bedtime compartments. -There were no instructions on the medication label indicating Pantoprazole should not be crushed. Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg DR (delayed-release) 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Pantoprazole 40mg DR was documented as administered daily from 01/01/23 - 01/19/23. -There was no information noted on the eMAR to indicate the medication should not be crushed. Interview with the MA on 01/19/23 at 10:42am revealed: -She usually crushed all of Resident #2's medications because the resident had swallowing problems. -She thought the facility had a Do Not Crush (DNC) list but she could not find one. -She thought she "messed up" because Pantoprazole should not be crushed because it was a delayed-release tablet. -The eMAR and the medication label were usually marked with "Do Not Crush" if a medication could not be crushed. Interview with Resident #2 on 01/19/23 at 10:34am revealed: -The MAs usually crushed his oral medications. -He could swallow the medications better when they were crushed. Interview with the Resident Care Coordinator (RCC) on 01/19/23 at 11:14am revealed: -There were usually instructions on the eMAR	D 358		

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D 358	Continued From page 16 and medication label indicating if a medication should not be crushed. -There was supposed to be a DNC list available in the facility for the MAs. -The MAs should check the DNC list prior to crushing medications. -Resident #2's Pantoprazole should not have been crushed. Telephone interview with Resident #2's primary care provider (PCP) on 01/20/23 at 1:04pm revealed: -Pantoprazole was a delayed-release medication and should not be crushed. -Crushing Pantoprazole would destroy the medication and decrease effectiveness which could result in heartburn or indigestion for the resident. c. Review of Resident #2's physician's order dated 11/02/22 revealed an order for Potassium Chloride packet 20mEq give 2 packets (40mEq) by mouth daily. (Potassium Chloride packet is a potassium supplement used to treat low potassium levels. Potassium Chloride powder packets need to be diluted according to the manufacturer's instructions prior to administering to prevent irritation of the lining of the esophagus and the stomach.) Observation of Resident #2's medications on hand on 01/19/23 at 10:47am revealed: -There was a supply of Potassium Chloride Powder Packets 20mEq dispensed on 12/10/22. -The instructions on the prescription label were to give 2 packets (40mEq) daily. -The manufacturer's instructions printed on the back of each packet were to dilute the contents of 1 packet of Potassium Chloride in at least 4 ounces of cold water.	D 358		

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D 358	Continued From page 17 Observation of the 8:00am medication pass on 01/19/23 revealed: -The medication aide (MA) mixed two packets of Potassium Chloride (40mEq) in a 9-ounce cup of water that was half filled with water, so approximately 4 ounces of water. -The Potassium Chloride was not diluted according to the manufacturer's instructions. -The resident grimaced as he drank about half of the prepared Potassium Chloride at 8:11am. -The resident hand the cup back to the MA without drinking anymore. Review of Resident #2's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride 20mEq give 2 packets (40mEq) daily scheduled at 8:00am. -There were no instructions for diluting the Potassium Chloride included on the eMAR. -Potassium Chloride was documented as administered from 01/01/23 - 01/19/23. Interview with the MA on 01/19/23 at 10:42am revealed: -She usually poured some water in the 9-ounce cups kept on the medication cart to mix with Resident #2's Potassium Chloride packets. -She had not noticed or read the instructions on the packet of how to dilute the Potassium Chloride. -The resident usually drank about half of the prepared amount of Potassium Chloride. Interview with Resident #2 on 01/19/23 at 10:34am revealed: -The Potassium Chloride was bitter and it did not taste good.	D 358		

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D 358	Continued From page 18 -He sometimes drank all of it but sometimes it was too bitter to drink. Interview with the Resident Care Coordinator (RCC) on 01/19/23 at 11:14am revealed: -She was not aware the MA was not diluting Resident #2's Potassium Chloride as required. -She was not aware until today (01/19/23) that the resident was not drinking all of the Potassium Chloride to get the full amount ordered. -Resident #2's two packets of Potassium Chloride should be mixed in 8 ounces of water as directed on the packet. Telephone interview with Resident #2's primary care provider (PCP) on 01/20/23 at 1:04pm revealed: -Potassium Chloride tastes "nasty" and should be diluted correctly for administration. -Resident #2's two Potassium Chloride packets should be diluted in 8 ounces of water. -Not diluting Potassium Chloride in enough water could contribute to the bad taste and could cause irritation of the gastrointestinal mucosa. d. Review of Resident #7's current FL-2 dated 11/16/22 revealed diagnosis included hyperthyroidism. Review of Resident #7's physician's order from a wound clinic dated 12/02/22 revealed: -There was an order for Debrox solution, apply to both ears twice a day. (Debrox is used for ear wax removal.) -The order did not specify how many drops should be administered in each ear. Review of Resident #7's physician's orders revealed no documentation of an order to clarify the Debrox instructions.	D 358		

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D 358	Continued From page 19 Observation of the 8:00am medication pass on 01/19/23 revealed: -The medication aide (MA) pulled Resident #7's right ear up and back and squeezed a stream of Debrox solution into the ear while the resident was sitting up in bed. -The MA did not have the resident to keep her head in a tilted position or put cotton in her ear to keep the Debrox in her ear. -The MA then pulled the resident's left ear up and back and squeezed a stream of Debrox solution into the ear while the resident was sitting up in bed. -The MA did not wait 5 minutes between the instilling Debrox in each ear. -The MA did not have the resident to keep her head in a tilted position or put cotton in her ear to keep the Debrox in her ear. -The resident immediately laid back down in the bed after the Debrox ear drops were instilled. Review of Resident #7's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Debrox ear drops use as directed in each ear twice a day scheduled at 8:00am and 8:00pm. -Debrox ear drops was documented as administered from 01/01/23 - 01/19/23. Observation of Resident #7's medications on hand on 01/19/23 at 10:57am revealed: -There was a bottle of Debrox ear drops dispensed on 12/09/22. -The instructions on the prescription label were to use as directed in each ear twice a day. -The instructions on the manufacturer's label were to place 5 to 10 drops into the ear twice daily; keep drops in ear by keeping head tilted or	D 358		

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D 358	Continued From page 20 placing cotton in the ear. Interview with the MA on 01/19/23 at 10:55am revealed: -She usually put 2 drops of the Debrox solution in each of the resident's ears. -She did not know what use as directed meant on the instructions. -She had put cotton in the resident's ears at times when administering the ear drops but she did not have any cotton in the medication cart currently. -She had not notified anyone that the instructions were unclear and she had not contacted the provider for clarification. Interview with Resident #7 on 01/19/23 at 10:30am revealed: -The provider ordered the Debrox ear drops to soften the wax in her ears. -She thought the ear drops were helping. -She was not sure how much Debrox was administered but she thought the MAs squeezed a drop in each ear. -She usually laid back down immediately after the ear drops were administered but she was not sure if the ear drops ran out of her ears when she laid down. Interview with the Resident Care Coordinator (RCC) on 01/19/23 at 11:07am revealed: -The MAs were responsible for notifying her of any discrepancies or unclear orders and she was responsible for getting orders clarified. -She was not aware Resident #7's order for Debrox ear drops was incomplete and needed clarifying. -The MAs had been trained on proper technique for instilling ear drops. -The MAs should have the resident tilt their head when administering ear drops and wait 2 to 5	D 358		

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D 358	Continued From page 21 minutes before changing the position of the head to instill drops in the other ear. Telephone interview with a nurse at Resident #7's wound clinic provider's office on 01/23/23 at 8:58am revealed: -No one from the facility had contacted their office to clarify the Debrox solution order. -The provider ordered the Debrox ear wax removal drops because Resident #7's ears were full of wax that needed to be cleared out prior to the resident being put in the hyperbaric chamber for a wound treatment. -It was determined sometime after the Debrox was ordered that the resident could not receive hyperbaric wound treatment due to the resident's pacemaker.	D 358		