STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH HENDERSON LLC	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

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E 000	Initial Comments An unannounced Recertification and complaint investigation survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 811D11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/25//22 through 4/28//22. Event ID # 811D11. 21 of the 21 complaint allegations were not substantiated. Intake #s: NC00185074, NC00184643, NC00184260, NC00182681, NC182108, NC180886.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		5/18/22

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

Electronically Signed | 05/15/2022

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F 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to protect confidential medical information by leaving the Medication Administration Record open during medication pass for 2 of 7 residents observed during medication pass (Resident #11 and #48). The findings included: 1. Resident #11 was admitted on 8/1/21. On 4/27/22 at 11:23 AM a medication pass was conducted with Nurse #2. The medication cart was in the hall outside of the nurse ' s station that was at the corner of 2 halls. Nurse #2 was observed to prepare a medication for Resident #11. The computer with the resident ' s medication administration record was on a rack over the medication cart and the screen could be easily seen by anyone that walked by the cart. Nurse #2 left the medication administration record open on the computer screen and walked to the end of the hall and went in the room of Resident #11 to administer the medication and then returned to the medication cart.	F 583	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents F583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)-(i)(ii) 1) How corrective action will be accomplished for residents(s) found to have been affected. -On 5/13/22, Resident #11 is deceased, and Resident #48 was notified by the	

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F 583	Continued From page 2 2. Resident #48 was admitted to the facility on 3/11/22. On 4/27/22 at 11:32 AM Nurse #2 was observed during a medication pass for Resident #48. The medication cart was in the hall outside of the nurse ' s station at the corner of 2 halls. The computer was hanging on a rack over the medication cart and the screen could be easily seen by anyone that walked by the cart. Nurse #2 was observed to leave the medication cart with the medication administration record open and went in the room of Resident #48. Nurse #2 was observed to return to the cart and then left the cart and went into the medication room at the back of the nurse ' s station. Nurse #2 then walked down the hall to another nurse ' s station, returned to the cart and returned to the room of Resident #48 to administer a medication. The medication administration record was observed to be open during the entire observation. Staff and residents were observed walking or wheeling in wheelchairs past the medication cart during the continuous observation. On 4/27/22 at 11:42 AM Nurse #2 stated in an interview that she usually clicked the lock icon to close the screen when she left the cart and she thought she did that. On 4/28/22 at 2:00 PM The Director of Nursing stated in an interview that the nurse was supposed to lock the computer screen when away from the medication cart.	F 583	Director of Nursing that during medication pass on 4/27/22, their electronic health record was left open where protected health information could have been potentially viewed by others. However, no adverse outcomes noted to date. -On 4/27/22, Nurse #2 was re-educated by the Director of Nursing on Privacy and Confidentiality of records with focus on locking screen of electronic health record when leaving cart. 2) How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: -The Staff Development Coordinator initiated re-education to all licensed nursing staff beginning on 5/2/22 on Privacy and Confidentiality of Records with focus on locking screen of electronic health record when leaving cart. 100% of licensed nursing staff will have this re-education completed by 5/18/2022. 3) What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: -On 5/3/22, a brightly colored visual card was placed on each medication cart by the Director of Nursing to remind licensed nursing staff to lock electronic health record before leaving cart. -The Director of Nursing or designee will complete an audit five (5) times per week x 4 weeks, then three (3) times per week x 4 weeks, then weekly x 4 weeks of medication cart electronic health record to	

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F 583	Continued From page 3	F 583	ensure locked when not attended. 4) Indicate how facility plan to monitor its performance to make sure that solution are achieved and sustained: - The Director of Nursing or designee will collect data from the audits, and it will be brought to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Executive Director will review the audit results with the IDT during the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months. Audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification. The facility alleges compliance on 5/18/2022	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, manufacturer's specifications and interviews, the facility failed to have a medication error rate of less than 5 percent as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4 percent for 2 of 7 residents observed during medication pass	F 759	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or	5/18/22

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F 759	Continued From page 4 (Resident #46 and #7). The findings included: 1. Review of the manufacturer's package insert for Rybelsus read: "Take Rybelsus on an empty stomach when patient first wakes up with a sip of plain water (no more than 4oz (ounces). Take at least 30 minutes before the first food, beverage or other oral medications of the day." Review of the April Medication Administration Record for Resident #46 revealed the following entries: Chewable Aspirin 81 milligrams (mg) 1 tablet in the AM (morning) and was scheduled for 8:00 AM. Lisinopril 10mg 1 tablet one time a day and was scheduled for 8:00 AM. Lasix 40mg 1 tablet one time a day and was scheduled for 8:00 AM. Rybelsus tablet (Antihyperglycemic) 14mg one time a day and was scheduled for 8:00 AM. Clonidine 0.1mg tablet three times a day and was scheduled for 10:00 AM. On 4/28/22 at 9:00 AM, Nurse #1 was observed to prepare medications for Resident #46. Nurse #1 was observed to place the following medications in a medicine cup: Chewable Aspirin 81 milligrams (mg) 1 tablet, Lisinopril 10mg 1 tablet, Rybelsus 14mg 1 tablet and Clonidine 0.1mg 1 tablet. The Nurse stated she did not have any Lasix for him on the cart and would have to give him the Lasix later. Nurse #1 was observed to enter the room of Resident #46 to administer the medications. Resident #46 removed the Rybelsus from the cup and took with a sip of water. Resident #46 stated he was supposed to not take any other medications with the Rybelsus for 45 minutes after taking the Rybelsus and he refused to take the other medications. Nurse #1 removed the rest of the	F 759	conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F759 Free of Medication Error Rates 5 Percent or More CFR(s): 483.45)f)(1) 1) How corrective action will be accomplished for residents(s) found to have been affected. -On 4/28/22, resident #1□s medication, Rybelsus, time was changed by the Physician to early AM to meet standards for recommendations for administration. A disclaimer was added by the Director of Nursing instructing staff to not change time. -On 4/28/22, resident #7 Keppra Liquid was validated by the physician to be on medication cart and tablets were removed from cart. Resident□s representative and Physician informed of potential missed dose with no adverse outcomes noted. -On 4/28/22, nurse #2 was re-educated by the Director of Nursing on Rights of Medication administration with focus on dose form and time. 2) How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: -On 5/12/22 an audit was completed by	

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F 759	Continued From page 5 medications from the resident's room and disposed of the medications and stated she would go back later and administer the medications and the Lasix. On 4/28/22 at 9:30 AM, Nurse #1 stated in an interview that at one time the Rybelsus was scheduled to be given at 7:30 AM but Resident #46 did not want to wake up at that time to take the medication, so the time had been changed. Nurse #1 further stated this was done to accommodate the resident's preference but did not know when the change was made. On 4/28/21 at 2:01 PM the Director of Nursing (DON) stated in an interview that Resident #46 could be difficult when taking his medications and thought that the time change was made to accommodate his preferences. The DON further stated it was her expectation that medications be given per physician orders as prescribed and at the correct time. 2. On 4/28/22 at 9:40 AM, Nurse #2 was observed to prepare medications for Resident #7 to administer via a gastric tube. Nurse #2 dispensed Aspirin 81 milligrams (mg) 1 tablet, Lisinopril 5mg 1 tablet, Metformin 500mg 1 tablet and Vimpat 150mg 1 tablet. Nurse #2 then crushed each tablet individually and placed each crushed tablet in a separate medication cup and added 5 milliliters (ml) of water to each of the 4 cups. Nurse #2 also prepared a multi-vitamin liquid 15ml in a cup and mixed 17 grams of Miralax in 4 ounces of water. Nurse #2 was observed to administer the medications via gastric tube per professional standards with no concerns.	F 759	Staff Development Coordinator of residents prescribed Rybelsus to ensure appropriate administration time. No additional issues were noted from audit. -On 5/13/22 an audit was completed by Staff Development Coordinator of all current residents for medications prescribed after 4/28/22 to ensure medications are available on medication cart in the prescribed form. No additional issues were noted from audit. - The Staff Development Coordinator initiated re-education to all licensed nursing staff beginning 5/2/22 on Rights of Medication Administration with focus on dose form and time. 100% of licensed nursing staff re-education will be completed by 5/18/2022. 3) What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: -The Director of Nursing or designee will complete audit five (5) times per week x 4 weeks, then three (3) times per week x 4 weeks, then weekly x 4 weeks of new medication order changes using Point Click Care Order Search tool for changes in dose form and for needed specific medication times to ensure availability on medication cart and appropriate time listed on MAR.	

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F 759	Continued From page 6 Upon review of the physician's orders and the Medication Administration Record there was an order for Keppra 1500mg (liquid) via gastric tube scheduled for 8:00 AM. The medication was not signed as given on the Medication Administration Record by Nurse #2 on 4/28/22. On 4/28/22 at 10:45 AM Nurse #2 stated in an interview that she gave the Keppra during the medication pass observation. Nurse #2 was asked if she gave the 8:00 AM dose prior to the medication pass observation and she stated no that she gave the Keppra during the observation of her medication pass at 9:40 AM. Nurse #2 stated the order was for liquid Keppra, but the pharmacy had sent the medication in pill form. Nurse #2 was observed to remove the Keppra tablets for Resident #7 from the medication cart and there were 2 blister packs held together with a rubber band and one package had a large tablet (1000mg) in each blister and the other package had 1/2 tablet (500mg) in each blister. The Nurse stated she gave the 1 ½ tablets during the observation of the medication pass. During the medication pass, Nurse #2 was observed to crush 4 small tablets and did not dispense the large Keppra tablets. On 4/28/22 at 2:04 PM the Director of Nursing stated in an interview that she expected medications to be given per physician's orders as prescribed and at the correct time.	F 759	4) Indicate how facility plan to monitor its performance to make sure that solution are achieved and sustained: The Director of Nursing or designee will collect data from the audits, and it will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Executive Director will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification. The facility alleges compliance on 5/18/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/18/22

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F 880	Continued From page 7	F 880		

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:
(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

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F 880	Continued From page 8 (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: Based on observations, record review and staff interviews, a staff member failed to wash or sanitize their hands after touching objects on the floor and while passing out meal trays to 3 of 3 residents observed the mid-day meal (Resident #3, #15 and #27). The findings included: The facility policy titled Hand Hygiene and dated 11/1/20 read under Policy: "All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors." The section titled Policy Explanation and	F 880	F880 Infection Prevention & Control CFR(s):483.80 (a)(1)(2)(4)(e)(f) 1) How corrective action will be accomplished for residents(s) found to have been affected: -Resident #3, #15, #27 affected by facility failed to implement infection prevention procedures by not performing hand hygiene after touching objects on the floor and while passing out meal trays; no adverse outcomes noted to date. -On 4/26/22, Nurse Aide #1 was re-educated on hand hygiene by the Staff	

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F 880	Continued From page 9 Compliance Guidelines #3 read: "Alcohol-based hand rub is the preferred method for cleansing hands in most clinical situations." The Hand Hygiene Table noted to wash hands with either soap or water or alcohol-based hand rub (preferred) between resident contacts and after handling contaminated objects. On 4/25/22 at 12:11 AM an observation was made of the delivery of the mid-day meal to residents on the hall and in the dining room. Nursing Assistant (NA) #1 was observed to deliver a meal tray to the overbed table for Resident #15. The NA left the room without sanitizing her hands and removed a tray off the meal cart and brought to Resident #3 who resided in the same room as Resident #15. The NA sat the tray down on the bedside table and moved the overbed table towards the resident's bed. A phone cord was observed to be wrapped around the wheel of the overbed table and when NA #1 tried to move the table, the table turned over and landed on its side on the floor. NA #1 removed the phone cord from around the wheel and sat the table upright and positioned the table in front of Resident #3 and proceeded to use the utensils on the tray to cut up the resident's food and removed the tops from containers on the tray and placed the utensils in front of the resident so the resident could eat. NA #1 then went over the Resident #15 without sanitizing or washing her hands and touched the utensils on the tray and opened containers on the tray. NA #1 was observed to leave the room without sanitizing or washing her hands. NA #1 returned to the meal cart and removed a tray and carried the tray to the main dining room and placed in front of Resident #27 and touched the utensils on the tray and opened the containers on the tray for the	F 880	Development Coordinator after the Director of Nursing was made aware of the breach in infection control practice. 2) How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: -All current residents are at risk for being affected by deficient practice. - Clinical staff were provided individualized alcohol-based hand rub starting 4/26/22 to keep on person to assist with frequent hand hygiene between resident contacts and after handling contaminated objects. - On 4/26/22, the Staff Development Coordinator initiated education to all staff on performing hand hygiene between resident contacts, between meal tray delivery, after touching contaminated objects and after removing gloves. 3) What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: -On 4/26/22 an AD Hoc Quality Assurance Performance Improvement (QAPI) committee meeting was held with the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, and Medical Director to identify the root cause of this alleged non-compliance by utilizing the 5 whys. Problem identified: A staff member failed to wash or sanitize their hands after touching objects on the floor and while passing out meal trays.	

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F 880	Continued From page 10 resident to eat. The NA did not wash or sanitize her hands. NA #1 was observed to touch her face mask and her hair with her hands and left the dining room and walked to the linen cart in the hall and removed a blanket from the cart and walked back to the dining room and placed the blanket over another resident. NA #1 then left the dining room and went in a hall bathroom and washed her hands. On 4/25/22 at 12:24 PM, an interview was conducted with NA #1. The NA was asked when she was supposed to wash or sanitize her hands and the NA responded: "I do it all day." The observation during the lunch meal was described for the NA and the NA stated that she sanitized her hands all day and did not acknowledge the breaches in infection control practices. On 4/28/22 at 2:02 PM the Director of Nursing stated in an interview that she expected the staff to sanitize or wash their hands between each resident when passing out meal trays.	F 880	1. Why? The staff was presumed to know what hand washing/sanitizing procedures to take during meal tray pass. 2. Why was staff presumed to know? The staff has not had any questions regarding the procedure and requirements for proper hand sanitation during meal pass and through observation all staff have performed the correct hand hygiene during meal pass. 3. Why has staff not had any questions? Multiple education sessions have been conducted with all staff regarding the proper hand sanitation requirements during meal pass. 4. Why have multiple education sessions been done? So that staff knows what hand washing/sanitizing procedures to take during meal pass. 5. Why does staff need to know what hand washing/sanitizing procedures to take during meal pass? To decrease and prevent the spread of infection to other personnel, residents, and visitors. Root cause analysis conducted revealed that even though education and training was provided and that proper hand hygiene has been achieved through the facilities observations of meal tray pass, the staff had an inadequate understanding of the required hand washing/sanitizing procedures to take during meal tray pass and a need for ongoing oversight and re-education is necessary to prevent re-occurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	C 04/28/2022

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F 880	Continued From page 11	F 880	-The Staff Development Coordinator initiated re-education on 4/26/2022 to all staff regarding proper hand hygiene with emphasis on hand washing/sanitizing procedures during meal tray pass. In addition to current facility staff, all agency staff will be part of this re-education as well. 100% of all staff re-education will be completed by 5/18/2022 by the Staff Development Coordinator or designee. Newly hired facility and agency staff and those who did not receive education by 5/18/22 will receive education during orientation and prior to working. -The Staff Development Coordinator or designee will complete an audit five (5) times per week x 4 weeks, then three (3) times per week x 4 weeks, then weekly x 4 weeks of hand hygiene being performed during meals to ensure done at appropriate times. During audits, any infractions will be corrected immediately. 4) Indicate how facility plan to monitor its performance to make sure that solutions are achieved and sustained: - The Director of Nursing or designee will collect data from the audits, and it will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) committee meeting. The Executive Director will review the audit results with the IDT during the monthly Quality Assurance Performance Improvement (QAPI) meeting for three months. Audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education,	

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F 880	Continued From page 12	F 880	or modification. The facility alleges compliance on 5/18/2022	