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PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 03/01/21 through 03/05/21. The survey was conducted onsite on 03/01/21 and remotely through 03/05/21. Event ID# 0CZ411. Three of five complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		3/30/21

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

Electronically Signed | 03/26/2021

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview, the facility failed to maintain a resident's dignity when a family member observed the resident during a window visit wearing no clothing, brief, or other covering and subsequently failed to respond to the family's request to cover and/or clothe the resident for a 45 minute time period. The facility also failed to respond to a family's request to reposition a resident for a 1 hour time period. This was for 1 of 1 residents (Resident #1) reviewed for dignity. The findings included: Resident #1 was admitted to the facility on 12/23/20 and most recently readmitted on 1/8/21 with multiple diagnoses that included mastoiditis (inflammation/infection of the mastoid bone located behind the ear), spinal stenosis, and diabetes mellitus type 2. Resident #1 ' s profile in the Electronic Medical Record (EMR) indicated family member #1 and family member #2 were emergency contacts.	F 550	1. Resident #1 is no longer a resident at the facility. 2. All Residents with potential to be affected were audited on 3/17/21 to ensure no other residents were noted to be without clothing, briefs, or other coverings during window visits or compassionate care visitation. No other requests from families or Responsible Parties were noted regarding appropriate positioning and untimeliness response for Activity of Daily Living assistance. 3. All nursing staff were in serviced on 3/24/21 by the Director of Nursing on the importance of ensuring that all residents were appropriately dressed in briefs and coverings as well as positioning properly. If any residents are identified to be inappropriately dress, not properly positions or in need of ADL Assistance the Staff will immediately assist. The Director of Nursing will monitor for appropriate dress, briefs, and coverings, proper positioning for all residents.	

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F 550	Continued From page 2 The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) and the mood interview were not completed. The behavior section (Section E) was also not completed. Resident #1 was assessed as requiring the limited assistance of 1 with bed mobility, transfers, dressing, toileting, and personal hygiene. Locomotion and walking had not occurred during the MDS review period. Resident #1 was occasionally incontinent of bladder. The EMR indicated that Resident #1 was discharged home at the resident and family ' s request on 1/22/21. A review of Resident #1 ' s care plan from his initial admission on 12/23/20 through his discharge on 1/22/21 revealed there was no mention of his needs related to Activity of Daily Living (ADL) care. The care plan additionally revealed no information related to behaviors for Resident #1. An interview was conducted with the Social Worker (SW) on 3/1/21 at 1:00 PM. She was asked if she was familiar with Resident #1. She revealed she had never met Resident #1 or spoken to him. She explained that he was diagnosed with COVID-19 shortly after being admitted to the facility and she had not visited with residents while they were COVID positive. She reported that she was aware that members of Resident #1 ' s family made frequent window visits when he was at the facility. The SW indicated that there was one day that family member #2 phoned the nurse ' s station and was	F 550	4. This will be monitored 4 times per week for 4 weeks. 3 times per week for 4 weeks, and 1 time per week for 4 weeks. The results of this process will be reviewed monthly in Quality Assurance Performance Improvement Meeting by the Interdisciplinary team for 3 months.	

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upset that Resident #1 was sleeping in his wheelchair and she wanted him put him in bed. She explained that family member #2 was visiting with Resident #1 from outside of the facility and observed him by window visit. The SW reported that one of the nurses, unable to recall who, had mentioned this phone call to her and that this was how she knew family member #2 was upset. She stated that after this phone call Resident #1 was transferred by nursing staff from his wheelchair to his bed within a few minutes.

A phone interview was conducted with Resident #1 ' s family member #1 on 3/2/21 at 12:19 PM. Family member #1 spoke about Resident #1 ' s history prior to being admitted to the facility. He indicated that Resident #1 was a very proud, humble, and conservative man. He stated that when he was at home he was always well dressed and neatly groomed. He indicated that during the time Resident #1 was at the facility that either he or family member #2 visited with Resident #1 by window daily. He revealed that every time he visited by window, Resident #1 was wearing a hospital gown. He stated that he had never seen Resident #1 dressed in actual clothes. Family member #1 further revealed that there was one instance in which family member #2 told him that she arrived at the facility and saw Resident #1 laying in bed fully nude through the window. He reported that this would have been very embarrassing for Resident #1. Family member #1 indicated that Resident #1 has since passed away and was unable to speak about this experience. He was asked if he had spoken to the facility about this concern. He revealed that he had not spoken specifically about this issue. He explained that he was concerned that

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complaining to the facility would cause Resident #1 to be treated in a negative manner. He further explained that there were some other concerns family member #2 had observed during her window visits so rather than bringing these concerns to the facility ' s attention he and family member #2 decided to remove Resident #1 from the facility. Family member #1 suggested that family member #2 be interviewed for additional information. He was asked if he was made aware of any behaviors for Resident #1 and he stated that he had not been made aware of any behaviors.

A phone interview was conducted with Resident #1 ' s family member #2 on 3/2/21 at 1:13 PM. She stated that there was a 4 day period from 1/15/21 through 1/18/21 that she visited Resident #1 by window daily. She reported that on Friday 1/15/21 when she arrived at the facility for the window visit she had to call the facility to request for them to open the window blinds. She indicated that on Saturday 1/16/21 when she arrived at the facility for her window visit, Resident #1 ' s blinds were open and she saw him through the window laying on his bed nude. She indicated he had nothing covering him, not even a brief. Family member #2 revealed that she phoned the facility and asked the person who answered, unable to recall who this was, to either have someone dress or cover Resident #1 as she could see from outside of his window that he was completely nude. She reported that it took 45 minutes from her first call for a staff member to enter Resident #1 ' s room and cover him. She explained that she had to call 2 additional times before a staff member attended to Resident #1 ' s needs. She stated that it was daylight outside,

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but she was unsure of the exact time of this incident and she was unable to state who the staff member was that attended to Resident #1 as she had never met any of the staff members because she was not permitted inside the facility due to their visitation restrictions. Family member #2 was asked if Resident #1 was visible to others from outside of the building. She stated that there were parking spaces outside of his room, but she had not believed Resident #1 would have been visible from the parking spaces as there was a grassy area between the parking spaces and the facility building. She reported that although others may not have seen him nude in bed, Resident #1 would have been very embarrassed for her to witness him in that condition as he was a very proud and conservative man. Family member #2 reported that on Monday 1/18/21 when she arrived at the facility for a window visit she observed Resident #1 in his wheelchair, he appeared to be sleeping, and he was "slumped over" with his head bent down towards his chest. She stated that she tried knocking on the window to get his attention, but Resident #1 was not responsive to her knocks. She indicated she phoned the facility and asked for someone to transfer him to his bed as she was afraid he was going to fall out of the wheelchair. Family member #2 revealed it took 2 additional calls during a 1 hour timeframe before a staff member entered the room to assist Resident #1. She added that during her 3rd phone call she was angry due to her previous 2 calls being ignored and she had used profanity with whoever she spoke with on the phone. She stated that after this 3rd phone call a staff member finally came to lay Resident #1 down in bed. She indicated that she was not sure who she spoke with on the phone. Family member #2

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reiterated that it was daylight outside, but she was unsure of the exact time of this incident and she was unable to state who the staff member was that attended to Resident #1 as she had never met any of the staff members.

Based on the schedule with assignments, staff working on Resident #1 ' s unit on Friday 1/16/21 during the 7:00 AM to 7:00 PM timeframe included Nurse #2, Medication Aide (MA) #2, Nursing Assistants (NA) #1, #3, #4, and #5.

A phone interview was attempted with Nurse #2 on 3/2/21 at 4:15 PM but she was unable to be reached.

A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. NA #1 stated that she worked with Resident #1 regularly when he was at the facility and she thought she was assigned to Resident #1 on Saturday 1/16/21. She stated that he needed assistance with most Activities of Daily Living (ADLs). She reported that this included dressing. She indicated that Resident #1 had a behavior of taking off his clothes and throwing them on the floor. NA #1 reported that he was sometimes dressed in a hospital gown because he normally had not removed the gown himself. The 1/16/21 incident in which Resident #1 was observed by family member #2 during a window visit to be lying in bed with no clothes, no brief, and no covering and it subsequently taking 45 minutes for staff to attend to Resident #1 was reviewed with NA #1. NA #1 revealed that she could not remember this specific incident from 1/16/21, but stated that there were times that the NAs were working "short". She explained that when they were working "short" she was still able

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to complete all of her essential assigned tasks, but it took longer to do things such as answering call bells and/or call bells were answered and the requested tasks had to be prioritized.

A phone interview was attempted with NA #3 on 3/3/21 at 1:35 PM but she was unable to be reached.

A phone interview was conducted with MA #2 on 3/3/21 at 2:05 PM. MA #2 reported that she was unable to recall anything specific about 1/16/21 and she was also unable to recall Resident #1.

A phone interview was conducted with NA #4 on 3/3/21 at 4:19 PM. NA #4 revealed she was an agency NA and she only worked at the facility for 2 days. She confirmed 1/16/21 was one of the days she worked. The 1/16/21 incident in which Resident #1 was observed by family member #2 during a window visit to be lying in bed with no clothes, no brief, and no covering and it subsequently taking 45 minutes for staff to attend to Resident #1 was reviewed with NA #4. NA #4 revealed that she could not remember this specific incident from 1/16/21, but stated that it had not surprised her that it took 45 minutes for Resident #1 to receive assistance. She explained that it was very busy that day and that although she was able to complete her essential assigned tasks, it was taking longer than she would have liked to answer call bells and complete non-emergent tasks.

A phone interview was conducted with NA #5 on 3/3/21 at 5:40 PM. NA #5 reported that she was unable to recall anything specific about 1/16/21 and she was also unable to recall Resident #1.

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Based on the schedule with assignments, staff working on Resident #1 ' s unit on Monday 1/18/21 during the 7:00 AM to 7:00 PM timeframe included Nurse #3, MA #1, NAs #1, #6, and #8.

During a phone interview with NA #1 on 3/3/21 at 8:50 AM she stated that she thought she was assigned to Resident #1 on 1/18/21. The 1/18/21 incident in which Resident #1 was observed by family member #2 during a window visit "slumped over" in his wheelchair and it subsequently taking 1 hour for staff to attend to Resident #1 was reviewed with NA #1. NA #1 revealed that she could not recall anything specific about this 1/18/21 incident. She indicated that if Resident #1 was in his wheelchair he would have required staff assistance to transfer to his bed.

A phone interview was conducted with Medication Aide (MA) #1 on 3/2/21 at 3:45 PM. The 1/18/21 incident in which Resident #1 was observed by family member #2 during a window visit "slumped over" in his wheelchair and it subsequently taking 1 hour for staff to attend to Resident #1 was reviewed with MA #1. MA #1 stated that she was aware Resident #1 ' s family made frequent window visits, but she was unable to recall this specific incident from 1/18/21 for Resident #1.

A phone interview was attempted with Nurse #3 on 3/3/21 at 11:30 AM but she was unable to be reached.

A phone interview was conducted with NA #6 on 3/3/21 at 9:30 AM. NA #6 reported that she was unable to recall anything specific about 1/18/21 and she was also unable to recall Resident #1.

A phone interview was conducted with NA #8 on

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F 550	Continued From page 9 3/3/21 at 5:20 PM. The 1/18/21 incident in which Resident #1 was observed by family member #2 during a window visit "slumped over" in his wheelchair and it subsequently taking 1 hour for staff to attend to Resident #1 was reviewed with NA #8. NA #8 reported that she was unable to recall this specific incident from 1/18/21 for Resident #1. She indicated that there were days that the NAs were working "short" and that although she was able to complete all of her assigned essential tasks it took longer than she would ' ve liked to answer call bells and/or call bells were answered and the requested tasks had to be prioritized. During a phone interview with the Administrator on 3/4/20 at 3:40 PM the 1/16/21 and 1/18/21 incidents for Resident #1 were reviewed with the Administrator. The Administrator stated that although he was unable to validate the response times reported by family member #2 for both incident dates (1/16/21: 45 minute response time and 1/18/21: 1 hour response time) that he would have expected staff to respond to the resident ' s needs as identified by family member #2 within 10 to 20 minutes depending on what other events were going on at the facility during that time. He indicated that he expected the facility residents to be treated with dignity and respect at all times.	F 550		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.	F 563		3/30/21

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F 563	Continued From page 10 (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview, the facility failed to honor a resident's right for compassionate care visitation in accordance with guidance from the Centers for Medicare and Medicaid Services (QSO-20-39-NH) and the facility's COVID-19 Visitation Policy for 1 of 1 residents reviewed for compassionate care visitation (Resident #1). The findings included: A Centers for Medicare and Medicaid Services (CMS) memo (QSO-20-39-NH) dated 9/17/20 titled "Nursing Home Visitation - COVID-19"	F 563	1. Resident #1 is no longer a resident at the facility. 2. All Residents with potential to be affected were audited. No other residents were affected. All Residents and families were notified Via Phone about compassionate care visitations in accordance with guidance from the Centers for Medicare and Medicaid Services (QSO-20-39-NH) and the facilities current visitation policy. 3. The Administrator was instructed about	

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F 563	Continued From page 11 included, in part, the following information under the heading of "Compassionate Care Visits": While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to: - A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support. - A resident who is grieving after a friend or family member recently passed away. - A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration. - A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past). Allowing a visit in these situations would be consistent with the intent of, "compassionate care situations" ... Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. A review of the facility ' s policy titled "COVID 19 Visitation Policy" last reviewed and reviewed on 9/29/20 under the heading of "Compassionate Care Visits" replicated the above information from the CMS memo dated 9/17/20 (QSO-20-39-NH). Resident #1 was admitted to the facility on 12/23/20 and most recently readmitted on 1/8/21 with multiple diagnoses that included mastoiditis (inflammation/infection of the mastoid bone	F 563	the compassionate care visitation during the weekly co-vid call updates. The administrator in-serviced The Interdisciplinary team which includes Director of Nursing,Social Services Director,Dietary manager, Activity Director, Business Office Manager, Rehabilitation Director, Medical Records Director, Housekeeping Director,and Minimum Data Set Nurse on compassionate care guidelines on 3/5/21. The Staff Development/Unit manager and Director of Nursing completed in-servicing of all nursing staff on compassionate care/current visitation guidelines. All residents responsible party will be notified upon Admission of the Compassionate care/visitation process. This will also be reviewed in the 72 hour/Care Plan Meetings. 4. The Social Services Director will call/coordinate the compassionate care/visitation process. This will be monitored 4 times per week for 4 weeks. 3 times per week for 4 weeks, and 1 time per week for 4 weeks. The results of this process will be reviewed monthly in Quality Assurance Performance Improvement Meeting by the Interdisciplinary team for 3 months.	

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located behind the ear), spinal stenosis, and diabetes mellitus type 2.

Resident #1 ' s care plan included, in part, the focus are of the risk for alteration in psychosocial well-being related to restriction on visitation due to COVID-19. This area was initiated on 12/24/20 and included the following interventions, also all initiated on 12/24/20: contact isolation related to new admission; encourage alternative communication with visitors; monitor for psychosocial changes; observe and report any changes in mental status caused by situational stressors; and provide opportunities for expression of feelings related to situational stressors.

The 5 day Minimum Data Set (MDS) assessment dated 12/27/20 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) and mood interview were not completed. The behavior section (Section E) was also not completed.

The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated Resident #1 had clear speech, was understood by others and understands others. The BIMS and the mood interview were not completed. The behavior section (Section E) was also not completed.

A review of the facility ' s COVID-19 testing log revealed Resident #1 tested positive for COVID-19 on 1/13/21.

A Social Worker (SW) note dated 1/18/21 indicated she was contacted by Resident #1 ' s family member #1 who reported he wished to

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discharge the resident to his home. A care plan meeting was scheduled for 1/19/21 to discuss discharge planning.

A SW note dated 1/19/21 indicated a care plan meeting was conducted for Resident #1 and family member #1 attended by phone and discharge planning was discussed.

A SW note dated 1/21/21 indicated she spoke with Resident #1 ' s family member and he wished to have Resident #1 discharged to his home on 1/22/21.

A nursing note dated 1/22/21 indicated Resident #1 was discharged home with family member #1. The nurse wrote that Resident #1 was happy and excited to be returning home.

An interview was conducted with the SW on 3/1/21 at 1:00 PM. She was asked what the facility ' s protocol was for compassionate care visits. She stated that the facility was only permitting indoor visitation for residents who were at the very end of life/actively dying. She revealed there were no other residents permitted to have compassionate care visits. The SW was asked if she was aware what the CMS guidance was for compassionate care visits and she indicated that she was not familiar with this information. The SW was asked if she was familiar with the facility ' s policy for compassionate care visits and she revealed she was not certain what this policy said. She reiterated that the facility was only permitting compassionate care visits for residents who were at the very end of life. She added that families who voiced an interest in visitation were told that they could have outdoor visitation. She

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acknowledged that outdoor visitation during the winter could be challenging due to inclement weather and cold temperatures.

This interview with the SW continued. She was asked if she was familiar with Resident #1. She revealed she had never met Resident #1 or spoken to him. She explained that he was diagnosed with COVID-19 shortly after being admitted to the facility and she had not visited with residents while they were COVID positive. The SW revealed that she had not completed a BIMS nor had she completed a mood interview for Resident #1 so she was unable to speak to his cognitive abilities or his mood state. The SW acknowledged that since she had never seen or spoken to Resident #1 she was unable to determine how he was adjusting to the facility. She reported that she was aware that his family was very involved with his care decisions and that they made frequent window visits while he was at the facility. The SW was asked if Resident #1 ' s family had ever requested an indoor compassionate care visit with the resident. She stated that they had not specifically asked this question, but that even if they had asked, it would not have been permitted as he was not actively dying. The SW was asked why Resident #1 ' s family had chosen to discharge him home prior to the completion of rehabilitation and she indicated she was not certain of the reason.

A phone interview was conducted with Resident #1 ' s family member #1 on 3/2/21 at 12:19 PM. He reported that Resident #1 was not in favor of going to the facility for rehabilitation, but he had been talked into it by the family. He indicated that either he or family member #2 visited with Resident #1 by window daily. He stated that

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Resident #1 had difficulty adjusting to the facility as he had wanted to be at home. Family member #1 stated that the SW told him that outdoor visitation was an option, but he had not wanted to make Resident #1 come outside during the winter weather conditions. He indicated that he had not known the CMS guidance allowed for indoor compassionate care visits so he had never asked anyone at the facility if he could visit with Resident #1 inside. Family #1 reported that while at the facility, Resident #1 had a decline in nutritional intake and that he appeared "sad" during all of his visits. He explained that this was part of the reason he and family member #2 made the decision to discharge Resident #1 home prior to the completion of rehabilitation.

A phone interview was conducted with Resident #1 ' s family member #2 on 3/2/21 at 1:13 PM. She reported that Resident #1 was not in favor of going to the facility for rehabilitation, but he had been talked into it by the family. She indicated that either she or family member #1 visited with Resident #1 by window daily. She reported that Resident #1 had difficulty adjusting to the facility as he had wanted to be at home. She stated that there was a 4 day period from 1/15/21 through 1/18/21 that she visited daily and had observed a meal during each observation and that Resident #1 had consumed only a butter packet and a glass of milk throughout the entirety of these 4 meal observations. She reported that she was trying to yell through the window encouraging words to try to get him to eat, but she was unsure if Resident #1 could even hear her. Family member #2 further reported that on one of these window visits she observed Resident #1 seated in his wheelchair "sobbing" and again she was trying to yell comforting words to him through the

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window. Family member #2 stated that family member #1 had been in touch with the SW and was told that outdoor visitation was an option, but they (the family) had not thought it was a good idea to make Resident #1 come outside during the winter weather conditions. She indicated that she had not known the CMS guidance allowed for indoor compassionate care visits so she had never asked anyone at the facility if she could visit with Resident #1 inside.

During an interview with the Administrator on 3/1/21 at 12:14 PM he was asked what the facility ' s policy was regarding compassionate care visits. He indicated that he needed to review the policy prior to speaking about it.

A second interview was conducted with the Administrator on 3/1/21 at 2:00 PM. The Administrator stated that the facility was permitting indoor compassionate care visits for residents who were actively dying. He revealed that they had permitted no other compassionate care visits. The facility ' s policy and the CMS guidance which both stated that compassionate care situations had not exclusively referred to end of life situations were reviewed with the Administrator. The Administrator reported that he was aware the guidance related to visitation allowed for compassionate care visits if necessary for reasons other than end of life. He indicated that the facility had no residents who had requested a compassionate care visit and no residents who were determined to require a compassionate care visit. The Administrator was asked who determined if a resident required a compassionate care visit. He was unable to explain this process.

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F 563	Continued From page 17 The Administrator requested to speak about compassionate care visits again on 3/1/21 at 2:45 PM. He reported that after speaking with staff he learned that care plan meetings were the time that it was determined if a compassionate care visit was determined to be necessary. He indicated that the SW was in charge of the care plan meetings. The interview with the SW conducted on 3/1/21 at 1:00 PM in which she stated that facility ' s protocol was to permit compassionate care visits only for residents who were at the end of life was reviewed with the Administrator. He acknowledged that up through this date, 3/1/21, there had been no compassionate care visits conducted for any reason other than end of life. A phone interview was conducted with Medication Aide (MA) #1 on 3/2/21 at 3:45 PM. She reported that she was familiar with Resident #1. She indicated that he was at the facility for short term rehabilitation and that he was alert and oriented with some periods of confusion. MA #1 stated that his family visited frequently by window visit while he was at the facility. She revealed that the facility was not permitting any indoor visitation for any residents unless they were actively dying. During a follow up interview with the Administrator by phone on 3/4/20 at 3:40 PM he stated that he expected the CMS guidance related to compassionate care visits to be followed.	F 563		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		3/30/21

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consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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F 580	Continued From page 19 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, staff, physician, and Registered Dietician, the facility failed to notify a resident ' s representative of a change in condition that included an altered mental status requiring hospitalization and also failed to notify the physician of a significant decline in nutritional intake with multiple meal refusals for 1 of 1 residents (Resident #1) reviewed for notification of changes. The findings included: 1. Resident #1 was admitted to the facility on 12/23/20 and most recently readmitted on 1/8/21 with multiple diagnoses that included mastoiditis (inflammation/infection of the mastoid bone located behind the ear), spinal stenosis, and diabetes mellitus type 2. 1a. Resident #1 ' s profile in the Electronic Medical Record (EMR) indicated he was his own Responsible Party (RP). Family member #1 was listed as emergency contact #1 and family member #2 was listed as emergency contact #2. The 5 day Minimum Data Set (MDS) assessment dated 12/27/20 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) was not completed.	F 580	1. Resident #1 is no longer a resident at the facility. 2. All Residents with the potential to be affected were audited on 3/20/21 By The Minimum Data set Nurse to verify if there was any significant change. No residents were found to have experienced a significant change. 3. 100% of staff were in-serviced on 3/24/21 by Director of Nursing about notifying families and responsible parties when change in condition is current. All residents who have a significant change of conditions Responsible Party and Medical Director will be notified by the unit nurse. The Director of Nursing will monitor the process of responsible parties being notified of significant changes. This monitoring will be reviewed in daily morning clinical meetings and as needed. 4. This will be monitored 4 times per week for 4 weeks. 3 times per week for 4 weeks, and 1 time per week for 4 weeks. The results of this process will be reviewed monthly in Quality Assurance Performance Improvement Meeting by the Interdisciplinary team for 3 months.	

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A Nursing Note dated 12/27/20 completed by Nurse #1 indicated Resident #1 had confusion during the day which continued to increase. He was noted with a decrease in response. The on call physician was notified and an order was received to send Resident #1 to the Emergency Department (ED) for evaluation. Emergency Medical Services (EMS) came to the facility and transported Resident #1 to the hospital.

A hospital transfer summary form dated 12/27/20 at 11:16 PM completed by Nurse #1 indicated Resident #1 was being sent to the hospital for altered mental status. This form had a section titled "Key Contacts" and listed Resident #1 as the key contact and indicated he, himself, was notified of the transfer to the hospital. There were no other family members noted on the form who were notified of the hospital transfer.

A phone interview was conducted with the Social Worker on 3/1/21 at 1:00 PM. She revealed that she had never met Resident #1 in person and could not speak to his cognition. She indicated that he had 2 family members, family member #1 and family member #2, who were involved with his care decisions and that she kept in contact with family member #1 for any necessary notifications such as COVID-19 information.

A phone interview was conducted on 3/2/21 at 12:19 PM with Resident #1 ' s family member #1. He stated that he was the primary contact for Resident #1 and that facility staff normally notified him of information pertaining to Resident #1 by phone. He revealed that he was not notified of Resident #1 ' s transfer to the hospital on 12/27/20. He reported that on the following day,

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he was with family member #2 and they phoned the facility in the late afternoon/early evening to speak with Resident #1 and they were told he wasn ' t there because he was sent to the hospital. Family member #1 stated that he felt he or family member #2 should have been contacted as Resident #1 was not in a condition where he, himself, could have notified his family.

A phone interview was conducted on 3/2/21 at 1:13 PM with Resident #1 ' s family member #2. She confirmed family member #1 ' s statement that they had not been notified of Resident #1 ' s transfer to the hospital on 12/27/20. She additionally confirmed that on the following day, she was with family member #1 and they called the facility to speak with Resident #1 and were told he had been sent to the hospital. Family member #2 stated that she felt she or family member #1 should have been contacted as Resident #1 was not in a condition where he, himself, could have notified his family.

A phone interview was conducted with Nurse #1 on 3/2/21 at 1:50 PM. Nurse #1 stated she had no recollection of Resident #1. Her notes from 12/27/20 were reviewed with her. She reported that although she could not recall this resident, that normally if there was a family member involved with the resident who was listed as an emergency contact, that she notified that family member regardless of the resident ' s cognition at the time of the transfer. Nurse #1 indicated that if she had notified Resident #1 ' s family member of the transfer to the hospital that she would have noted this on the hospital transfer summary form. She was unable to explain why she had not notified Resident #1 ' s family member #1 or family member #2.

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A phone interview was conducted with the Administrator on 3/4/21 at 3:40 PM. He was asked what the facility ' s protocol was for notification of family when a resident who was cognitively intact was sent to the hospital for a change in mental status that included increased confusion and decreased responsiveness. The Administrator indicated the facility ' s protocol was for a designated family member to be notified of significant changes in the resident ' s health status, such as hospital transfers, because the resident may not be able to notify them personally. He further indicated that Nurse #1 should have notified Resident #1 ' s family member #1 when he was transferred to the hospital on 12/27/21.

1b. The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) was not completed. The behavior section (Section E) was also not completed. Resident #1 was assessed as independent with set up assistance only for eating. He was 182 pounds with no significant weight loss noted.

The Care Area Assessment (CAA) related to nutrition for the 1/12/21 MDS indicated Resident #1 was on a therapeutic diet which could affect his meal intake, he had a high Body Mass Index (BMI) and was currently eating less than 75 percent (%) most of the time. He was to be care planned for nutrition due to low meal intake and the risk for unplanned weight loss. Resident #1 was also to be referred to the Registered

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Dietician (RD) due to low meal intake.

Resident #1 ' s care plan included the focus area of a nutritional problem related to meal intake less than 75% and the risk for weight loss. This area was initiated and last revised on 1/13/21. The interventions, initiated on 1/13/21, included: monitoring/documenting/reporting as needed any signs or symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearance of being concerned during meals; and provide/serve diet as ordered and monitor nutritional intake and record every meal.
A Registered Dietician (RD) note dated 1/11/21 indicated Resident #1 was on a regular-textured no added salt diet with thin liquids and he was consuming approximately 26-100% of meals. He ate independently and had no chewing/swallowing difficulties noted.

An Occupational Therapy (OT) note dated 1/15/21 indicated Resident #1 ' s lunch meal was on his tray table and he stated he had no appetite to eat.

A nursing note dated 1/16/21 completed by Nurse #2 indicated Resident had no appetite to eat, but he drank fluids.

A review of Resident #1 ' s physician ' s orders from 1/8/21 through 1/22/21 indicated he was on a regular, no added salt diet, and he was ordered no nutritional supplements.

Resident #1 ' s nutritional intake documentation from 1/8/21 through 1/22/21 was reviewed and revealed a decline in nutritional intake resulting in

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	345520	A. BUILDING _____ B. WING _____	C 03/05/2021

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PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

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little to no oral intake with no nutritional supplementation from the dinner meal on 1/15/21 through the dinner meal on 1/18/21. The Nursing Assistant (NA) nutritional intake documentation revealed the following:

- 1/15/21 resident refused dinner
- 1/16/21 resident refused breakfast and lunch and there was no documentation of dinner intake
- 1/17/21 there was no documentation of breakfast or lunch intake and he consumed 0-25% of dinner
- 1/18/21 he consumed 0-25% of breakfast and there was no documentation of lunch or dinner intake

A phone interview was conducted with Resident #1 ' s family member #2 on 3/2/21 at 1:13 PM. She stated that she completed window visits daily from 1/15/21 through 1/18/21 and observed a meal during each observation. She reported that Resident #1 consumed little to nothing during each meal she observed. She indicated that one meal she saw him eat only a butter packet and on a separate meal he drank his milk and ate no food.

A phone interview was attempted with Nurse #2 on 3/2/21 at 4:15 PM but she was unable to be reached.

Based on the schedule and assignment information provided by the Administrator on 3/4/21 at 1:31 PM NA #1 was assigned to Resident #1 on 1/15/21, 1/16/21, and 1/18/21. NA #2 was assigned to Resident #1 on 1/17/21.

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A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for Resident #1 were reviewed with NA #1. NA #1 indicated she had no recollection of documenting meal refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake on 1/16/21 or lunch and dinner on 1/18/21. NA #1 was asked if she informed the nurse and/or MA on the unit of Resident #1 ' s poor nutritional intake and she reported that she thought she had mentioned this to the nurse or MA, but she was unable to recall with certainty.

A phone interview was conducted with NA #2 on 3/3/21 at 5:34 PM. He reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #2 stated that he was unable to recall Resident #1. He added that assignments frequently changed and he may have only worked with this resident once or twice as he was agency staff. The nutritional intake documentation from 1/17/21 for Resident #1 were reviewed with NA #2. He indicated that there were times that he was very busy with his tasks on the floor and he was

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unable to complete his documentation. He was unable to recall if he reported Resident #1 ' s poor nutritional intake on 1/17/21 to the nurse or MA on the unit.

Based on the Medication Administration Record (MAR) the following Nurses/Medication Aides (MAs) worked with Resident #1 from 1/15/21 through 1/18/21:
- 1/15/21: MA #1
- 1/16/21: Nurse #3
- 1/17/21: Nurse #4
- 1/18/21: MA #1

A phone interview was conducted with MA #1 on 3/2/21 at 3:45 PM. MA #1 stated she was familiar with Resident #1 and recalled a few times when his assigned NA reported that he ate little to no food during a meal. She stated that after she was made aware of this information she normally relayed the information to one of the nurses who were working. She added that there were a lot of agency nurses working at the facility during that time period and she was unable to recall who she spoke with.

A phone interview was attempted with Nurse #3 on 3/3/21 at 11:30 AM and she was unable to be reached.

A phone interview was attempted with Nurse #4 on 3/3/21 at 9:13 AM and he was unable to be reached.

A phone interview was conducted with the Dietary Manager (DM) on 3/2/21 at 2:50 PM. She was asked if she had been made aware of Resident #1 ' s minimal oral intake from the dinner meal on 1/15/21 through the dinner meal on 1/18/21. The

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DM indicated that during this timeframe she was out sick so she was unaware of this information.

A phone interview was conducted with the RD on 3/2/21 at 2:35 PM. She was asked if she had been made aware of Resident #1 ' s minimal oral intake from the dinner meal on 1/15/21 through the dinner meal on 1/18/21. She indicated that she had not been made aware of this information. The RD reported that if she had been made aware of this information she could have reassessed the resident and possibly would ' ve added a nutritional supplement to increase Resident #1 ' s caloric intake.

A phone interview was conducted with Resident #1 ' s physician on 3/2/21 at 3:23 PM. She was asked if she had been made aware of Resident #1 ' s minimal oral intake from the dinner meal on 1/15/21 through the dinner meal on 1/18/21. The physician stated that she had not been informed of this information. She reported that she expected to be notified of this information and that normally the staff would share this type of information with her so she could reassess the resident and determine if any changes were necessary with his plan of care.

A phone interview was conducted with the Administrator on 3/4/21 at 3:40 PM. During this interview the NA documentation of nutritional intake for Resident #1 from 1/15/21 through 1/18/21 was reviewed with the Administrator. He indicated that he would have expected the physician and/or the RD to be made aware of repeat meal refusals as well as minimal oral intake for multiple days in a row.