STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 01/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted 01/13/20 - 01/14/20. There were 50 allegations investigated and 4 were substantiated. Event ID# LKNR11.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, nurse practitioner (NP) interview, staff interviews, and record review, the facility failed to provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #8). Findings included: Resident #8 admitted to the facility on 8/6/2019. Diagnoses included chronic obstructive pulmonary disease (COPD) and chronic pulmonary embolism. Resident #8's quarterly Minimum Data Set (MDS) dated 11/22/2019 revealed she had moderate cognitive impairments. She was coded as receiving oxygen therapy. Resident #8 had a plan of care in place, with	F 695		

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

Electronically Signed

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

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F 695	Continued From page 1	F 695		

most recent revision dated 11/3/2019, related to alteration in respiratory status due to COPD. Interventions were inclusive of administering oxygen as needed per physician order.

Resident #8's January 2020 physician's orders revealed the following:

Oxygen at 2 liters continuous via nasal cannula

An observation was completed on 1/13/2020 at 2:21 PM of Resident #8. Resident #8 was observed in the east day room without her oxygen in place. The portable oxygen tank was observed to the back of her wheelchair in a black sling. No tubing was applied via nasal cannula to her nares. Her portable oxygen tank was observed to be set at 3 liters. The portable oxygen tank was turned off. Resident #8 did not appear in any distress.

An observation and interview was attempted with Nurse #1 on 1/13/2020 at 2:25 PM. She was not available at that time.

An observation and interview was completed on 1/13/2020 at 2:32 PM with the Unit Manager (UM). The UM reviewed the electronic medication administration record (eMAR) which revealed Resident #8 had an order in place for oxygen 2 liters continuous via nasal cannula. Resident #8 was observed by the UM which revealed her oxygen was not applied to her nares via nasal cannula. Continued observation revealed the portable oxygen tank to be set at 3 liters and turned off. The UM verbalized the portable oxygen tank setting should have been on 2 liters, per the physician order, and turned on. The UM communicated Resident #8 would not be

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F 695	Continued From page 2	F 695		

able to manipulate the portable oxygen tank settings, just the removal or placement of her nasal cannula. An oxygen saturation reading was obtained from Resident #8, by the UM, which revealed 80% on room air. Resident #8 did not appear in any distress. The UM took Resident #8 to the nurse's station and reapplied her portable oxygen via nasal cannula to her nares. The setting was observed at 2 liters continuous.

An interview was completed on 1/13/2020 at 2:35 PM with Nurse #1. Nurse #1 stated she last visualized Resident #8 in her wheelchair around 10:15 AM with her portable oxygen applied to her nares via nasal cannula. Resident #8 was on her way to the Beauty Shop. Nurse #1 explained she recalled Resident #8's portable oxygen tank being set at 2 liters continuously. She further verbalized Resident #8's oxygen saturation for the morning was 98% with in-room oxygen applied via nasal cannula. This was taken prior to Nurse #1 administering Resident #8's morning inhalations. Nurse #1 communicated if something were wrong with a resident while getting their hair done, the beautician would notify staff immediately. Nurse #1 expressed the beautician did not notify her of any concerns related to Resident #8. Nurse #1 was not certain when Resident #8 departed from the Beauty Shop or why Resident #8's portable tank was turned off.

An interview was completed on 1/13/2020 at 2:52 PM with the Nurse Practitioner (NP). The NP stated Resident #8's oxygen should not be turned off. Her oxygen should remain in place continuously as ordered. She further verbalized Resident #8 had a history of chronic lung disease.

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A follow up observation of Resident #8 was completed on 1/13/2020 at 2:58 PM. She was observed sitting in her wheelchair with her portable oxygen set at 2 liters with the nasal cannula applied to her nares. She was not in distress. Her oxygen saturation was obtained by the UM and the reading was 94%.

An additional observation was completed on 1/14/2020 at 8:40 AM of Resident #8 in her room. The observation revealed Resident #8's in-room oxygen concentrator was set on 3 liters. Resident #8 did not appear in distress.

An interview and observation was completed on 1/14/2020 at 8:47 AM with Nurse #1. She stated Resident #8's in-room concentrator should be set on 2 liters. The observation revealed Resident #8's in-room oxygen concentrator set on 3 liters. Nurse #1 explained nurse aides were not responsible for manipulating in-room oxygen settings. She continued to explain hall nurses were responsible for monitoring and completing that task. Nurse #1 verbalized when she started her shift, she would spot check her residents and speak to them. Nurse #1 continued to explain when she administered medication, she would complete a more thorough assessment of the resident and any devices. Nurse #1 placed the in-room oxygen concentrator at the ordered setting of 2 liters.

An interview was completed with the Director of Nursing (DON) on 1/14/2020 at 8:55 AM. He stated staff should have assisted Resident #8 out of the Beauty Shop when she was done with her service. He further explained staff would have seen Resident #8's oxygen was not in place and could have reapplied her oxygen and checked

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F 695	Continued From page 4 her oxygen saturation level. The DON expressed in-room oxygen concentrators should be checked on rounds and during report by nursing staff. Anything over 2 liters should be questioned by nursing staff and orders verified to ensure the setting was correct. The DON verbalized Resident #8 should have had her oxygen in place per the physician's order and been properly saturated.	F 695		