STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite 2/14/22 through 2/16/22 and offsite on 2/17/22. 8 of 15 complaint allegations were substantiated and cited.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 636		2/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2022

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 636	Continued From page 1 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an annual Minimum Data Set (MDS) for 1of 2 sampled residents reviewed for MDS accuracy. (Resident #63) Findings included: Resident #63 was admitted on 9/3/2020. Review of Resident #63's medical record on	F 636	1) On 2/22/22, the Minimum Data Set (MDS) nurse completed annual MDS assessment with Assessment Reference Date (ARD) of 1/7/22 for Resident #63. 2) On 2/23/22, the MDS nurse completed an audit of current residents with scheduled comprehensive MDS assessments to identify those not completed timely as scheduled. All MDS	

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	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 636	Continued From page 2 2/15/22 revealed an incomplete annual MDS with Assessment Reference Date (ARD) of 1/7/22. During an interview on 2/15/22 at 4:25 PM, the MDS Nurse revealed the facility was behind on assessments when she was hired. She explained she completed the newer assessments first and then the late assessments. During an interview on 2/15/22 at 2:57 PM, the Administrator stated she was aware of the incomplete MDS assessments. A new MDS nurse was in the position and priority was given to completing the admission assessments. The Administrator stated she expected MDS assessments to be completed on time. During an interview on 2/15/22 at 4:00 PM, the Consultant Nurse stated she was aware the facility was behind on assessments. The Consultant Nurse explained the plan of correction the facility put into place had not been fully implemented. She further explained the facility was actively recruiting for an additional MDS Nurse.	F 636	assessments identified were completed by the facility MDS nurse and Regional MDS nurse by 2/24/22. 3) On 2/18/22, the Regional MDS nurse provided education to the facility MDS nurse, Activities Director, Dietary Manager and Social Worker on completing comprehensive MDS assessments (admission, annual and readmission if significant change in condition) within 14 calendar days per Resident Assessment Instrument (RAI) guidelines. Newly hired MDS nurses, Activities Directors, Dietary Managers and Social Workers will receive education during orientation and will not work until education completed. 4) The Director of Nursing or designee will monitor comprehensive MDS assessments for timeliness and completion 2 times weekly for 4 weeks; then 1 time weekly for 8 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with completing comprehensive MDS assessments within 14 days. 5) Completion Date: 2/24/22	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State	F 638		2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 638 Continued From page 3
and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 7 of 7 sampled residents reviewed (Residents #1, #8, #66, #5, #78, #43 and #80).

The findings included:

1. Resident #1 was admitted to the facility on 10/31/20.

Review of Resident #1's electronic medical record revealed the most recent MDS assessment was coded as a quarterly MDS with an Assessment Reference Date (ARD) of 1/5/22. The MDS assessment was marked with a status of "in progress."

An interview with the MDS Coordinator on 2/15/22 at 4:25 PM revealed she just started working at the facility on 1/12/22 and was currently orienting for her position. She stated the assessments were behind when she was hired. She also stated she had been completing late assessments as best as she could with the exception of admission assessments which needed to be completed as soon as possible.

A phone interview with the Regional MDS Consultant on 2/15/22 at 4:00 PM revealed she had been aware that the facility was behind on assessments since the end of January 2022. She stated that the plan the facility had put into

F 638

1) Effective 2/24/22, the Minimum Data Set (MDS) nurse completed quarterly MDS assessments for the following cited residents: 1) Assessment Reference Date (ARD) of 1/5/22 for Resident #1, 2) ARD of 1/13/22 for Resident #8, 3) ARD of 1/15/22 for Resident #66, 4) ARD of 1/6/22 for Resident #5, 5) ARD of 1/22/22 for Resident #78, 6) ARD of 1/4/22 for Resident #43, and 7) ARD of 1/14/22 for Resident #80.

2) On 2/22/22, the MDS nurse completed an audit of current residents with scheduled quarterly MDS assessments to identify those not completed timely as scheduled. All MDS assessments identified were completed by the facility MDS nurse and Regional MDS nurse by 2/24/22.

3) On 2/18/22, the Regional MDS nurse provided education to the facility MDS nurse, Activities Director, Dietary Manager and Social Worker on completing quarterly MDS assessments within timeframe per Resident Assessment Instrument (RAI) guidelines. Newly hired MDS nurses, Activities Directors, Dietary Managers and Social Workers will receive education during orientation and will not work until education completed.

4) The Director of Nursing or designee will monitor quarterly MDS assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ____ B. WING ____	C 02/17/2022

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F 638	Continued From page 4 place had not been fully implemented. The facility was actively recruiting for another MDS nurse and utilized traveling MDS nurses at times. She added that whenever she was available to come to the facility, she assisted the MDS Coordinator as needed. An interview with the Administrator on 2/15/22 at 3:25 PM revealed the assessments should be completed in the designated timeframe per the RAI manual. She stated the previous MDS nurse retired at the end of December 2021 and remained as needed 2 to 3 days per week through January 2022. She stated the facility had put a plan in place related to late assessments, but this had not been fully implemented. 2. Resident #8 was admitted to the facility on 3/4/20. Review of Resident #8's electronic medical record revealed the most recent MDS assessment was coded as a quarterly MDS with an Assessment Reference Date (ARD) of 1/13/22. The MDS assessment was marked with a status of "in progress." An interview with the MDS Coordinator on 2/15/22 at 4:25 PM revealed she just started working at the facility on 1/12/22 and was currently orienting for her position. She stated the assessments were behind when she was hired. She also stated she had been completing late assessments as best as she could with the exception of admission assessments which needed to be completed as soon as possible. A phone interview with the Regional MDS Consultant on 2/15/22 at 4:00 PM revealed she	F 638	for timeliness and completion 2 times weekly for 4 weeks; then 1 time weekly for 8 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with completing quarterly MDS assessments within 14 days. 5) Completion Date: 2/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 5	F 638		

had been aware that the facility was behind on assessments since the end of January 2022. She stated that the plan the facility had put into place had not been fully implemented. The facility was actively recruiting for another MDS nurse and utilized traveling MDS nurses at times. She added that whenever she was available to come to the facility, she assisted the MDS Coordinator as needed.

An interview with the Administrator on 2/15/22 at 3:25 PM revealed the assessments should be completed in the designated timeframe per the RAI manual. She stated the previous MDS nurse retired at the end of December 2021 and remained as needed 2 to 3 days per week through January 2022. She stated the facility had put a plan in place related to late assessments, but this had not been fully implemented.

3. Resident #66 was admitted to the facility on 6/9/21.

Review of Resident #66's electronic medical record revealed the most recent MDS assessment was coded as a quarterly MDS with an Assessment Reference Date (ARD) of 1/15/22. The MDS assessment was marked with a status of "in progress."

An interview with the MDS Coordinator on 2/15/22 at 4:25 PM revealed she just started working at the facility on 1/12/22 and was currently orienting for her position. She stated the assessments were behind when she was hired. She also stated she had been completing late assessments as best as she could with the exception of admission assessments which needed to be completed as soon as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 6	F 638		

A phone interview with the Regional MDS Consultant on 2/15/22 at 4:00 PM revealed she had been aware that the facility was behind on assessments since the end of January 2022. She stated that the plan the facility had put into place had not been fully implemented. The facility was actively recruiting for another MDS nurse and utilized traveling MDS nurses at times. She added that whenever she was available to come to the facility, she assisted the MDS Coordinator as needed.

An interview with the Administrator on 2/15/22 at 3:25 PM revealed the assessments should be completed in the designated timeframe per the RAI manual. She stated the previous MDS nurse retired at the end of December 2021 and remained as needed 2 to 3 days per week through January 2022. She stated the facility had put a plan in place related to late assessments, but this had not been fully implemented.

4. Resident #5 was admitted to the facility on 7/19/21.

A review of the electronic medical record (EMR) on 2/14/22 at 11:00 AM for Resident #5 revealed a quarterly MDS assessment was completed 10/26/21. Further review of the EMR revealed the next quarterly MDS dated 1/16/22 was "in progress."

An interview with the MDS Coordinator on 2/15/22 at 4:25 PM revealed she just started working at the facility on 1/12/22 and was currently orienting for her position. She stated the assessments were behind when she was hired. She also stated she had been completing late

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ____ B. WING ____	C 02/17/2022

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F 638	Continued From page 7	F 638		

assessments as best as she could with the exception of admission assessments which needed to be completed as soon as possible.

A phone interview with the Regional MDS Consultant on 2/15/22 at 4:00 PM revealed she had been aware that the facility was behind on assessments since the end of January 2022. She stated that the plan the facility had put into place had not been fully implemented. The facility was actively recruiting for another MDS nurse and utilized traveling MDS nurses at times. She added that whenever she was available to come to the facility, she assisted the MDS Coordinator as needed.

An interview with the Administrator on 2/15/22 at 3:25 PM revealed the assessments should be completed in the designated timeframe per the RAI manual. She stated the previous MDS nurse retired at the end of December 2021 and remained as needed 2 to 3 days per week through January 2022. She stated the facility had put a plan in place related to late assessments, but this had not been fully implemented.

5. Resident #78 was admitted to the facility on 6/9/20.

A review of the EMR for Resident #78 on 2/14/22 at 1:00 PM revealed a quarterly MDS assessment was completed on 10/22/21. Further review of the EMR revealed the next quarterly MDS dated 1/22/22 was "in progress."

An interview with the MDS Coordinator on 2/15/22 at 4:25 PM revealed she just started working at the facility on 1/12/22 and was currently orienting for her position. She stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 638		F 638		

Continued From page 8
assessments were behind when she was hired. She also stated she had been completing late assessments as best as she could with the exception of admission assessments which needed to be completed as soon as possible.

A phone interview with the Regional MDS Consultant on 2/15/22 at 4:00 PM revealed she had been aware that the facility was behind on assessments since the end of January 2022. She stated that the plan the facility had put into place had not been fully implemented. The facility was actively recruiting for another MDS nurse and utilized traveling MDS nurses at times. She added that whenever she was available to come to the facility, she assisted the MDS Coordinator as needed.

An interview with the Administrator on 2/15/22 at 3:25 PM revealed the assessments should be completed in the designated timeframe per the RAI manual. She stated the previous MDS nurse retired at the end of December 2021 and remained as needed 2 to 3 days per week through January 2022. She stated the facility had put a plan in place related to late assessments, but this had not been fully implemented.

6. Resident #43 was admitted on 8/27/21.

Review of Resident #43's electronic medical record revealed an incomplete quarterly MDS assessment with an ARD of 1/4/22. At the time of the review 2/15/22, the quarterly MDS was 28 days past due.

During an interview on 2/15/22 at 2:57 PM, the Administrator stated she was aware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 638	Continued From page 9	F 638		

incomplete MDS assessments. A new MDS nurse was in the position and priority was given to completing the admission assessments. The Administrator stated she expected MDS assessments to be completed on time.

During an interview on 2/15/22 at 4:00 PM, the Consultant Nurse stated she was aware the facility was behind on assessments. The Consultant Nurse explained the plan of correction the facility put into place had not been fully implemented. She further explained the facility was actively recruiting for an additional MDS Nurse.

During an interview on 2/15/22 at 4:25 PM, the MDS Nurse revealed the facility was behind on assessments when she was hired. She explained she completed the newer assessments first and then the late assessments.

7. Resident #80 was admitted on 1/24/21.

Review of Resident #80's electronic medical record revealed an incomplete MDS assessment with an ARD of 1/24/22. At the time of the review on 2/15/22, the quarterly MDS was past due.

During an interview on 2/15/22 at 2:57 PM, the Administrator stated she was aware of the incomplete MDS assessments. A new MDS nurse was in the position and priority was given to completing the admission assessments. The Administrator stated she expected MDS assessments to be completed on time.

During an interview on 2/15/22 at 4:00 PM, the Consultant Nurse stated she was aware the facility was behind on assessments. The

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	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 638	Continued From page 10 Consultant Nurse explained the plan of correction the facility put into place had not been fully implemented. She further explained the facility was actively recruiting for an additional MDS Nurse. During an interview on 2/15/22 at 4:25 PM, the MDS Nurse revealed the facility was behind on assessments when she was hired. She explained she completed the newer assessments first and then the late assessments.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect a pressure ulcer for 1 of 3 residents (Resident #8) reviewed for wound care. The findings included: Resident #8 was admitted to the facility on 3/4/20 with diagnoses that included dementia, diabetes, and chronic kidney disease. Resident #8's care plan initiated on 3/28/21 indicated Resident #8 was at risk for impaired skin integrity due to bowel and bladder incontinence, decreased and impaired mobility and diabetes. Interventions included to administer treatments as ordered and to monitor for effectiveness.	F 641	1) On 2/17/22, the Minimum Data Set (MDS) nurse modified and resubmitted MDS assessment with Assessment Reference Date (ARD) of 12/29/22 for Resident #8 to accurately reflect pressure wound. 2) On 2/22/22, the Regional MDS Nurse and the wound nurse completed an audit of current residents with pressure wounds to ensure most recently submitted MDS assessment was properly coded to reflect pressure wound. Resident #334 MDS assessment with ARD of 11/17/21 was modified and resubmitted by the facility MDS nurse on 2/17/22. 3) On 2/18/22, the Regional MDS nurse provided education to the facility MDS	2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 641

Continued From page 11

A review of the Weekly Pressure Wound Observation Tool dated 12/16/21 for Resident #8 revealed an unstageable pressure ulcer to the left heel was identified on 12/15/21. The wound was covered with 100% necrosis and measured 4.5 cm (centimeters) in length, 7 cm in width and 0 cm in depth.

The most recent Minimum Data Set (MDS) assessment was a discharge return anticipated MDS dated 12/29/21 and it indicated Resident #8 was severely cognitively impaired, required extensive physical assistance with bed mobility and did not have any pressure ulcers/injuries.

A phone interview with the previous MDS Coordinator on 2/16/22 at 3:50 PM revealed she couldn't remember enough about what had happened when she completed Resident #8's discharge MDS. She couldn't remember if she had been aware of Resident #8's pressure ulcer and stated that if she had, she would have indicated it in her MDS assessment. She also stated she usually reviewed wound assessments and skin assessments in the medical record and could not remember how she missed Resident #8's pressure ulcer.

A phone interview with the wound nurse on 2/17/22 at 11:05 AM revealed she did not know why the previous MDS Coordinator had not been aware of Resident #8's pressure ulcer because her wound assessments were in her medical record.

An interview with the Director of Nursing on 2/16/22 at 2:14 PM revealed that she did not know why the previous MDS Coordinator did not

F 641

nurse, Activities Director, Dietary Manager and Social Worker on accurately coding residents with pressure wounds when completing MDS assessments (admission, annual and readmission if significant change in condition) within 14 calendar days per Resident Assessment Instrument (RAI) guidelines. Newly hired MDS nurses, Activities Directors, Dietary Managers and Social Workers will receive education during orientation and will not work until education completed.

4) The Director of Nursing or designee will monitor submitted MDS assessments for accuracy of coding residents with pressure wounds 2 times weekly for 4 weeks; then 1 time weekly for 8 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with accurately coding resident MDS assessments for pressure wounds.

5) Completion Date: 2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 12 indicate Resident #8's pressure ulcer in her MDS but she should have if it was identified prior to the MDS date.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the care plan to reflect pressure ulcer care for 1 of 3 residents (Resident	F 657	1) On 2/21/22, the Minimum Data Set (MDS) nurse reviewed and revised Resident #8 care plan to reflect pressure	2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345134	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/17/2022

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F 657	Continued From page 13	F 657		

#8) reviewed for pressure ulcers.

The findings included:

Resident #8 was admitted to the facility on 3/4/20 with diagnoses that included dementia, diabetes, and chronic kidney disease.

Resident #8's care plan initiated on 3/28/21 indicated Resident #8 was at risk for impaired skin integrity due to bowel and bladder incontinence, decreased and impaired mobility and diabetes. Interventions included to administer treatments as ordered and to monitor for effectiveness. The care plan was marked as overdue and had not been revised since 3/28/21.

A review of the Weekly Pressure Wound Observation Tool dated 12/16/21 for Resident #8 revealed an unstageable pressure ulcer to the left heel was identified on 12/15/21. The wound was covered with 100% necrosis and measured 4.5 cm (centimeters) in length, 7 cm in width and 0 cm in depth.

The most recent Minimum Data Set (MDS) assessment was a discharge return anticipated MDS dated 12/29/21 and it indicated Resident #8 was severely cognitively impaired, required extensive physical assistance with bed mobility and did not have any pressure ulcers/injuries.

A phone interview with the previous MDS Coordinator on 2/17/22 at 10:42 AM revealed she had been responsible for updating Resident #8's care plan but she received input from the other members of the interdisciplinary team. Any staff member could add information to the care plan and revise it including the wound nurse. The

ulcer care.

2) On 2/22/22 the Regional MDS nurse and wound nurse completed an audit of current residents with pressure wounds to ensure care plans were current and accurate to reflect pressure wound care. Resident #334 care plan reviewed and revised to reflect pressure ulcer care.

3) On 2/18/22, the Regional MDS nurse provided education to the facility MDS nurse on care plan timing and revision to ensure residents with pressure wounds will have a current and accurate pressure wound care plan. The MDS nurse will ensure resident care plans are reviewed and revised timely for residents with pressure wounds. Newly hired MDS nurses will receive education during orientation and will not work until education completed.

4) The Director of Nursing or designee will monitor 3 residents with pressure wounds to ensure timely revision of wound care plan 2 times weekly for 4 weeks: then 1 time weekly for 8 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with care plan timing and revision.

5) Completion Date: 2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 657	Continued From page 14 MDS Coordinator had no idea why Resident #8's care plan had not been updated to include care for her pressure ulcer. A phone interview with the wound nurse on 2/17/22 at 11:05 AM revealed she had nothing to do with the care plans. The wound nurse did not know why the previous MDS Coordinator had not been aware of Resident #8's pressure ulcer because her wound assessments were in her medical record. A phone interview with the Director of Nursing and the Administrator on 2/17/22 at 11:17 AM revealed they were not sure how the previous MDS Coordinator had missed including Resident #8's pressure ulcer to her care plan but she should have because it had been communicated to her and she should have reviewed the wound reports that were available in Resident #8's medical record. They were not sure why Resident #8's care plan had not been updated.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide incontinence care for 1 of 2 residents who were dependent on staff for assistance with activities of daily living (ADL) (Resident #43). Findings included:	F 677	1) On 2/14/22, the nurse aide provided incontinence care for Resident #43. Incontinence care will continue to be provided every two hour and as needed. 2) On 2/18/22, the Director of Nurse (DON) and licensed nurses completed a	2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677 Continued From page 15

Resident #43 was admitted on originally on 4/7/21 with a readmit date of 8/27/21, his diagnoses included Covid-19, muscle weakness, dementia without behavioral disturbance and history of falls.

Record review of Resident #43's care plan revised on 8/24/21 revealed resident had bladder incontinence related to activity intolerance. The goal was to remain free from skin breakdown due to incontinence and brief use. Interventions included to clean peri-area with each incontinent episode.

Record review of Resident #43's care plan revised on 8/24/21 revealed ADL self-care performance deficit related to activity intolerance. The goal was to improve current level of function in ADLs. Interventions included resident required assistance with personal care and oral hygiene.

Review of Resident #43's quarterly Minimum Data Set (MDS) assessment dated 10/24/21 revealed severe cognitive impairment, total dependence on staff for ADL assistance and always incontinent of bowel and bladder.

An observation was made on 2/14/22 at 12:27 PM Resident #43 was in bed with his incontinence brief exposed. Resident #43's gown was pulled up to his stomach. The brief was saturated and leaking, the draw sheet underneath Resident #43 had a large yellow circular stain, the outermost portion of the stain was observed as dried.

An interview with Nurse Aide#1 2/14/22 12:32 PM revealed the last time she rounded on Resident #43 was around 8:00 AM and at that time she

F 677

rounding observation of residents□ dependent on staff for incontinence care to ensure incontinence care provided to maintain resident incontinence care needs and quality of life.

3) Effective 2/24/22, the DON and Assistant DON provided education to current facility and agency licensed nurses and nurse aides on providing incontinence care for resident□s dependent on staff to maintain incontinence care needs. Education included performing resident incontinence rounds every two hours and as needed. Newly hired facility or agency licensed nurses and nurse aides will receive education during orientation and prior to working.

Effective 2/24/22, the DON and Assistant DON provided education to Department Heads on completing incontinence rounds utilizing the Guardian Angel Rounds tool and Manager on Duty (MOD) Rounds tool and reporting any incontinence care needs to the nurse aide or licensed nurse as appropriate. Newly hired Department Heads will receive education during orientation and prior to working.

Effective 2/24/22, the nurse aide or licensed nurse will round every two hours and as needed to provide incontinence care and the licensed nurse will provide care as needed. Department heads will complete incontinence rounds daily by visual observations and resident interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 677	Continued From page 16 provided incontinence care. Nurse Aide #1 further revealed incontinence care should have been provided every 2 hours. She stated she was doing the best she could in her assignment, and they were struggling with the number of staff working that day. On 2/14/22 at 12:43 PM Nurse Aide #1 was observed providing incontinence care and a bed bath for Resident #43. Nurse Aide #1 removed Resident #43's brief, it was saturated with urine and stool. Dried stool was stuck to the resident's buttocks. As Nurse Aide #1 rolled away the linen the fitted sheet was also observed with a yellow stain. The area was cleaned and dried, there was a small dime sized pink area on Resident #43's tailbone, the skin was intact. Nurse Aide #1 completed the incontinence care applied a clean brief. During an interview on 2/15/22 at 2:57 PM the Director of Nursing (DON) stated incontinence care was expected to be provided every two hours or as frequently as needed.	F 677	Monday through Friday during business hours and the Manager on duty will complete incontinence rounds after hours and weekends. Rounding tools will be maintained by the Administrator. 4) The DON or RN Supervisor will complete monitoring of 5 incontinent residents and review Guardian Angel Rounds tool and MOD Rounds tool for completion to ensure incontinence care is provided. Monitoring will be completed five 3 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with incontinence care. 5) Completion Date: 2/24/22	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 686 Continued From page 17

with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review, and interviews with resident, staff, and the wound doctor, the facility failed to provide pressure ulcer care per physician orders for 2 of 3 residents (Resident #334 and Resident #8) reviewed for pressure ulcers.

The findings included:

1. Resident #334 was admitted to the facility on 11/10/21 with diagnoses that included hepatic failure.

A review of the Admitting Daily Skin Assessment dated 11/10/21 indicated Resident #334 had existing bruises and had an open area or pressure ulcer to the right buttock.

The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #334 was cognitively intact, required extensive physical assistance with bed mobility and toileting, and was frequently incontinent of urine and bowel. The MDS further indicated Resident #334 was at risk of developing pressure ulcers/injuries and had a pressure reducing device for bed but did not have a pressure ulcer.

Resident #334's care plan revised on 11/21/21 indicated Resident #334 had potential impairment to skin integrity related to fragile skin. Interventions included to keep skin clean and dry, and to use lotion on dry skin.

A physician order dated 2/1/22 for Resident #334

F 686

1) Resident #334 and Resident #8 will continue to have wound treatments completed and documented on the Treatment Administration Record (TAR) as ordered. On 2/15/22, the wound nurse assessed resident wound condition, changed dressing per physician orders and no changes were noted in wound condition as a result of missed treatments.

2) On 2/15/22, the Director of Nursing (DON) and wound nurse completed a review of TARs from for residents with pressure wounds to ensure treatments completed and documented as ordered by the physician. Residents with omissions identified on the TAR were assessed to ensure skin condition did not worsen. No residents identified with negative outcomes.

3) Effective 2/24/22, the DON and wound nurse provided education to current facility and agency licensed nurses on completing and documenting treatments for residents with pressure wounds as ordered by the physician. The licensed nurse or wound nurse is responsible for completing pressure wound treatments as ordered by the physician and documenting completion on the TAR. Nursing Supervisors will provide staff assistance as needed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 686

Continued From page 18

indicated the application of a collagenase ointment to the right buttock topically every day shift for wound care. Clean wound with wound cleanser, gently pat dry, apply (collagenase ointment) nickel thickness, pack with gauze packing strips and apply dry dressing daily and as needed when soiled or off.

A review of Resident #334's Treatment Administration Record (TAR) for February 2022 indicated the treatment order for Resident #334's right buttock was left blank on 2/12/22, 2/13/22 and 2/14/22.

An interview with Resident #334 on 2/16/22 at 8:46 AM revealed she was not getting her wound dressings changed every day. Resident #334 stated the wound doctor, and the wound nurse did a good job, but they were not at the facility every day. The wound doctor only came to the facility once a week and the wound nurse did her treatments when she was at the facility, but she didn't work on the weekends. She stated she was not sure if they delegated the treatments to someone else when they were not at the facility. Resident #334 stated nobody did her treatments on 2/12/22, 2/13/22 and 2/14/22.

Prior to an observation of wound care on Resident #334 on 2/15/22 at 8:15 AM, the wound nurse revealed she had already removed the dressing to Resident #334's right buttock. The wound nurse stated she could not remember the date on the dressing that she removed.

Further interview with the wound nurse on 2/15/22 at 9:56 AM revealed she was responsible for doing the wound treatments from Monday to Friday on the day shift, but she had not been able

F 686

treatments are completed as ordered. The Director of Nursing will review the TAR report in the Electronic Medical Record (EMR) during daily clinical meeting to monitor for ongoing compliance. Newly hired facility and agency licensed nurses will receive education during orientation and prior to working.

4) The DON or Assistant DON will complete an audit of 5 residents with pressure wounds to ensure completion and documentation as ordered. Monitoring will be completed at a frequency of 3 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with treatments for residents with pressure wounds.

5) Completion Date: 2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 686	Continued From page 19	F 686		

to work as much as she used to, so she was off on 2/14/22. The wound nurse also stated she did not work on the weekends. The wound nurse stated the unit manager would been responsible for wounds on the weekends and if she or the unit manager were not available, the nurses on the halls should have done the treatments. Medication aides were not allowed to do the treatments so the other nurses should have done the treatments for the residents on the medication aide's workload.

A phone interview with Nurse #1 on 2/15/22 at 3:00 PM revealed she had worked on 2/12/22 on the day shift and she never did treatments on the other halls because there was no way she could do any of them except the ones she was directly assigned to. Nurse #1 stated she did not do wound care on Resident #334 on 2/12/22 because she wasn't on her hall.

A phone interview with Nurse #2 on 2/15/22 at 3:11 PM revealed she worked at the facility on 2/12/22 on the day shift and was only able to do the treatments that were scheduled for her residents. Nurse #2 stated she did not do Resident #334's treatments on 2/12/22 and Resident #334 was not on her hall.

A phone interview with Nurse #3 on 2/15/22 at 4:18 PM revealed she was not assigned to Resident #334 on 2/12/22 and 2/14/22 and she didn't do any treatment for Resident #334 on the day shift.

A phone interview with Nurse #4 on 2/15/22 at 4:35 PM revealed she worked on the day shift on 2/13/22 and remembered that it had been a very busy day because she only had one nurse aide to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 686	Continued From page 20	F 686		

her hall. She remembered doing treatments that were assigned to her and nobody asked her to do any treatment for Resident #334 who wasn't on her hall.

An interview with the wound doctor on 2/15/22 at 8:10 AM revealed the facility did not have enough staff in order to be able to take care of all the treatments. He stated it was not unusual to find treatments that had not been done especially from the weekend. He also stated he often observed dressings not being changed from his last assessment and had brought it to the wound nurse's attention. He also told the previous Director of Nursing and the previous Administrator, but the facility had other issues that took priority over wound care.

An interview with the Director of Nursing (DON) on 2/16/22 at 9:06 AM revealed the concern about treatments not being done as ordered had occurred in the past and she attributed it to them having to utilize agency nurses and medication aides. The other nurses were supposed to oversee the medication aides who were not able to do any of the treatments. If the nurses were not able to do them, then the unit manager should have helped them. It should also have been reported to the next shift. The DON stated the medication aides were probably used to having the wound nurse available that it didn't occur to them to ask for help with the treatments when the wound nurse was not in the facility.

2. Resident #8 was admitted to the facility on 3/4/20 with diagnoses that included dementia, diabetes, and chronic kidney disease.

Resident #8's care plan initiated on 3/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

(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 686	Continued From page 21	F 686		

indicated Resident #8 was at risk for impaired skin integrity due to bowel and bladder incontinence, decreased and impaired mobility and diabetes. Interventions included to administer treatments as ordered and to monitor for effectiveness.

A review of the Weekly Pressure Wound Observation Tool dated 12/16/21 for Resident #8 revealed an unstageable pressure ulcer to the left heel was identified on 12/15/21. The wound was covered with 100% necrosis and measured 4.5 cm (centimeters) in length, 7 cm in width and 0 cm in depth.

The most recent Minimum Data Set (MDS) assessment was a discharge return anticipated MDS dated 12/29/21 and it indicated Resident #8 was severely cognitively impaired, required extensive physical assistance with bed mobility and did not have any pressure ulcers/injuries.

A physician order dated 12/31/21 for Resident #8 indicated the application of povidone-iodine (antiseptic used for skin disinfection) every day shift to an unstageable pressure ulcer (due to necrosis) of the left heel.

A review of Resident #8's Treatment Administration Record (TAR) for February 2022 indicated the treatment order for Resident #8's left heel was left blank on 2/13/22 and 2/14/22.

A phone interview with Nurse #4 on 2/15/22 at 4:35 PM revealed she worked on the day shift on 2/13/22 and remembered that it had been a very busy day because she only had one nurse aide to her hall. She remembered doing treatments that were assigned to her and nobody asked her to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 686	Continued From page 22	F 686		

any treatment for Resident #8 who was on another hall.

A phone interview with Nurse #3 on 2/15/22 at 4:18 PM revealed she was not assigned to Resident #8 on 2/14/22 and she didn't do any treatment for Resident #8 on the day shift.

An interview with the wound nurse on 2/15/22 at 9:56 AM revealed she was responsible for doing the wound treatments from Monday to Friday on the day shift, but she had not been able to work as much as she used to, so she was off on 2/14/22. The wound nurse also stated she did not work on the weekends. The wound nurse stated the unit manager would have been responsible for wounds on the weekends and if she or the unit manager were not available, the nurses on the halls should have done the treatments. Medication aides were not allowed to do the treatments so the other nurses should have done the treatments for the residents on the medication aide's workload.

An interview with the wound doctor on 2/15/22 at 8:10 AM revealed the facility did not have enough staff in order to be able to take care of all the treatments. He stated it was not unusual to find treatments that had not been done especially from the weekend. He also stated he often observed dressings not being changed from his last assessment and had brought it to the wound nurse's attention. He also told the previous Director of Nursing and the previous Administrator, but the facility had other issues that took priority over wound care.

An interview with the Director of Nursing (DON) on 2/16/22 at 9:06 AM revealed the concern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH RANDOLPH LLC	**4801 RANDOLPH ROAD CHARLOTTE, NC 28211**

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F 686	Continued From page 23 about treatments not being done as ordered had occurred in the past and she attributed it to them having to utilize agency nurses and medication aides. The other nurses were supposed to oversee the medication aides who were not able to do any of the treatments. If the nurses were not able to do them, then the unit manager should have helped them. It should also have been reported to the next shift. The DON stated the medication aides were probably used to having the wound nurse available that it didn't occur to them to ask for help with the treatments when the wound nurse was not in the facility.	F 686		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725

Continued From page 24

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, resident interviews and record reviews the facility failed to have sufficient nurse staffing to provide incontinence care for 1of 2 dependent residents and to provide pressure ulcer care per physician orders for 2 of 3 residents reviewed for pressure ulcers (Resident #43 and Resident #8).

The findings included:

This tag is cross referred to:

F677: Based on observation, record review and staff interviews, the facility failed to provide routine incontinence care for 1 of 2 residents who were dependent on staff for assistance with activities of daily living (ADL) (Resident #43).

F686: Based on record review, and interviews with resident, staff, and the wound doctor, the facility failed to provide pressure ulcer care per physician orders for 2 of 3 residents (Resident #334 and Resident #8) reviewed for pressure ulcers.

An interview on 2/14/22 at 1:15 PM Nurse Aide #1 revealed there were residents that she provided care for at breakfast time but was unable to round on them again until after lunch. Nurse Aide #1 explained she is also the staff scheduler for the facility, and she had been attempting to get more staff to come in but was having trouble getting

F 725

1) On 2/14/22, the nurse aide provided incontinence care for Resident #43. Incontinence care will continue to be provided every two hour and as needed. (F677)

Resident #8 will continue to have wound treatments completed and documented on the Treatment Administration Record (TAR) as ordered. On 2/15/22, the wound nurse assessed resident wound condition, changed dressing and no changes were noted as a result of missed treatments.

2) On 2/23/22, the Administrator and Director of Nursing (DON) completed review of current staffing levels to determine sufficient staffing needed to ensure care is provided for incontinent residents and residents with pressure wounds. As a result of this review, the facility has implemented additional monitoring and oversight by Nurse Managers and Department Heads to ensure sufficient staffing to maintain incontinence care for dependent residents and pressure wound care and treatment for residents with pressure wounds.

3) On 2/24/24, the Regional Director of Clinical Services provided education to the Administrator and DON on maintaining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725

Continued From page 25

staff to come to work. She stated she was doing the best she could with her assignment, and they were struggling with the number of staff they had working on that date.

On 2/14/22 at Nurse #3 expressed residents complained about not receiving baths, showers and incontinence care when she worked. Nurse #1 indicated there were 4 nurse aides assigned but some did not show up. She was not aware where her assigned nurse aide was or what her name was.

Observation of daily posted nurse staffing sheet revealed information dated 2/14/2022 with a census of 78.

Review of Employee Punch Report revealed there were 3 Nurse Aides working 7:00 AM - 3:00 PM on 2/14/22.

An Interview on 2/15/22 at 5:00 PM, Nurse Aide #6 stated she had worked for the facility on 3:00 PM to 11:00 pm shift and she was the only permanent nurse aide on that shift. She indicated that the facility was short staffed multiple shifts per week.

An interview on 2/16/22 at 1:14 PM Nurse Aide #4 stated he was an agency staff member at the facility and he worked there 3 to 4 days a week on 1st shift. He further stated there were multiple days a week that Nurse Aides would have 15 to 20 residents each.

Interview with the Scheduler on 2/15/22 at 5:45 PM revealed the facility only had 10 permanent staff members and they use staffing agencies to supplement staff. She further revealed she was

F 725

sufficient staffing to ensure incontinence care and pressure wound care is provided to meet resident needs. Department Heads and/or Nurse Managers were educated on monitoring incontinent residents using visual observations and interviews as well as review of Treatment Administration Record (TAR) to ensure incontinence care completed and wound treatments are completed as ordered. Education included monitoring and oversight by Nurse Supervisors and Department Heads and ongoing staffing level reviews during staff meetings to ensure sufficient staff to provide incontinence care and pressure wound care for facility residents.

4) The DON or RN Supervisor will complete monitoring of 5 incontinent residents for timely incontinence care (F677) and 5 residents with pressure wounds (F686) for completion and documentation of treatments as ordered. Monitoring will be completed five 3 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with sufficient staffing.

5) Completion Date: 2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725	Continued From page 26 in contact with the staffing agencies daily, but if they had a call out, the staffing agency usually could send a replacement on the same day. The Scheduler stated she tried to staff heavily on the weekends, but they usually only had 2 nurse aides. She stated they did not put staff on call but, they did offer bonuses for staff to come in on their day off. She expressed Friday through Monday were the hardest to staff and most days there were not enough staff to provide care for the residents. The Scheduler explained when there was not enough staff she would work as a nurse aide and take an assignment which was 3-4 days a week. She further explained when the facility was short staffed on 2/14/22, she worked in an assignment with 30 residents from 8:00 AM to 11:00 PM. She stated she often worked double shifts. An interview on 2/16/22 at 1:56 PM the Administrator stated if they have call outs, they notify the DON and adjust the assignments. They would also call agencies to request additional staff and call their staff to see if anyone could have come in. The Administrator stated the facility staffs according to census and acuity. An interview on 2/16/22 3:45 PM the DON revealed staffing was challenging on the weekends. If there were call outs, they would call the staffing agency to replace staff or utilize staff already in the facility. The DON revealed their staff/resident ratios were based on census and acuity and stated "I can't put a cap on how many residents a staff member can have".	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 732	Continued From page 27 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the	F 732	1) Cited deficiency cannot be corrected	

F 732

Continued From page 28

facility failed to post complete and accurate nurse staffing data for 12 of 15 days of nurse staffing data reviewed.

The findings included:

A review of the posted nurse staffing data from 2/1/22 - 2/15/22 revealed the following:

1a. An observation occurred on 2/14/22 at 9:34 AM of nurse staffing data posted in the lobby of the facility which recorded nurse staffing for 2/11/22.

1b. The daily nurse staffing data sheets recorded Certified Medication Aides but did not record actual hours worked on the following dates:
·2/2/22
·2/3/22
·2/4/22
·2/6/22
·2/7/22
·2/9/22
·2/11/22
·2/12/22
·2/13/22
·2/14/22
·2/15/22

1c. A review of daily nurse staffing data sheets for the 7A - 3P shift, revealed licensed and unlicensed nursing staff was not recorded accurately for the following days:
·2/3/22, daily nurse staffing data sheets recorded 3 licensed practical nurses (LPN) provided 24 hours of nursing care; staff assignment data recorded 5 LPN
·2/4/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care and 4

F 732

retrospectively for dates cited.

2) All current residents have the potential to be affected by current deficiency.

3) Effective 2/24/2022, the Director of Nursing (DON) and/or designee educated current Staff Scheduler to post the nursing information daily Monday through Friday and makes changes to the posted schedule throughout the day with changes as necessary and to post projected weekend schedule prior to end of shift Friday. Education was also provided to the receptionist on verifying posted nurse staffing and updating schedule with any changes on the weekend. Newly hired staff schedulers and receptionists will receive education during orientation.

The Staff Scheduler will post nurse staffing in the lobby hall daily Monday through Friday and post projected weekend scheduled prior to end of shift on Fridays. The receptionist will verify posted nurse staffing on weekends. Any changes to schedule will be completed as delegated by the staff scheduler or DON.

4) Director of Nursing and/or designee will audit nurse staff posting daily to ensure posting is current and accurate. Audits will be completed 5 times a week for 4 weeks then weekly for 8 weeks. The Administrator will report results of these audits with the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 732	Continued From page 29 nurse aides (NA) provided 45 hours of nursing care; staff assignment data recorded 4 LPN and 5 NA ·2/7/22, daily nurse staffing data sheets recorded 2 LPN provided 16 hours of nursing care; staff assignment data recorded 4 LPN ·2/8/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care; staff assignment data recorded 5 LPN ·2/9/22, daily nurse staffing data sheets recorded 2 LPN provided 16 hours of nursing care; staff assignment data recorded 4 LPN ·2/11/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care; staff assignment data recorded 5 LPN ·2/13/22, daily nurse staffing data sheets recorded 1 RN provided 8 hours of nursing care and 2 LPN provided 16 hours of nursing care; staff assignment data recorded 0 RN and 1 LPN ·2/14/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care and 4 NA provided 37.5 hours of nursing care; staff assignment data recorded 4 LPN and 6 NA ·2/15/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care and 7 NA provided 60 hours of nursing care; staff assignment data recorded 4 LPN and 9 NA 1d. A review of daily nurse staffing data sheets for the 3P - 11P shift, revealed licensed and unlicensed nursing staff was not recorded accurately for the following days: ·2/3/22, daily nurse staffing data sheets recorded 0 RN and 3 LPN provided 24 hours of nursing care; staff assignment data recorded 1 RN and 4 LPN ·2/4/22, daily nurse staffing data sheets recorded 1 LPN provided 8 hours of nursing care and 3 NA	F 732	necessary to maintain compliance with nurse staff posting. 5) Completion Date: 2/24/22	

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F 732	Continued From page 30	F 732		

provided 37.5 hours of nursing care; staff assignment data recorded 3 LPN and 6 NA
·2/7/22, daily nurse staffing data sheets recorded 2 LPN provided 16 hours of nursing care and 6 NA provided 60 hours of nursing care; staff assignment data recorded 4 LPN and 5 NA
·2/6/22, daily nurse staffing data sheets recorded 3 NA provided 37.5 hours of nursing care; staff assignment data recorded 1 NA
·2/8/22, daily nurse staffing data sheets recorded 2 LPN provided 16 hours of nursing care and 7 NA provided 52.5 hours of nursing care; staff assignment data recorded 6 LPN and 5 NA
·2/9/22, daily nurse staffing data sheets recorded 2 LPN provided 16 hours of nursing care; staff assignment data recorded 4 LPN
·2/11/22, daily nurse staffing data sheets recorded 1 RN provided 8 hours of nursing care and 2 LPN provided 16 hours of nursing care; staff assignment data recorded 2 RN and 4 LPN
·2/13/22, daily nurse staffing data sheets recorded 3 RN provided 16 hours of nursing care; staff assignment data recorded 1 RN
·2/15/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care and 6 NA provided 52.5 hours of nursing care; staff assignment data recorded 4 LPN and 7 NA

1e. A review of daily nurse staffing data sheets for the 11P - 7A shift, revealed licensed and unlicensed nursing staff was not recorded accurately for the following days:
·2/3/22, daily nurse staffing data sheets recorded 0 RN and 3 LPN provided 24 hours of nursing care; staff assignment data recorded 1 RN and 2 LPN
·2/4/22, daily nurse staffing data sheets recorded 4 NA provided 30 hours of nursing care; staff

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	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 732	Continued From page 31 assignment data recorded 5 NA ·2/7/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care; staff assignment data recorded 4 LPN ·2/9/22, daily nurse staffing data sheets recorded 3 LPN provided 24 hours of nursing care; staff assignment data recorded 2 LPN ·2/11/22, daily nurse staffing data sheets recorded 1 LPN provided 8 hours of nursing care and 5 NA provided 37.5 hours of nursing care; staff assignment data recorded 3 LPN and 6 NA ·2/12/22, daily nurse staffing data sheets recorded 1 LPN provided 8 hours of nursing care and 3 NA provided 22.5 hours of nursing care; staff assignment data recorded 0 LPN and 2 NA ·2/15/22, daily nurse staffing data sheets recorded 4 NA provided 30 hours of nursing care; staff assignment data recorded 2 NA During an interview with the scheduler on 2/15/22 at 5:55 PM she stated that she was responsible for posting the daily nurse staffing data forms and completing the staff assignment sheets. The scheduler stated she used an old staff assignment sheet that included staff that did not always work, or the staff 's role changed and that she would need to update the staffing records when this occurred. The scheduler stated that she posted nurse staffing data in the lobby in the evenings for the next day before she left the facility at 11 PM and that she did not update the staff data sheets for staffing changes. The scheduler also stated that she left the nurse staffing data forms for the weekend receptionist to post, but that the facility did not always have a receptionist on weekends so many times when she arrived to work on Monday the same posting was in place from Friday.	F 732		

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F 732	Continued From page 32 The Director of Nursing (DON) was interviewed on 2/16/22 at 11:55 AM. During the interview, the DON stated that the scheduler was responsible for completing and posting nurse staffing data. The DON stated that the scheduler used a template to record staffing and sometimes staff who were not working in the facility that day were still recorded as working per the template. The DON stated that the nurse staffing data should be updated to reflect actual staff in the facility and weekend postings should be done by the weekend supervisors. The DON stated the facility would have to develop a plan for who would be responsible for posting nurse staffing data if a weekend supervisor was not assigned. An interview with the administrator on 2/16/22 at 12:00 PM revealed she expected the nurse staffing data to be accurately recorded and when posted the data should reflect the current staffing patterns in the facility.	F 732		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based record review, observation, resident interview, staff interview, and Physician interview the facility failed to administer prescribed antiseizure medications to 2 of 3 residents which resulted in significant medication errors (Resident #36 and #4). Findings included:	F 760	1) On 2/14/22, the licensed nurse notified physician of medication error for Resident #36 and Resident #4. Residents #36 and #4 will continue to receive antiseizure medication as prescribed by the physician. No adverse side effects occurred as a result of this deficiency. 2) On 2/15/22 the Director of Nursing	2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 760

Continued From page 33

1. Resident #36 was admitted to the facility on 6/18/21, with diagnoses that included seizures, traumatic brain injury.

Record review of Resident #36's Minimum Data Set assessment revealed she had moderate cognitive impairment.

A record review of physician orders dated February 2022:

Levetiracetam Solution 100 milligrams (MG)/milliliters (ML) via feeding tube twice a day for seizures at 9:00 AM and 9:00 PM
Lamotrigine Tablet 100 MG via feeding tube daily for seizures at 9:00 AM
Lamotrigine Tablet 150 MG via feeding tube daily at bedtime for seizures

An observation on 2/14/22 at 6:02 PM revealed Resident #36's call bell was activated, and yelling was heard from the room. During the observation an interview was conducted, Resident #36 stated she had not received any of her medications for the day. Resident #36 expressed that she was worried because her medications were important, she was taking medications to prevent seizures. She expressed she didn't want to have a seizure.

A review of Resident #36's electronic Medication Administration Record (MAR) revealed Resident #36 had not received medications to prevent seizures on 2/14/2022 from 7:00 AM through 6:00 PM, Levetiracetam and Lamotrigine. Both medications were scheduled for 9:00 AM.

An interview was conducted on 2/14/22 at 6:10 PM Medication Aide #1 stated she was not permitted to administer medications through a

F 760

audited the Medication Administration Record (MAR) for all residents with antiseizure medications to ensure administration as ordered by the physician. No additional concerns noted.

3) Effective 2/24/22, the Director of Nursing (DON) and Assistant Director of Nursing educated the facility and agency licensed nursing staff on the facility policy and procedure on medication administration as prescribed by the physician to prevent medication errors. Education included notification to the attending physician if medication not available or administered as ordered for follow-up as indicated. The DON Newly facility and agency licensed nurses will receive education prior to working as a part of the orientation process.

4) The Director of Nursing or Unit Manager will conduct random audits of 5 resident medication orders for availability and administration as ordered. Monitoring will be completed for five residents (3) times weekly for 4 weeks then weekly for 8 weeks and as necessary thereafter until substantial compliance is met. The Administrator will report these finding to the Quality Assurance Process Improvement (QAPI) monthly for and will make changes to the plan as necessary to maintain compliance with medication administration.

5) Compliance date: 2/24/22

F 760 Continued From page 34 F 760

feeding tube. Medication Aide #1 revealed she had made Nurse #5 aware that Nurse #5 had needed to give Resident #36 her medications.

During an interview on 2/14/22 at 6:34 PM Nurse #5 revealed she was agency staff and had not given medications to Resident #36 because Medication Aide #1 was assigned to administer the medications to Resident #36. Nurse #5 stated she was not aware that she needed to give medications to Resident #36 or that Medication Aide #1 could not administer the medications.

An interview on 2/15/22 at 2:33 PM The Physician stated Resident #36 had a history of seizures and continued to be at risk for having seizures. He further stated missing her anti-seizure medication was significant and nursing staff needed to administer the medications as ordered.

An interview on 2/15/22 at 2:57 PM the Director of Nursing (DON) stated medication aides cannot give medications through feeding tubes, IVs or injections, those medications would be given by the licensed nurse. She indicated the licensed nurse and the medication aide needed to be in communication about medications the medication aide would not be able to administer. The DON stated there was a miscommunication on this date. She further stated that all medications should be given in the 2-hour time frame.

2. Resident #4 was admitted to the facility on 3/16/20 with diagnoses that included conversion disorder with seizures.

A review of a physician order dated 3/16/20 for Resident #4 indicated an active order for Levetiracetam (a medicine used to treat epilepsy) 1000 mg (milligrams) - give 1 tablet by mouth two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 35	F 760		

times a day for seizure.

The annual Minimum Data Set (MDS) assessment dated 12/5/21 indicated Resident #4 was severely cognitively impaired.

A review of Resident #4's Medication Administration Record for February 2022 indicated the 9:00 AM dose for Levetiracetam on 2/14/22 was left blank.

An interview with Medication Aide (MA) #1 on 2/14/22 at 6:06 PM revealed she normally worked in medical records, but she was also a nurse aide and a medication aide. Sometime after 9:00 AM on 2/14/22, she was told by the Assistant Director of Nursing (ADON) that she needed to administer medications because there was no nurse for one of the medication carts. MA #1 explained that she also scheduled all resident appointments and coordinated transportation for those appointments. MA #1 stated between 9:00 AM and 12:00 PM on 2/14/22, she was working both on the medication cart and answering calls for follow up appointments. She did not have enough time to administer Resident #4's 9:00 AM dose of Levetiracetam. At 12:36 PM, the ADON told her that she needed to go back and administer the 8:00 AM and 9:00 AM medications to the residents who didn't receive them. MA #1 said she declined to do that because some residents had the same medications with the next dose scheduled soon.

An interview with the Assistant Director of Nursing (ADON) on 2/14/22 at 5:55 PM revealed she found out on the morning of 2/14/22 between 8:00 AM and 8:15 AM that one of the day shift nurses had called in. The ADON stated she told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 760	Continued From page 36	F 760		

MA #1 to take over the medication cart and she thought she had followed her direction. Sometime before lunch, the ADON noticed that the medication cart that MA #1 was supposed to take over had been parked to the side, so she went to look for MA #1 and she found out that she had been in her office. MA #1 told the ADON that she thought she was just filling in for MA #3 who was coming at 9:00 AM and she didn't know she was supposed to take over the other medication cart. The ADON stated there had been a misunderstanding between her and MA #1 when she gave her instructions to take over the medication cart.

An interview with the Director of Nursing and the Administrator on 2/14/22 at 6:41 PM revealed they were both aware of an agency nurse who had called in and an agency medication aide was scheduled to come in at 9:00 AM on 2/14/22. They both knew that the ADON had instructed MA #1 around 9:00 AM to take the cart for the agency nurse who did not show up. MA #1 took the cart around 9:00 AM and started passing medications. When the ADON did her rounds before lunch, she noticed MA #1 was not on the medication cart. The ADON found MA #1 in her office who said to her that she did not realize the ADON wanted her to stay on the medication cart. MA #1 thought the ADON just wanted her to take the cart until MA #3 came in at 9:00 AM. When the ADON realized that the residents did not receive their morning medications, she notified the Medical Director (MD) who gave her no new orders. The MD said to just monitor the residents during the day shift and continue medications as ordered.

A phone interview with the Medical Director (MD) on 2/15/22 at 2:25 PM revealed Resident #4 was

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F 760	Continued From page 37 a fairly stable resident and the staff had not witnessed any breaks in seizures or changes in her mood. The MD stated he expected the nurses to continue giving her seizure medications as scheduled and not giving them as ordered could potentially cause her to have a seizure. The MD also stated he did not believe it was life-threatening, but it was significant that she missed one dose of her seizure medication.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		2/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 38 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 39 Based on record review, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 6 of 6 staff members (Nurse Aide #2, Nurse #3, Medication Aide #1, Nurse #5, Nurse Aide #1 and Nurse Aide #3) failed to wear eye protective gear while providing care to 8 of 8 residents (Residents #11, #80, #9, #1, #3, #43, #10 and #334) reviewed for infection control. These failures occurred during a COVID-19 pandemic. The findings included: A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 2/14/22 indicated that the county where the facility was located had a high level of community transmission for COVID-19. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): *If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow standard precautions (and transmission-based precautions if required based on the suspected diagnosis). Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and	F 880	1) On 2/24/22 a Quality Assurance Process Improvement (QAPI) meeting was conducted by the Administrator, Director of Nursing (DON), Infection Preventionist (IP), Medical Director Social Worker, Unit Coordinator, Therapy Director, Maintenance Director, Housekeeping Director, Activities Director and Minimum Data Set (MDS) Nurse to determine root cause analysis of the facilities failure to ensure staff wear eye protective gear. The QAPI committee determined that the facility failed to ensure that effective infection surveillance monitoring was being routinely conducted to monitor for infection control practices with wearing appropriate PPE to include eye protective gear during a COVID-19 pandemic. 2) On 2/16/22, the Infection Preventionist Assistant Director of Nursing completed infection control environmental surveillance rounds of all current staff working during that shift to ensure eye protective gear is worn per infection control policies and CDC guidance. No additional concerns were identified during this observation and proper infection prevention practices were being followed. 3) Effective 2/24/22, the Infection Preventionist and DON provided reeducation to current facility and agency staff on wearing eye protective gear per infection control policies and CDC guidance to prevent the spread of	

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F 880

Continued From page 40

sides of the face) should be worn during all patient care encounters.

A review of the facility policy entitled, "Personal Protective Equipment," revised on 10/28/20 included the following statements: 3. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status., 4. c. ii. Wear goggles or face shield as added face/eye protection. Personal eyeglasses are not a substitute for goggles.

a. Nurse Aide (NA) #2 was observed on 2/14/22 at 10:15 AM going into Resident #11's room while wearing a surgical mask and no eye protective gear. At 10:20 AM, she was further observed leaving Resident #11's room and going into Resident #80's room while wearing a surgical mask and no eye protection. After five minutes, NA #2 exited Resident #80's room while carrying a plastic bag with soiled linen which she placed in the utility room.

A phone interview with NA #2 on 2/16/22 at 1:04 PM revealed she had been under the impression that they only needed to wear eye protection when they had COVID-19 residents in the facility. NA #2 stated she didn't have an assignment on 2/14/22 and was just helping answer call lights.

b. Nurse #3 was observed on 2/14/22 at 10:50 AM obtaining ice for a water pitcher from the nourishment room and then walking back to the medication cart. She started preparing medications and was observed mixing a drink on top of the medication cart. At 11:00 AM, Nurse #3 entered Resident #9's room to give him his medications while wearing a surgical mask and no eye protective gear.

F 880

infection to others. Newly hired facility and agency staff will be educated prior to working as a part of the orientation process. The designated Infection Preventionist will be responsible routine infection control environmental surveillance rounds to observe for compliance with wearing protective eye gear. Newly hired facility and agency staff will receive education prior to working as a part of the orientation process.

4) The Infection preventionist or Nurse Manager will monitor infection control practices via visual observations of 5 staff for protective eye gear. Monitoring will be completed 5 times weekly for four weeks, then weekly for eight weeks and as needed thereafter. The Director of Nursing or Infection Preventionist will bring results to our monthly Quality Assurance and Performance Improvement (QAPI) meeting monthly to present results and make changes to the plan as necessary to maintain compliance with infection prevention practices.

5) Root Cause Analysis using 5-Whys Tool (see attachment)
6) Timeline of Events (see attachment)
7) Attestation of Infection Control education and competency (see attachment)
8) Completion Date: 2/24/22

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F 880	Continued From page 41	F 880		

An interview with Nurse #3 on 2/14/22 at 3:40 PM revealed she had not been aware that she was supposed to wear eye protection and stated that no one had told her that it was needed while providing resident care.

c. Medication Aide (MA) #1 was observed on 2/14/22 at 12:10 PM assisting Resident #1 with lunch at the nurses' station. Medication Aide #1 was wearing a surgical mask and prescription glasses while feeding Resident #1 using a spoon.

An interview with MA #1 on 2/14/22 at 3:55 PM revealed she knew she was supposed to wear eye protection and that her prescription glasses were not sufficient to use as PPE, but she couldn't wear goggles over her glasses. MA #2 stated she always kept a face shield in her office but didn't have time to get it because she had to go ahead and start giving medications when she was asked to.

d. Nurse #5 was observed on 2/14/22 at 12:15 PM assisting Resident #1 at the nurses' station. Nurse #5 handed Resident #1 a cup of tea and then pulled up Resident #1's socks. Nurse #5 was wearing a surgical mask with no eye protective gear. At 12:20 PM, Nurse #5 was further observed administering medications to Resident #3 while wearing a surgical mask and no eye protection.

An interview with Nurse #5 on 2/14/22 at 4:20 PM revealed she knew that she needed to wear eye protection when providing direct care to the residents and whenever she went inside the residents' rooms. Nurse #5 stated she usually had a face shield but had only been wearing it off

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F 880	Continued From page 42	F 880		

and on because it was hard to see with a face shield on.

e. NA #1 was observed on 2/14/22 at 12:27 PM providing incontinence care to Resident #43 while wearing an N-95 mask and goggles but her goggles were pulled up on top of her head and were not covering her eyes. NA #1 was further observed on 2/14/22 at 3:40 PM entering Resident #10's room and assisting her to get up out of the bed. NA #1 was wearing an N-95 mask and goggles but her goggles were still pulled up on top of her head.

An interview with NA #1 on 2/14/22 at 6:18 PM revealed she knew she was supposed to wear her goggles over her eyes, but she had been so busy and had not paid attention to it. NA #1 was also the supply clerk and was responsible for ordering PPE. She stated the facility had enough goggles and face shields for the staff to wear.

f. NA #3 was observed on 2/14/22 at 4:10 PM carrying a blanket and a gown and then entering Resident #334's room. NA #3 was wearing a surgical mask with no eye protective gear on.

An interview with NA #3 on 2/14/22 at 4:10 PM revealed he knew he was supposed to wear eye protection, but he could not find any goggles or face shield to wear. NA #3 stated he did not like using a face shield because it fogged up his vision but there were no goggles available at the front lobby and he checked the PPE at the nurses' station and did not find any goggles.

An interview with the facility's Infection Preventionist (IP) on 2/16/22 at 9:48 AM revealed that staff needed to wear a mask, goggles or face

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F 880	Continued From page 43	F 880		

shields and gloves if needed while providing care to the residents. The IP stated she had provided education to all staff members about PPE use especially the use of eye protection. She sometimes walked around handing out face shields to staff members who she saw were not wearing one. The IP also stated staff had access to PPE and they always kept supplies at the nurses' station.

An interview with the Director of Nursing (DON) on 2/16/22 at 9:06 AM revealed all staff should wear a mask and goggles or face shield when working with all the residents. The DON stated they tried to have PPE available, but some staff had taken a lot of them all at once, so she asked the supply clerk and the IP to try to distribute them to staff daily as needed. The DON stated all staff members had been educated about PPE use especially regarding use of eye protective gear. The DON stated she sometimes observed staff for compliance with their infection control policies, but the IP mainly did the infection control audits.

An interview with the Administrator on 2/16/22 at 11:45 AM revealed PPE such as goggles and face shields were available at the nurses' station and the supply room. The Administrator stated infection control was important to the facility and she would not tolerate anyone who knew they were supposed to wear eye protection but chose not to do so. She said it was not acceptable that some staff chose not to follow the facility's infection control policies and guidelines from the CDC.