

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/07/2024
NAME OF PROVIDER OR SUPPLIER WALTONWOOD LAKE BOONE		STREET ADDRESS, CITY, STATE, ZIP CODE 3560 HORTON STREET RALEIGH, NC 27607		
(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 Th Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 02/06/24 to 02/07/24. The complaint investigation was initiated by the Wake County Department of Social Services on 01/30/24.	D 000	D358 10A NCAC 13F .1004(a) Medication Administration Corrective Action: 1. On 3/15/24, the Resident Care Manager and/or designee will begin reviewing all residents Physician Orders vs. Medications available for administration in the Medication carts. The Resident Care Manager and/or designee will address any discrepancies identified.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1, #4) including errors with a controlled substance used to treat moderate to severe pain and a controlled substance used to treat nerve pain (#1) and a potassium supplement used to treat and prevent low potassium levels (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 09/20/23 revealed diagnoses included diabetes	D 358	2. On 3/20/24, the Resident Care Manager and/or designee will begin reeducating Medication Technicians regarding: Process to follow up for Physician and Emergency Department visits for order changes, Pharmacy Services Policy including removal of discontinued medications from the medication carts, Reordering medication process, Verification of pharmacy Emar order changes, Verification of new ordered medications available on Medication cart and Medication Technician responsibilities. Systemic Changes: 3. On 03/13/24, the Executive Director conducted a meeting with the staff regarding: Process to follow up for Physician and Emergency Department visits for order changes, Pharmacy Services Policy including removal of discontinued medications from the medication carts, Reordering medication process, Verification of pharmacy Emar order changes, Verification of new ordered medications available on Medication cart and Medication Technician responsibilities. On 03/20/24, the Resident Care Manager will conduct a meeting with the Medication Technician staff reeducating regarding: Process to follow up for Physician and Emergency Department visits for order changes, Pharmacy Services Policy including removal of discontinued medications from the medication carts, Reordering medication process, Verification of pharmacy Emar order changes, Verification of new ordered medications available on Medication cart and Medication Technician responsibilities. Effective 03/18/24, the Resident Care Manager and/or designee will conduct random weekly audits for: Follow up for Physician and Emergency Department visits for order changes, Removal of discontinued medications from the medication carts, Reordering medication process is timely, Verification of pharmacy Emar order changes, Verification of new ordered medications available on Medication carts. The Resident Care Manager and/or designee will address any discrepancies identified.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shanelle Armas

TITLE

Executive Director

(X6) DATE

03/14/2024

STATE FORM

6899

68BW11

If continuation sheet 1 of 17

Reviewed and acknowledged 03/15/24 *Anna A. Hight*

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D 358	Continued From page 1 mellitus type 2, hypertension, dilated cardiomyopathy, atrial fibrillation, hyperlipidemia, sleep apnea, chronic anticoagulation, and cataract of both eyes. a. Review of the facility's Pharmacy Services Policy revised 02/13/20 revealed all refills of medications must occur within 7 to 10 days before the last dose of the previous month to maintain resident supply. Review of Resident #1's spine center provider's order dated 11/20/23 revealed an order for Xtampza ER 9mg twice a day. (Xtampza ER is a controlled substance used to treat moderate to severe pain.) Review of Resident #1's spine center provider's order dated 01/18/24 revealed: -There was an order for Xtampza ER 13.5mg 1 capsule twice a day. -There was a fax confirmation date of 02/05/24 at the top of the page with the order. Review of Resident #1's facility electronic progress notes revealed: -01/30/24 at 10:13am: the physician was faxed for a refill of Xtampza ER 9mg capsule; resident had 11 capsules (5.5 days supply) remaining at that time. -02/01/24 at 5:08pm: the physician was faxed again for a refill for Xtampza; resident had 7 capsules (3.5 days supply) remaining; the Assisted Living Wellness Coordinator (ALWC) was also notified. -02/04/24 at 2:56pm: late entry for 02/03/24; the resident had 3 Xtampza ER 9mg capsules remaining; the physician had not responded to the faxes that were previously sent to refill the medication; the resident, ALWC, and the	D 358	Monitoring: 4. Results on the random weekly audits, for: Follow up for Physician and Emergency Department visits for order changes, Removal of discontinued medications from the medication carts, Reordering medication process is timely, Verification of pharmacy Emar order changes, Verification of new ordered medications available on Medication carts will be reviewed monthly for 3 months, by the Executive Director and/or designee at the Quality Assurance and Assessment Committee. After 3 months, the facility will re-evaluate. Corrective Date 5. 4/7/2024	4/7/24

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D 358	Continued From page 2 Resident Care Manager (RCM) were made aware. -02/04/24 at 8:52pm: the resident received his last Xtampza ER. -02/05/24 at 11:30am: the RCM called the physician's office and left a voice mail about a refill for Xtampza; the resident was out of medication. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Xtampza ER 9mg take 1 capsule twice daily scheduled for 8:00am and 8:00pm. -Xtampza ER 9mg was documented as administered twice a day from 01/01/24 - 01/31/24. -There was no entry for Xtampza ER 13.5mg as ordered on 01/18/24. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Xtampza ER 9mg take 1 capsule twice daily scheduled for 8:00am and 8:00pm. -Xtampza ER 9mg was documented as not administered at 8:00am and 8:00pm on 02/05/24 due to "awaiting from pharmacy". -The entry for Xtampza ER 9mg had a stop date of 02/05/24 at 10:00pm. -There was an entry for Xtampza ER 13.5mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -The date written noted on the eMAR for Xtampza ER 13.5mg was 01/18/24 but it was started on 02/06/24 at 8:00am. Review of Resident #1's controlled substance (CS) logs for Xtampza ER 9mg revealed:	D 358			

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D 358	Continued From page 3 -There was a CS log for Xtampza ER 9mg with a dispensed date of 12/29/23 for 60 capsules. -The first dose was documented as administered on 01/06/24 at 8:48am and the last dose was documented as administered on 02/04/24 at 7:51pm, leaving a balance of 0. -There were no subsequent CS logs for Xtampza ER 9mg and no doses were documented as administered on 02/05/24. Review of Resident #1's CS logs for Xtampza ER 13.5mg revealed: -There was a CS log for Xtampza ER 13.5mg with a dispensed date of 02/05/24 for 60 capsules and only 2 doses had been documented as administered. -The first dose was documented as administered on 02/06/24 at 8:20am and a second dose was documented as administered on 02/07/24 at 8:02am, leaving a total balance of 58 capsules. -There was no Xtampza ER 13.5mg capsule documented as administered on 02/06/24 at 8:00pm as ordered. Observation of Resident #1's medications on hand on 02/07/24 at 4:40pm revealed: -There was a supply of Xtampza ER 13.5mg capsules dispensed on 02/05/24. -There were 58 of 60 capsules of Xtampza ER 13.5mg remaining. -There were no Xtampza ER 9mg capsules on hand. Interview with a medication aide (MA) on 02/07/24 at 4:55pm revealed: -The MAs were responsible for ordering medications when there was an 8-day supply of medication remaining. -She faxed Resident #1's spine center provider several times but the provider's office never	D 358			

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D 358	Continued From page 4 responded to her knowledge. -The resident did not complain of pain when he was out of Xtampza ER. Interview with the ALWC on 02/07/24 at 11:41am revealed: -The MAs had been faxing Resident #1's spine center provider to get a new order for Xtampza ER but the provider did not respond. -When the MAs told her they were out of Resident #1's Xtampza ER (on 02/05/24), she called the spine center provider's office. -The spine center provider indicated they had already faxed a prescription for the Xtampza ER. -The spine center provider's office faxed a prescription dated 01/18/24 for Xtampza ER 13.5mg to the facility on 02/05/24. -The facility never received the faxed order for Xtampza ER dated 01/18/24 until 02/05/24. Interview with the RCM on 02/07/24 at 11:10am revealed: -The MAs should fax the provider when there was a 7-day supply of a controlled substance remaining. -If no response, the MAs should resend the fax at least every other day. -The MAs should notify the ALWC if they did not receive a response back from the provider. -The ALWC was responsible for contacting the provider. -The facility had difficulties getting refills for Xtampza ER for Resident #1. -The MAs notified the ALWC on 02/05/24 that Resident #1 was out of Xtampza ER. -The MAs had sent several faxes to Resident #1's spine center provider regarding the Xtampza ER. -The ALWC called the spine center provider and left a message on 02/05/24. -The ALWC had called the spine center provider	D 358			

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D 358	Continued From page 5 prior to 02/05/24 and should have documented it in the electronic progress notes. -The spine center provider sent a fax on 02/05/24 with a new prescription for Xtampza ER dated 01/18/24 and the dosage had changed. -The MA should have administered Xtampza ER 13.5mg to Resident #1 last night on 02/06/24. -The MA made an error last night on 02/06/24 and administered two Lyrica capsules instead of one Lyrica and one Xtampza ER. (Lyrica is a controlled substance used to treat nerve pain.) Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/24 at 3:18pm revealed: -The pharmacy received a faxed prescription dated 01/18/24 for Xtampza ER 13.5mg twice a day for Resident #1 on 02/05/24 from a spine center provider. -They did not receive the prescription dated 01/18/24 prior to 02/05/24. -They dispensed 60 Xtampza ER 13.5mg capsules on 02/05/24 and it was delivered to the facility on 02/05/24 at 11:00pm. -Prior to that, they had dispensed 60 Xtampza ER 9mg capsules each on 12/29/23 and 12/03/23. -For controlled substances, the facility usually let the provider know when they needed a new prescription and the provider usually sent electronic prescriptions. -There was no documentation in the pharmacy records that the facility contacted them regarding the need for a refill on Resident #1's Xtampza ER. Telephone interview with a pharmacy technician at Resident #1's spine center provider's office on 02/07/24 at 4:17pm revealed: -Resident #1 was seen by the spine center provider for a visit on 01/18/24.	D 358			

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D 358	Continued From page 6 -She usually faxed any prescriptions from patient visits to the pharmacy and the facility. -She was not working on 01/18/24 so Resident #1's prescriptions for that visit were faxed to the facility's contracted pharmacy. -A prescription for an increase to Xtampza ER 13.5mg twice a day was faxed to the pharmacy on 01/18/24. -She did not see a fax confirmation to indicate the prescription was faxed to the facility on 01/18/24. -The facility faxed a refill request to their office a few times and each time she sent a fax to the facility that the resident should not be low on the Xtampza ER because a prescription was sent to the pharmacy on 01/18/24. -She received a fax confirmation each time she responded via fax to the facility (could not recall specific dates). -No one from the facility called them regarding her faxed response to their request for a new prescription for Xtampza ER. -The provider increased Resident #1's Xtampza ER from 9mg to 13.5mg on 01/18/24 because the resident was having increased pain and the resident was scheduled for right shoulder surgery in March 2024. -She was contacted by the facility's ALWC on 02/05/24 regarding the Xtampza ER so she refaxed the prescription to the facility and the pharmacy on 02/05/24 at 11:24am. -Missing the doses of Xtampza ER could potentially cause the resident to have increased or uncontrolled pain. -Not starting the increased Xtampza ER 13.5mg dosage when ordered on 01/18/24 was not a big concern as they typically told patients to finish out their current dosage of medication and then start the new dosage. b. Review of Resident #1's spine center	D 358			

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D 358	Continued From page 7 provider's order dated 12/15/23 revealed an order for Lyrica 75mg 1 capsule twice a day. (Lyrica is a controlled substance used to treat nerve pain.) Review of Resident #1's spine center provider's order dated 01/18/24 revealed: -There was an order for Lyrica 100mg 1 capsule twice a day. -The faxed stamp date at the top of the page was 02/05/24. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lyrica 75mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -Lyrica 75mg was documented as administered twice daily from 01/01/24 - 01/31/24. -There was no entry for Lyrica 100mg, and none documented as administered in January 2024. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Lyrica 75mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -Lyrica 75mg was documented as administered twice daily from 02/01/24 - 02/05/24. -Lyrica 75mg was noted to be discontinued with a stop date of 02/05/24. -There was an entry for Lyrica 100mg 1 capsule twice daily scheduled at 8:00am and 8:00pm. -Lyrica 100mg was documented as administered from 8:00am on 02/06/24 through 8:00am on 02/07/24. Review of Resident #1's controlled substance (CS) logs for Lyrica 75mg and Lyrica 100mg revealed: -There was a CS log for Lyrica 75mg with a dispensed date of 01/15/24 for 60 capsules.	D 358			

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D 358	Continued From page 8 -The first dose was documented as administered on 01/20/24 at 8:52am and the last dose was documented as administered on 02/06/24 at 7:26pm, leaving a balance of 25 capsules. -There was a CS log for Lyrica 100mg with a dispensed date of 02/05/24 for 60 capsules with 3 doses documented as administered. -The first dose was documented as administered on 02/06/24 at 8:20am and a second dose was documented as administered on 02/06/24 at 7:26pm. -There was documentation on the CS logs that Resident #1 was administered Lyrica 75mg and Lyrica 100mg for the 8:00pm dose on 02/06/24 for a total of 175mg of Lyrica. -The resident should have received Lyrica 100mg instead of 175mg at 8:00pm on 02/06/24. Observation of Resident #1's medications on hand on 02/07/24 at 4:40pm revealed: -There was a supply of Lyrica 100mg capsules dispensed on 02/05/24. -There were 57 of 60 capsules of Lyrica 100mg remaining. -There was a supply of Lyrica 75mg capsules dispensed on 01/15/24. -There were 25 of 60 capsules of Lyrica 75mg remaining. Telephone interview with a medication aide (MA) on 02/07/24 at 5:20pm revealed: -She did not realize she had made an error last night with Resident #1's medications until the Resident Care Manager (RCM) called her today, 02/07/24. -She administered 2 medications to Resident #1 last night, but she did not scan the labels on the medication cards. -She thought she pulled the cards for Xtampza and Lyrica.	D 358			

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D 358	Continued From page 9 -She did not realize the dosage for Lyrica had changed. -The Lyrica 75mg card should have been pulled from the medication cart by the MA on duty when the order changed to Lyrica 100mg. -She documented she administered Xtampza and Lyrica on the eMAR last night (02/06/24) because that was what she thought she had administered. -She should have scanned the labels and read the labels more closely before administering the medications. -Resident #1 did not complain of pain last night and he was not sleepy or oversedated. Interview with Resident #1 on 02/07/24 at 5:40pm revealed: -He usually received two pills at night. -He received two pills from the MA last night (02/06/24). -He did not have any problems with pain or drowsiness last night. Interview with the Assisted Living Wellness Coordinator (ALWC) on 02/07/24 at 11:41am revealed: -The facility did not receive Resident #1's prescription for Lyrica dated 01/18/24 until 02/05/24. -She had not noticed there was an order change for Lyrica on the prescription dated 01/18/24. -She did not realize Resident #1 should have been receiving Lyrica 100mg instead of 75mg since 01/18/24. Interview with the RCM on 02/07/24 at 11:10am revealed: -The spine center provider sent a fax on 02/05/24 with a new prescription for Lyrica dated 01/18/24 and the dosage had changed to 100mg. -The MA made a medication error last night on	D 358		

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D 358	Continued From page 10 02/06/24 when she administered Lyrica 75mg and Lyrica 100mg to Resident #1. -The Lyrica order was increased to 100mg and the resident should have only received Lyrica 100mg. -Lyrica 75mg should have been removed from the medication cart by the MA on duty when the order was changed to Lyrica 100mg. -The MA should have administered Lyrica 100mg to Resident #1 last night on 02/06/24. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/07/24 at 3:18pm revealed: -The pharmacy received a faxed prescription dated 01/18/24 for Lyrica 100mg twice a day for Resident #1 on 02/05/24 from a spine center provider. -They did not receive the prescription dated 01/18/24 prior to 02/05/24. -They dispensed 60 Lyrica 100mg capsules on 02/05/24 and it was delivered to the facility on 02/05/24 at 11:00pm. -Prior to that, they had dispensed 60 Lyrica 75mg capsules on 01/15/24. -For controlled substances, the facility usually let the provider know when they needed a new prescription and the provider usually sent electronic prescriptions. -There was no documentation in the pharmacy records that the facility contacted them regarding Resident #1's Lyrica prior to 02/05/24. Telephone interview with a pharmacy technician at Resident #1's spine center provider's office on 02/07/24 at 4:17pm revealed: -Resident #1 was seen by the spine center provider for a visit on 01/18/24. -She usually faxed any prescriptions from patient visits to the pharmacy and the facility.	D 358			

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D 358	Continued From page 11 -She was not working on 01/18/24 so Resident #1's prescriptions for that visit were faxed to the facility's contracted pharmacy. -A prescription for an increase to Lyrica 100mg twice a day was faxed to the pharmacy on 01/18/24. -She did not see a fax confirmation to indicate the prescription was faxed to the facility on 01/18/24. -The facility faxed a refill request to their office a few times and each time she sent a fax to the facility that a prescription was sent to the pharmacy on 01/18/24. -She received a fax confirmation each time she responded via fax to the facility (could not recall specific dates). -No one from the facility called them regarding her faxed response to their request for a new prescription for Lyrica. -The provider increased Resident #1's Lyrica dosage on 01/18/24 because the resident was having increased pain and the resident was scheduled for right shoulder surgery in March 2024. -She was contacted by the facility's ALWC on 02/05/24 so she refaxed the prescription to the facility and the pharmacy on 02/05/24 at 11:24am. -Not starting the increased Lyrica 100mg dosage when ordered on 01/18/24 was not a big concern as they typically told patients to finish out their current dosage of medication and then start the new dosage. -Receiving Lyrica 75mg and 100mg at the same time could cause the resident to have increased drowsiness. 2. Review of Resident #4's current FL-2 dated 11/14/23 revealed: -Diagnoses included urinary retention, symptomatic benign prostatic hypertrophy, and atherosclerotic disease.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/07/2024
NAME OF PROVIDER OR SUPPLIER WALTONWOOD LAKE BOONE		STREET ADDRESS, CITY, STATE, ZIP CODE 3560 HORTON STREET RALEIGH, NC 27607		
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D 358	Continued From page 12 -There was an order for Potassium Chloride ER 10mEq, 1 tablet by mouth 3 times weekly on Monday, Wednesday and Friday. (Potassium Chloride is used to treat and prevent low potassium levels.) Review of a hospital emergency room (ER) After Visit Summary (AVS) dated 02/01/24 revealed: -Resident #4 was seen for syncope (fainting or sudden loss of consciousness). -Diagnoses included fall, low blood potassium, and head injury. -There was a change to the Potassium Chloride to 20mEq, 1 tablet by mouth 2 times daily for 7 days. -The Potassium Chloride 20mEq prescription was sent to a local pharmacy. Review of Resident #4's electronic progress note dated 02/01/24 revealed: -Resident #4 had a new order for Potassium Chloride 20mEq by mouth two times a day for 7 days. -A new order was faxed to the facility's contracted pharmacy. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride 10mEq 1 tablet three times weekly on Monday, Wednesday and Friday scheduled at 8am. - Potassium Chloride 10mEq was documented as administered from 02/02/24 - 02/05/24. -There was no entry for Potassium Chloride 20mEq on the eMAR and none was documented as administered. Review of Resident #4's record revealed there was no current signed order for Potassium	D 358		

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D 358	Continued From page 13 Chloride 20mEq in the record. Observations of Resident #4's medications on hand on 02/07/24 at 4:45pm revealed: -There was a supply of Potassium Chloride 10mEq on hand that was dispensed on 01/14/24 and was to be administered 3 times weekly on Monday, Wednesday, and Friday. -There were 5 Potassium Chloride 10mEq tablets on hand. -There were no Potassium Chloride 20mEq tablets available to be administered. Interview of the Assisted Living Wellness Coordinator (ALWC) on 02/07/24 at 4:10pm revealed: -She was not aware Resident #4's Potassium Chloride dosage changed. -She was responsible for reviewing the hospital discharge papers. -She was responsible for sending hospital discharge papers to the facility's contracted pharmacy. -The process was to check the eMAR the next day to see if the order was in the system. -The eMAR was not checked the next day to see if there was an order in the system for Resident #4's Potassium Chloride. -She was out of the office on the day of Resident #4's return to the facility on 02/01/24. -In her absence, a medication aide (MA) faxed the hospital discharge paper to the pharmacy. -Hospital staff usually called the facility to notify them of a resident's discharge and discharge papers were usually sent to the facility prior to the resident returning so she could review any changes. -Facility staff were not informed by hospital staff that Resident #4 would be returning to the facility prior to his return on 02/01/24.	D 358		

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D 358	Continued From page 14 -Resident #4's hospital discharge papers were not sent to the facility prior to his return, but were sent with the resident when he returned on 02/01/24. -She did not see the change to Resident #4's Potassium Chloride the next day because the MA had put the AVS in the contracted facility provider's box. -The facility's contracted pharmacy would not fill a prescription using an AVS because it was not signed by a physician. -The MA did not know the AVS was not signed by a physician. -The facility never received a copy of the signed order for Potassium Chloride 20mEq. Interview with the MA on 02/07/24 at 4:30pm revealed: -She remembered Resident #4's hospital papers with the change to the Potassium Chloride. -Hospital discharge papers were supposed to be placed in either the facility's contracted primary care provider's (PCP) box or the Resident Care Manager's (RCM) box. -She faxed Resident #4's hospital discharge papers to the facility's contracted pharmacy and then placed the papers in the box of either the ALWC, RCM, or the facility's contracted PCP. -She could not recall which box she placed the discharge paper in. -The facility's contracted pharmacy usually automatically added the medication to the eMAR. -Third shift MAs were supposed to verify that the orders were in the system because the medications would be on eMAR on third shift. -She did not know the AVS was not signed by a physician. -She told Resident #4's family member not to pick the medication up from the local pharmacy because the order had to be sent to the facility's	D 358		

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D 358	Continued From page 15 contracted pharmacy. -The RCM usually followed up behind the MAs to ensure that the orders were done. Telephone interview with a pharmacist at the local pharmacy on 02/07/24 at 5:50pm revealed: -Potassium Chloride 20mEq tablets for Resident #4 were delivered to the facility on 02/01/24. -He did not think there would have been an adverse effect to the resident not receiving the increased dosage of the Potassium Chloride 20mEq 1 tablet by mouth 2 times daily for 7 days since it was only ordered to be increased for 1 week. Interview with the RCM on 02/07/24 at 5:54pm revealed: -She was off last week when Resident #4 returned to the facility on 02/01/24. -The ALWC was responsible for following up on orders. -She was not aware of the Potassium Chloride change from 10mEq 3 times weekly to Potassium Chloride 20mEq 1 tablet 2 times daily for 7 days for Resident #4. -She was not aware of a delivery of the Potassium Chloride 20mEq tablets for Resident #4 on 02/01/24 from a local pharmacy. -She had not seen any Potassium Chloride 20mEq tablets on hand for Resident #4. Interview with Resident #4 on 02/07/24 at 3:40pm revealed: -He was tired but unsure how long he had been tired. -Resident #4 did not answer anymore questions. Attempted telephone interview with Resident #4's PCP on 02/07/24 at 4:05pm was unsuccessful.	D 358		

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D 358	Continued From page 16 Attempted telephone interview with the facility's contracted pharmacy on 02/07/24 at 5:48pm was unsuccessful.	D 358			