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D 000	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services of conducted a follow up survey on 10/17/23 to 10/18/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including razors, body wash, personal hygiene products, throat spray, hand sanitizer, floor cleaner and other cleaning products on the special care unit (SCU). The findings are: Review of the facility's census report dated 10/17/23 revealed there were 20 residents on the special care unit (SCU). Observation of the SCU on 10/17/23 at 9:00am - 9:30am revealed: -There were razors, bodywash and other personal care items in an unlocked cabinet in the shower room. -There was floor and toilet cleaner in the unlocked soiled linen room. -There was throat spray and other personal care	D 079		

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items on the dresser in room # 41.
-There were 2 bottles of hand sanitizer at the nursing station accessible to residents.

Interview with personal care assistant (PCA) on 10/17/23 at 9:05am revealed:
-The shower room door was open at all times.
-The cabinet in the shower room containing personal care items and razors was usually locked.

Interview with the Housekeeper on 10/17/23 at 9:10am revealed:
-The lock on the soiled linen closet was broken.
-The door to the soiled linen closet was always open.
-The soiled linen closet was not supposed to have chemicals in it.

Interview with another PCA on 10/17/23 at 9:20am revealed:
-The shower room door was always open.
-All residents on the SCU had baskets in the shower room labeled with their names on them and this was where all personal care items were kept.
-The cabinet in the shower room which contained razors and personal care items was usually locked.
-She was not sure why the personal care items were in bedroom #41.
-The soiled linen closet should have been locked but the lock was broken.

Interview with Business Office Manager on 10/17/23 at 9:30am revealed:
-The cabinet in the shower room containing razors and personal care items should have been locked when not in use.
-PCA's should have locked the cabinet in the

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D 079	Continued From page 2 shower room. -Chemicals should not have been stored in the soiled linen closet. -It was the responsibility of the Special Care Unit Director to ensure the SCU is free of hazards. Interview with the Special Care Unit Coordinator (SCUC) on 10/17/2023 at 3:21pm revealed: -There should not have been any personal care items, hand sanitizer or sore throat spray in bedroom #41. -No residents on the Special Care Unit (SCU) had self-administration orders. -There should never be chemicals in the soiled linen closet. -The cabinet containing razors and personal care items should be locked when not in use. -She was not sure why the personal care items, hand sanitizer and the sore throat spray were in bedroom. #41. -She was not sure why the cabinet containing all the personal care items in the shower room was left unlocked.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to notify the resident's primary care physician for 1 of 5 sampled residents (#4) related to the care of a blister and open wound. The findings are:	D 273		

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Review of Resident #4's current FL-2 dated 09/14/23 revealed:
-Diagnoses included Parkinson's disease, encephalopathy, aphasia following unspecified cerebrovascular disease, chronic kidney disease, and history of transient ischemic attack (TIA).
-The resident was intermittently disoriented.
-The resident was semi-ambulatory.

Review of Resident #4's Resident Register revealed that he was admitted to the facility on 08/30/23.

Review of Resident #4's facility progress notes revealed:
-On 09/28/23 at 11:15pm, the medication aide (MA) documented that the resident had a blister on his right heel with some drainage and basic first aid was performed.
-On 10/03/23 at 10:08am, the MA documented that the resident's right heel was cleaned and wrapped and that the skin was attached with some drainage.
On 10/04/23 at 10:15am, the MA documented that the resident's heel was cleaned and wrapped.
-On 10/10/23 at 12:02pm, the MA documented that the resident's heel was cleaned and wrapped.
-On 10/11/23 at 9:40am, the MA documented that the resident's heel was cleaned and wrapped.

Observation of Resident #4 on 10/17/23 at 9:05am revealed that he was sitting in a recliner with the footrest elevated, with a pillow under his lower legs, and a bandage on his right foot.

An interview with Resident #4's family member on 10/17/23 at 9:06am revealed:

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-Resident #4 had a wound on his right foot that started as a blister around three weeks ago.
-She lived out of state and wanted to be informed of any changes in Resident #4's condition.
-She was informed by one of the staff members at the facility on 09/29/23 that Resident #4 had a small blister on his right foot.
-Resident #4 had visitors at the facility on 10/08/23 and they notified her that he had a bandage on his right foot and that the bandage was soiled with drainage.
-She had spoken with a nurse at the facility on 10/10/23 and the nurse told her that she was not aware of a wound on Resident #4's right foot.
-Other than the phone call on 09/29/23, no one at the facility informed her that the wound on his foot was not improving.
-She was concerned about the delay in medical attention regarding the wound on his foot and lack of communication from facility staff.
-On 10/11/23, she requested that the facility send Resident #4 to the hospital, and he was referred to the wound clinic by the hospital.
-The blister on Resident #4's heel had progressed to a pressure ulcer and was being treated by home health and he was going to the wound clinic weekly.
-Resident #4 was ambulatory with a walker but now had to use a wheelchair since he could not put weight on his right foot due to the pressure ulcer.
-She had photos of the wound on Resident #4's right heel.

Review of photos shared by Resident #4's family member on 10/17/23 at 9:15am revealed:
-Resident #4's right heel had a wound that extended the entire width and length of the right heel.
-The wound bed was pink with no visible

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drainage.
-There was a thick layer of skin with approximately a one-centimeter cracked area exposing the wound bed.

Review of Resident #4's after visit summary from a local hospital dated 10/11/23 revealed:
-Resident #4 was treated in the emergency room (ER) at a local hospital on 10/11/23.
-Resident #4's diagnosis was pressure ulcer of heel.
-Resident #4 received a prescription at the ER on 10/11/23 for Bactrim DS (an antibiotic used to treat or prevent infections) with the instructions: Take two tablets by mouth in the morning and two tablets by mouth before bedtime. Do all this for seven days.
-There was a referral to a wound care clinic and an appointment scheduled for 10/13/23.

Review of Resident #4's discharge instructions from the wound clinic dated 10/13/23 revealed:
-Resident #4 received instructions for no weight bearing to right heel, transfer with assistance, and float heels when sitting or lying.
-Resident #4 received wound care orders for treatment three times weekly, with instructions to clean the wound with normal saline, pat dry, and apply thin layer of MediHoney Gel (MediHoney Gel is a gel used for the treatment of wounds).
-Dressing supplies ordered included sterile woven gauze sponges, ABD pads (a dressing used to absorb drainage), sterile gauze bandage roll, and Medipore H Soft Cloth Surgical Tape.
-Resident #4 had an appointment to return to the wound center in one week.

Review of Resident #4's Home Health Care Skilled Nursing Evaluation Visit notes dated 10/14/23 revealed:

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-The home health nurse documented that skilled nursing services were indicated for wound care management based on physician's orders due to the complexity of the wound.
-The wound on Resident #4's right heel was documented as a stage two pressure ulcer.
-The wound measurements on for Resident #4's right heel wound measured 3.5 centimeters in length, six centimeters in width, and zero centimeters in depth.
-There was moderate watery, thin, pale red/pink drainage.
-The home health nurse documented on 10/14/23 that the wound was cleaned with normal saline, patted dry, MediHoney applied, and covered with sterile gauze, ABD pad, and covered with rolled gauze and secured with Medipore tape.

Interview with the medication aide (MA) on 10/17/23 at 3:30pm revealed:
-She was the admissions director, but she participated in the on-call rotation and sometimes worked as a MA.
-The second shift supervisor informed her on 09/28/23 that Resident #4 had a blister on his right foot.
-She instructed the supervisor to contact Resident #4's family and inform them of the blister on his foot.
-Each time she sawnthe wound between 09/28/23-10/11/23, the wound looked the same with the skin intact and was a blister the size of a golf ball.
-There were no orders for wound care on Resident #4's right heel, but she performed basic first aid on the days she worked on the medication cart, which consisted of cleaning the wound with saline and wrapping it with gauze.
-Resident #4 was ambulatory and used a walker.
-Resident #4 did not talk much but could inform

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staff if he had pain.
-Resident #4 did not complain of pain in his right foot any of the days that she worked on the medication cart.
-Resident #4's family member requested for him to be sent to the hospital on 10/11/23 for the wound on his right foot.

A second interview with the MA on 10/18/23 at 9:30am revealed:
-She did not notify Resident #4's primary care provider (PCP) about the wound on his right heel.
-She was not aware of anyone from the facility contacting Resident #4's PCP to inform them of the wound on his right heel.
-She participated in the on-call rotation for the facility but did not always work on the medication cart since her main responsibility was admissions.
-Since she did not work on the medication cart every day, she was not always aware of changes in residents' condition.

Interview with the Registered Nurse (RN) consultant on 10/18/23 at 10:10am revealed:
-The facility did not have a Resident Care Coordinator (RCC) at this time, and the Administrator was currently in the process of hiring someone for that position.
-She became aware of the wound on Resident #4's foot after speaking with his family member on the phone on 10/10/23.
-On 10/10/23, she removed the bandage on Resident #4's right foot and she observed the wound on his right heel and the skin appeared wrinkled, white in color, and moist.
-There was no drainage, redness, or odor coming from the wound on his right heel and Resident #4 did not complain of pain in his right foot.
-She did not reapply the bandage to Resident

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#4's right foot because the area appeared moist.
-She instructed the staff to keep pressure off Resident #4's right foot.
-She did not contact Resident #4's family member after she assessed the wound on his right foot.
-She informed the person responsible for transporting residents to appointments that Resident #4 should be seen by a physician and thought the transportation person would call Resident #4's family member to follow up and arrange transportation to a physician's appointment.
-She reported the wound on Resident #4's right foot to the facility's Administrator immediately after leaving the resident's room.
-The staff at the facility did not normally report skin issues or other changes in the residents' condition to her.
-She was primarily responsible for staff training and usually worked at the facility two days a week.
-The supervisor on each shift was responsible for communicating changes in resident condition to the resident's primary care provider (PCP).

A review of additional photos taken 10/17/23 of Resident #4's right heel shared by his family member on 10/18/23 revealed:
-The wound covered the entire width and length of the right heel.
-There was no skin covering the wound bed.
-The skin surrounding the wound bed was darkened and peeling away from the wound bed.
-The wound bed was pink with areas of red and purple discoloration.

Based on interviews, record reviews, and observations, Resident #4 was not interviewable.

An attempted interview with Resident #4's PCP

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D 273	Continued From page 9 on 10/18/23 at 11:57am was unsuccessful. An attempted interview with the second shift supervisor on 10/18/23 at 9:10am was unsuccessful. The Administrator was unavailable for interview on 10/17/23-10/18/23.	D 273		
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 A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 2 residents (#6) observed during the medication pass including errors with a decongestant, fiber powder and blood thinner (#6); and for 1 of 5 residents (#1) sampled for record review which included pain patch not being administered as ordered (#1). The findings are:	D 358		

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D 358	Continued From page 10 1.The medication error rate was 11% as evidenced by 3 errors out of 27 opportunities during the 8:00am medication pass on 10/18/23. a. Review of Resident #6's FL2 dated 11/30/22 revealed: -Diagnoses included hypertension, history of trans ischemic attacks, and cerebral infarction, Epilepsy, vascular dementia, hyperlipidemia, vitamin D deficiency, iron deficiency, and anemia. -There was an order for aspirin 81mg tablet (used as a blood thinner) CHEW one tablet and swallow. Observation of the 8:00am medication pass on the Special Care Unit (SCU) on 10/18/23 revealed: -At 7:42am, the medication aide (MA) prepared Resident #6's medication from the medication cart outside the dining room door. -There was an entry on the electronic medication administration record (eMAR) computer screen indicating aspirin 81mg tablet CHEW 1 tablet and swallow was due to be administered at 8:00am for Resident #6. -There was an entry on the electronic medication administration record (eMAR) computer screen indicating Mucinex ER 600mg take one tablet twice a day was due to be administered at 8:00am for Resident #6. -There was an entry on the electronic medication administration record (eMAR) computer screen indicating Benefiber powder 248G mix 1 scoop with 4-8 ounces of liquid and take once daily. was due to be administered at 8:00am for Resident #6. -The MA took a cup of water and the paper soufflé cup with Resident #6's medications (which included his aspirin 81 mg but did not include	D 358		

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Mucinex ER 600mg and no Benefiber was mixed) due at 8:00am into the SCU dining room.
-Resident #6 was seated at the dining room table with his breakfast.
-The MA proceeded to administer Resident #6's medications.
-Resident #6 took his medications with the water provided and continued to eat his breakfast once he had swallowed his medications.
-The aspirin 81mg was not chewed as directed on the eMAR and on the medication card.
-The MA documented aspirin 81mg was administered during the 8:00am medication pass
-The MA documented that the Mucinex ER 600mg and Benefiber were not on the cart and not available for administration during the 8:00am medication pass.

Review of physician's orders dated 10/11/23 revealed there was an order for Mucinex ER 600mg take one twice a day for seven days.

Review of Resident #6's October 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for aspirin 81mg tablet CHEW 1 tablet and swallow with administration at 8:00am.
-Aspirin 81mg was documented as administered on 10/01/23 - 10/18/23 at 8:00am.

Observation of Resident #6's medications on hand on 10/18/23 at 7:42am revealed there were 9 of 30 aspirin tablets available for administration dispensed on 09/27/23.

Interview with a medication aide (MA) on 10/18/23 at 11:30am revealed:
-She was aware there were residents who had medication that required them to be administered

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in other ways other than just swallowing them.
-The order directions were on the medication cards for any "special" things that needed to be followed.
-She was not sure how any of the MAs would have administered Resident #6's a without seeing the aspirin instructions of CHEW then swallow since it was on the medication card and on the computer for the electronic medication administration record (eMAR).
-The MAs were all supposed to do their 3 checks when they pulled the medication from the cart.
-The three checks included making sure the medication on the card matched the medication on the computer screen and what was on the screen matched the medication card and then again when they documented the medication as administered.
-Resident #6's medications were given within the correct time except the aspirin should not have been swallowed without first chewing as directed by the instructions on the medication card and on the computer screen.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 10/18/23 at 9:33am revealed:
-Resident #6's aspirin 81mg chewable was dispensed on 09/27/23.
-Since the aspirin dispensed was chewable and ordered to be chewed then swallowed, the MA should not have administered it with the other medications that the resident would swallow whole.
-It should have been administered in a separate cup for the resident to chew then swallow as directed on the order.
-Resident #6 would not get the full desired effects but just swallowing the chewable aspirin.

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(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 358	Continued From page 13 Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable. The Executive Director was not available for interview on 10/17/23 and 10/18/23. b. Review of Resident #6's FL2 dated 11/30/22 revealed: -Diagnoses included hypertension, history of trans ischemic attacks, and cerebral infarction, Epilepsy, vascular dementia, hyperlipidemia, vitamin D deficiency, iron deficiency, and anemia. -There was an order for 248G of Benefiber powder mix 1 to scoop with 4-8 ounces of liquid and take once daily. Observation of Resident #6's medications on hand on 10/18/23 at 7:42am revealed there was no Benefiber powder available for administration. Review of Resident #6's October 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Benefiber powder 248G mix 1 scoop with 4-8 ounces of liquid and take daily with administration at 8:00am. -Benefiber powder 248G was documented as administered on 10/01/23 - 10/17/23 at 8:00am. -Benefiber powder 248G was documented as not on cart on 10/17/23 at 8:00am. Review of Resident #6's eMAR dated September 2023 revealed: -There was an entry for Benefiber powder 248G mix 1 scoop with 4-8 ounces of liquid and take daily with administration at 8:00am. -Benefiber powder 248G was documented as administered on 09/01/23-09/31/23 at 8:00am.	D 358		

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	HAL047014	A. BUILDING: _____ B. WING _____	R 10/18/2023

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Review of Resident #6's eMAR dated August 2023 revealed:
-There was an entry for Benefiber powder 248G mix 1 scoop with 4-8 ounces of liquid and take daily with administration at 8:00am.
-Benefiber powder 248G was documented as administered on 08/01/23-08/18/23 and 08/20/23-08/31/23 at 8:00am.
-Benefiber powder 248G was documented as not administered on 08/19/23 at 8:00am.

Interview with a medication aide (MA) on 10/18/23 at 11:30am revealed:
-She could not find his Benefiber powder this morning during the medication pass.
-She did not remember if she had given it to him the last time, she worked on the Special Care Unit (SCU) medication cart.
-The MAs reordered medications when they were "getting low."
-She was not sure if anyone had reordered his Benefiber powder, but she ordered it this morning.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 10/18/23 at 9:33am revealed:
-Resident #6's Benefiber 248G bottle was dispensed on 02/03/23.
-There were no other dispense dates for Benefiber since 02/03/23 through today (10/18/23).
-A 248G bottle would normally last about 3 months or "a little longer" if given daily as ordered.

Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable.

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The Executive Director was not available for interview on 10/17/23 and 10/18/23.

c. Review of Resident #6's FL2 dated 11/30/22 revealed:
-Diagnoses included hypertension, history of trans ischemic attacks, and cerebral infarction, Epilepsy, vascular dementia, hyperlipidemia, vitamin D deficiency, iron deficiency, and anemia.
-There was no order for Mucinex ER 600mg.

Review of physician orders dated 10/11/23 there was an order for Mucinex ER 600mg take one tablet twice a day for seven days.

Observation of Resident #6's medications on hand on 10/18/23 at 7:42am revealed there was no Mucinex ER available for administration.

Review of Resident #6's October 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Mucinex ER 600mg take one tablet twice a day for seven days was to be administered at 8:00am and 8:00pm.
-Mucinex ER 600mg was documented as administered on 10/12/23 - 10/17/23 at 8:00am and at 8:00pm.
-Mucinex ER 600mg was documented as not on cart on 10/17/23 at 8:00am.
-Mucinex ER 600mg should have had two tablets available for administration on 10/18/23 at 8:00am and at 8:00pm.

Interview with a medication aide (MA) on 10/18/23 at 11:30am revealed:
-She was not sure why the last two Mucinex ER 600mg tablets were not in the cart for administration.
-She worked on 10/12/23 and administered the

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first tablet out of the medication card.
-She had not worked on the Special Care Unit (SCU) medication cart since 10/15/23 until today 10/18/23 so she was not sure what had happened to make Resident #6 short two tablets of Mucinex.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 10/18/23 at 9:33am revealed:
-Resident #6's Mucinex ER 600 was dispensed on 10/11/23.
-It would have arrived the evening of 10/11/23 but may not have been before the administration time of 8:00pm.
-There should have been 2 doses remaining for administration on 10/18/23.
-Resident #6 would need to complete the order as written for his congestion.
-The PCP could order another 2 tablets if the resident's congestion had not improved.

Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable.

The Executive Director was not available for interview on 10/17/23 and 10/18/23.

2. Review of Resident #1's current FI-2 dated 12/28/22 revealed:
-Diagnoses included anemia, Type II diabetes, Vitamin D deficiency, hyperlipidemia, unspecified dementia, cerebral infraction, essential hypertension, benign prostatic hyperplasia, and gastro-esophageal reflux disease.
-Resident #1 was intermittently disoriented.

Review of Resident #1's physicians orders dated 07/26/23 revealed:

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D 358	Continued From page 17 -On 06/02/23 Resident #1 was ordered a pain patch (4%) to be applied topically to the lower back, 12 hours on and 12 hours off. -The pain patch was to be applied at 8:00am and taken off at 8:00pm. Interview with Resident #1 on 10/17/23 at 2:33pm revealed: -He did not have the pain patch on today; but wanted it -He needed the patch for the pain in his back -He did not refuse the pain patch; he just "doesn't have anyone to put the pain patch on for him." -He had not had the pain patch on since last week. Review of Resident #1's pain patch medication on hand on 10/17/2023 revealed: -There were 6 boxes of pain patches with 5 patches in each box; the date on the pain patch boxes was 09/26/23. -Of the 6 boxes of pain patches, only 1 box was opened with 1 patch removed from the box. Review of Resident #1's TAR dated 09/01-09/30/23 revealed: -It was documented Resident #1 refused the pain patch on 09/03/23 at 9:45am. -It was documented Resident #1 refused the pain patch on 09/06/23 at 8:41am. -It was documented Resident #1 refused the pain patch on 09/14/23 at 11:16am. -It was documented Resident #1 was not wearing his pain patch on 09/16/23 at 8:26pm. -It was documented Resident #1 refused the pain patch on 09/21/23 at 10:05am. -It was documented Resident #1 refused the pain patch on 09/22/23 at 9:41am. -It was documented Resident #1 refused the pain patch on 09/25/23 at 8:41am.	D 358		

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D 358	Continued From page 18 -It was documented Resident #1 refused the pain patch on 09/27/23 at 8:17am. -It was documented Resident #1 refused the pain patch on 09/28/2023 at 8:37am. -It was documented Resident #1 refused the pain patch on 09/29/23 at 8:47am. -It was documented Resident #1 refused the pain patch on 09/30/23 at 8:25am. Review of Resident #1's TAR dated 10/01/23-10/31/23 revealed: -It was documented Resident #1 refused the pain patch on 10/01/23 at 8:34am. -It was documented Resident #1 refused the pain patch on 10/02/23 at 9:59am. -It was documented Resident #1 refused the pain patch on 10/06/23 at 8:31am. -It was documented Resident #1 refused the pain patch on 10/07/23 at 7:17am. -It was documented Resident #1 was not wearing his pain patch on 10/09/23 at 8:19pm. -It was documented Resident #1 refused the pain patch on 10/10/23 at 9:11am. -It was documented Resident #1 was not wearing his pain patch on 10/10/23 at 8:36pm. -It was documented Resident #1 was not wearing his pain patch on 10/11/23 at 8:20pm. -It was documented Resident #1 refused the pain patch on 10/12/23 at 9:21am. -It was documented Resident #1 refused the pain patch on 10/13/23 at 9:13am. -It was documented Resident #1 refused the pain patch on 10/14/23 at 9:04am. -It was documented Resident #1 refused the pain patch on 10/15/23 at 8:20am. -It was documented Resident #1 refused the pain patch on 10/16/23 at 8:45am. -It was documented Resident #1 refused the pain patch on 10/17/23 at 9:34am.	D 358		

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D 358	Continued From page 19 Interview with a medication aide (MA) on 10/17/23 at 2:43pm revealed: -She worked as an MA on second shift. -Most of the time the treatment authorization record (TAR) was blank and did not say anything related to Resident #1 refusing the pain patch. -When she went to remove the pain patch at 8:00pm if the patch was not on Resident #1, she would document on the TAR "not wearing". -The pain patch was to be applied to Resident #1's lower back at 8:00am and removed at 8:00pm. -Resident #1 would tell the MA if he did not have the pain patch on. Interview with the Special Care Unit Coordinator (SCUC) on 10/17/23 at 3:00pm revealed she was not aware that the staff had documented Resident #1 had refused the pain patch as documented on the TAR for 09/23 and 10/23. Interviews with a second MA on 10/18/23 at 8:41am and at 9:35am revealed: -If Resident #1 refused the pain patch three days in a row, she was to notify his primary care provider (PCP). -She had not informed Resident #1's PCP after he refused the pain patch for three consecutive days. -When the MA asked Resident #1 if he wanted the pain patch applied today; he answered he wanted the pain patch "everyday" (he said he did not refuse it). Review of Resident #1's facility record on 10/18/23 revealed there was no documentation that Resident #1's PCP had been notified that he had refused the pain patch for three consecutive days.	D 358		

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D 358	Continued From page 20 Telephone interview with Resident #1's PCP on 10/18/23 at 10:01am revealed she had no notifications or documentation from the facility staff that Resident #1 had refused the pain patch for three consecutive days. The Executive Director was not available for interview on 10/17/23 and 10/18/23.	D 358		