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 02/28/2023

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
E 000	Initial Comments The survey team eantered the facility on 02/20/23 to conduct a recertification survey and complaint investigation. The survey team was onsite 02/20/23 through 02/24/23. Additional information was obtained offsite on 02/27/23 and 02/28/23. Therefore, the exit date was 02/28/23. The facility was found in compliane with the requirement CFR 483.73, Emergency Preparedness. Event ID# Q26211.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/20/23 to conduct a recertification survey and complaint investigation. The survey team was onsite 02/20/23 through 02/24/23. Additional information was obtained offsite on 02/27/23 and 02/28/23. Therefore, the exit date was 02/28/23. Event ID# Q26211. The following intakes were investigated: NC00187955, NC00188390, NC00188589, NC00188774, NC00188847, NC00188885, NC00189782, NC00191767, NC00192095, NC00192201, NC00192304, NC00193191, NC00194370, NC00194678, NC00194810, NC00196598, NC00197078, NC00197148, NC00198262, NC00198311, and NC00198392. 41 of the 70 complaint allegations resulted in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		3/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/24/2023

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 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a resident's dignity by not providing incontinence care and oral hygiene	F 550	1.Dignity F550D 1. On 02/20/2023 the Charge Nurse and the Nurse Aide provided incontinence	

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F 550

Continued From page 2

when needed, ensuring bed linen and fall mat were clean and free of food debris, and ensuring the room was free of odor for 1 of 12 residents reviewed for dignity (Resident #48). The reasonable person concept was applied to this deficiency. Individuals would expect to receive care needed and would be upset if observed with dried food debris on their mouth, bed, and floor; lying on bed linen that was not clean; and if their room smelled of urine.

Findings included:

Resident #48 was admitted to the facility 08/16/19 with diagnoses including cerebrovascular accident (abbreviated as CVA and meaning a stroke) and non-Alzheimer's dementia.

The quarterly Minimum Data Set (MDS) dated 01/17/23 revealed Resident #48 was severely cognitively impaired, had no behaviors or rejection of care, required set-up assistance with eating, and was always incontinent of bladder.

a. While touring the 100 hall on 02/20/23 at 10:16 AM Resident #48 was observed to be in bed with his eyes closed and a strong odor or urine was noted in his room.

An observation of Nurse Aide (NA) #8 on 02/20/23 at 10:52 AM revealed she entered Resident #48's room and pulled back his top sheet. Lying in bed beside Resident #48 was a urine saturated incontinence brief. Resident #48 was partially lying on a bath blanket being used as a bed pad and the bath blanket contained a dried ring of urine. No bottom sheet was on Resident #48's bed and a large moist area was noted to his mattress below the bath blanket.

F 550

care, oral hygiene and changed the bed linen, the Housekeeper cleaned the fall mat and mopped the floor for Resident #48.
2. All dependent residents have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers completed an observation of dependent residents to identify other residents with dignity concerns related to ADL care. Any opportunities identified were addressed immediately by the Director of Nursing.
3. By 3/23/23 the Nurse Managers re-educated all facility staff, including agency staff on the facility policy for maintaining dignity for residents including providing ADL Care and maintaining a clean environment. Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff. The Nurse Managers and Director of Nursing will observe 5 dependent residents 3 times per week for 12 weeks to ensure the residents dignity is maintained.
4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.
Date of Completion 3/24/23

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F 550	Continued From page 3	F 550		

An interview with NA #8 on 02/20/23 at 10:58 AM revealed she reported for work around 08:30 AM the morning of 02/20/23. She stated she checked Resident #48 shortly after arriving for her shift and noted he had been incontinent of urine. NA #8 stated she did not provide incontinence care to Resident #48 when she noted he was wet because breakfast trays arrived on the hall and she could not perform incontinence care while trays were on the hall. She stated after breakfast was served, she began her incontinence round at room 139 and was working her way down the hall to Resident #48's room. NA #8 stated she did not ask another staff member for assistance with providing incontinence care to Resident #48. She stated she had not provided any incontinence care to Resident #48 on 02/20/23 until she was observed providing incontinence care at 10:52 AM. NA #8 confirmed there was a dried ring of urine on Resident #48's bath blanket.

An interview with the Director of Nursing (DON) on 02/21/23 at 5:00 PM revealed NA #8 should have performed an incontinence round before breakfast and after breakfast. She stated NAs could stop passing meals trays to provide incontinence care if needed. The DON stated NA #8 should have provided incontinence care when it was known Resident #48 was wet or asked another staff member for assistance.

An interview with the Administrator on 02/21/23 at 5:06 PM revealed NA #8 should have provided incontinence care to Resident #48 at the time she discovered he was wet or she could have asked her peers for assistance with passing meal trays or providing incontinence care. She stated NA #8

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F 550	Continued From page 4 could have notified Resident #48's nurse he had been incontinent and asked her for assistance with providing incontinence care. b. An observation of Resident #48 on 02/21/23 at 2:43 PM revealed he was lying in bed with his eyes closed and his mouth open. Dried food particles were noted to the corners of his mouth and partially chewed food was lying on his bottom sheet next to his head. Pieces of food were lying on the fall mat beside Resident #48's bed. A strong odor of urine was noted in Resident #48's room but no evidence of incontinence was observed. A bath blanket was being used as a bed pad underneath Resident #48. An interview with the Director of Nursing (DON) on 02/21/23 at 3:13 PM was conducted at Resident #48's bedside. At the time of the interview the food had been removed from Resident #48's bottom sheet but dried food particles remained at the corners of his mouth, food pieces remained on the fall mat beside his bed, and the odor of urine remained in his room. The DON stated, "Oh, that's just how he is" and she would get someone to clean his mouth up and clean his fall mat. She stated Resident #48 frequently had an odor of urine about him and refused incontinence care at times. The DON stated Resident #48 had been given around 3 new mattresses since admission to try to reduce the odor of urine and she would bring the issue of the continued odor of urine to the Interdisciplinary Team for discussion. She confirmed bath blankets were being used instead of bed pads and stated bed pads could probably decrease the amount of urine soaking into the mattress but she had been told by the Housekeeping Manager there was no room in the budget for bed pads	F 550		

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F 550	Continued From page 5 and they could not be ordered. During an interview with the Director of Environmental Services on 02/24/23 at 10:15 AM he confirmed he had asked corporate multiple times for bed pads and had been told they were not in the budget.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 2 residents reviewed for self-administration of medications (Resident # 186). Resident #186 was admitted to the facility on 02/06/23. Review of the admission Minimum Data Set dated 02/13/23 revealed Resident #186 was assessed as being cognitively intact. Review of Resident #186's medical records revealed no assessment for self-administering medications was included. Review of physician orders revealed on 02/15/23 an order was written for triamcinolone acetonide external lotion 0.1 % to apply to affected area topically two times a day for 14 days for atopic	F 554	2. Self Admin of Meds F554D 1. On 02/21/2023, the Medication Aide and the Charge Nurse collected the medications at the bedside, reviewed the physician orders and administered the medications to resident #186 as ordered by the physician. The Nurse Manager provided one on one education to the Medication Aide on 02/21/2023 regarding medication administration including the requirement to observe the resident swallow the medication prior to leaving the resident room. 2. All residents receiving medications have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers conducted a review of all resident rooms to ensure no medications were available at the bedside. Any opportunities identified were addressed immediately by the Director of Nursing. 3. By 3/23/23 the Nurse Managers	3/24/23

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F 554 Continued From page 6

dermatitis. On 02/17/23 and order was written for regular strength suspension 200-200-20 milligram (mg)/5 milliliters (ml) of Aluminum and Magnesium Hydroxide-Simethicone give 30 ml every 4 hours as needed for indigestion and do not exceed 6 doses in 24 hours.

An observation and interview were conducted on 02/21/23 at 8:42 AM with Resident #186. Observation of the bedside table in Resident #186's room revealed a 16-ounce bottle labeled Stomach Relief Bismuth Subsalicylate 525mg/ml and a bottle labeled triamcinolone acetonide lotion 0.1%. Resident #186 revealed his wife brought the bottle of Bismuth Subsalicylate to him from home and he had taken it a couple times a day. Resident #186 revealed he used the triamcinolone acetonide lotion for his eczema and stated it was given to him by someone at the facility. Resident #186 revealed he took the medications on his own with no assistance from the nursing staff.

An interview and observation with the Director of Nursing (DON) on 02/21/23 at 11:21 AM revealed the bottles of medications remained on the bedside table in Resident #186's room. The nightstand drawer was ajar and contained a bottle labeled micro daily dietary supplements 180 capsules. The DON removed all bottles observed and stated she would discuss this with Resident #186 and his wife. DON stated the morning nurse should have removed the bottles from the bedside table and nurses just received in-service training about medications left at the bedside.

An interview was conducted on 02/21/23 at 11:29 AM with Nurse #7. Nurse #7 confirmed she was the morning nurse for Resident #186 and had

F 554

re-educated all Licensed Nurse and Medication Aides, including agency staff on the facility policy for medication administration including the requirement to observe the resident swallow the medication prior to leaving the room.
Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff.
The Nurse Managers and Director of Nursing will observe 5 Licensed Nurses or Medication Aides 3 times per week for 12 weeks to ensure there are no medications left at bedside and residents are observed swallowing medications prior to leaving the room.
4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.
Date of Completion 3/24/23

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F 554	Continued From page 7 been in the room multiple times. Nurse #7 stated she didn't observe medications left on the bedside table and didn't open the nightstand drawer to check for any. Nurse #7 revealed she did receive an in-service yesterday (02/20/23) related to medications being left at the bedside and did a bird's eye view in her assigned resident rooms but Resident #186 was not on her assignment. Nurse #7 stated Resident #186 was able to open and close the drawers to the nightstand and move about in his room and could have been storing the bottles of medication out of her sight. An interview was conducted on 02/23/23 at 3:21 PM with the Nurse Practitioner (NP). The NP explained the nurses typically let her know when a resident brought medications into the facility from home they wanted to continue taking. The NP revealed either her or the nurse would assess the abilities of a resident to self-administer, and stated Resident #186 was capable. The NP explained a self-administer assessment was completed to ensure the medication the resident wanted to use wasn't contraindicated with other medications they were currently taking, and medications should be stored on the medication cart. A joint interview was conducted on 02/24/23 at 3:59 PM with the Administrator, DON, and Corporate Nurse Consultant. The Corporate Nurse Consultant explained the family had brought the medication and supplements into the facility and staff weren't aware Resident #186 had those in his room therefore the assessment to self-administer wasn't done.	F 554		
F 561 SS=E	Self-Determination	F 561		3/24/23

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F 561	Continued From page 8 CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide residents with their preferred method of bathing (Residents #135, #1, #12, #58, and #284) and failed to accommodate a resident's request to be assisted out of bed (Resident #70) for 6 of 8 residents reviewed for choices and dignity.	F 561	3.Choices F561E 1. By 3/23/23 the Nurse Managers completed interviews to assess preferences for showering and when to be assisted out of bed for Residents #135, #1, #12, #58, and #284 and #70. By	

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F 561	Continued From page 9 Findings included: 1. Resident #135 was admitted to the facility on 02/07/23 with multiple diagnoses that included arthritis, left hand cellulitis, heart failure, and hypertension. The Nursing Admission Assessment dated 02/07/23 noted Resident #135 was alert and oriented to person, place and situation. The baseline care plan dated 02/07/23 revealed Resident #135 could communicate easily with staff, understand others and his daily preferences included receiving a shower. The undated Master Shower Schedule provided by the facility revealed Resident #135 was scheduled to receive his showers on Mondays and Fridays during the hours of 3:00 PM and 11:00 PM. Review of the February 2023 Nurse Aide (NA) bathing documentation report for Resident #135 revealed bed baths were documented as provided on 02/08/23, 02/09/23, 02/11/23, 02/12/23, 02/14/23, 02/15/23, 02/16/23, 02/17/23, 02/19/23, 02/20/23, 02/21/23, 02/22/23, and 02/23/23. There were no showers documented as provided. During an interview on 02/20/23 at 2:08 PM, Resident #135 voiced he had not received a shower since admitting to the facility approximately 2 to 3 weeks ago. Resident #135 stated staff "cleaned him up here and there" but he wanted to have a shower.	F 561	3/23/23 the Nurse Managers updated electronic record was updated to reflect these preferences. 2. All residents receiving assistance with showers and assistance with getting out of bed have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers conducted an interview with all residents to assess preferences for showering and getting out of bed. By 3/23/23 to Nurse Managers updated resident preferences for showers and getting out of bed in the electronic record. Any opportunities identified were addressed immediately by the Director of Nursing. 3. By 3/23/23 the Nurse Managers re-educated all Nursing staff, including agency staff on the facility process for assessing preferences for showering and getting out of bed on admission. Beginning 3/23/23 the Nurse Managers were educated by the Director of Nursing on the responsibility of entering these preferences in the electronic record. Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff. The Nurse Managers and Director of Nursing will observe 5 residents 3 times per week for 12 weeks to ensure the scheduled shower was completed and they are being assisted out of bed according to their preferences. 4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make	

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F 561 Continued From page 10

During a telephone interview on 02/27/23 at 1:40 PM, Resident #135's Responsible Party (RP) stated Resident #135 preferred showers instead of bed baths and had mentioned not getting his showers.

During an interview on 02/24/23 at 9:28 AM, NA #10 revealed she had been working at the facility since the end of October 2022 through a staffing agency. NA #10 confirmed she had been assigned to provide care to Resident #135 but could not state for certain why he was provided bed baths instead of showers. NA #10 explained there were times the facility was short-staffed and she would have 18 or more residents on her assignment, which made it difficult to get all resident care provided. NA #10 stated when working short-staffed, she might not be able to get the resident up out of bed but she made sure they were kept turned, clean and fed and while they might not get a shower they did get a complete bed bath.

Telephone attempts made on 02/24/23 at 1:48 PM and 02/27/23 at 9:15 AM for interview with NA #12 who had provided care to Resident #135 were unsuccessful.

During a telephone interview on 02/27/23 at 11:53 AM, NA #11 revealed she worked various shifts at the facility through a staffing agency and when she had worked evening shifts during the hours of 3:00 PM to 11:00 PM, there were often only 3 to 4 NAs scheduled for the entire building which was not enough. NA #11 explained when working short-staffed, she was not able to assist residents with getting up out of bed and bed baths were provided instead of a shower. NA #11 confirmed she often worked on the rehab hall where

F 561

recommendations.
Date of Completion 3/24/23

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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 561	Continued From page 11 Resident #135 resided but could not specifically recall him or the care she may have provided. A joint interview was conducted with the Director of Nursing, Administrator and Corporate Consultant on 02/24/23 at 3:54 PM. The Administrator stated the NAs should be going to their nurse and asking for help if they were having trouble getting their work done or resident care provided. The Administrator further stated all residents should be receiving a shower instead of a bed bath if that was their preference. 2. Resident #1 was admitted to the facility on 7/31/15 diagnoses that included multiple sclerosis, epilepsy, and age-related cognitive decline. Review of the Quarterly Minimum Data Set (MDS) dated 12/26/22 revealed Resident #1 was cognitively intact. Review of Resident #1's active care plan, last reviewed 5/21/22 included a focus area for Activities of Daily Living (ADL) self-care performance deficit. Review of the master Shower Schedule revealed Resident #1 was to receive showers Wednesday and Saturday evenings. Review of the December 2022 bathing documentation for Resident #1 revealed no showers were given. There was no documentation of any shower refusals. Review of the December 2022 bathing documentation for Resident #1 revealed bed baths were given 12/2/22, 12/3/22, 12/4/22, 12/5/22, 12/7/22, 12/8/22, 12/9/22, 12/11/11,	F 561		

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 02/28/2023

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F 561	Continued From page 12	F 561		

12/12/22, 12/13/22, 12/17/22, 12/19/22, 12/20/22, 12/21/22, 12/22/22, 12/24/22, 12/26/22, 12/27/22, 12/28/22, and 12/31/22.

Review of the January 2023 bathing documentation for Resident #1 revealed no showers were given. There was no documentation of any shower refusals.

Review of the January 2023 bathing documentation for Resident #1 revealed bed baths were given 1/1/23, 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/8/23, 1/12/23, 1/13/23, 1/16/23, 1/18/23, 1/19/23, 1/22/23, 1/24/23, 1/25/23, 1/26/23, 1/28/23, and 1/30/23.

Review of the February 2023 bathing documentation for Resident #1 revealed 1 shower was given 2/11/23. There was no documentation of any shower refusals.

Review of the February 2023 bathing documentation for Resident #1 revealed bed baths were given 2/2/23, 2/3/23, 2/5/23, 2/6/23, 2/9/23, 2/13/23, 2/17/23, and 2/21/23.

Review of the December 2022 through February 2023 progress notes for Resident #1 revealed no documentation of shower refusals.

An interview with Resident #1 on 2/20/23 at 3:52 PM revealed she was supposed to get a shower on Wednesday and Saturday but had not received one in 2 weeks. Resident #1 stated she had gotten bed baths, but her preference was to get showers. Resident #1 also stated staff told her there was not enough staff working to give her a shower.

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 02/28/2023

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F 561	Continued From page 13	F 561		

An interview on 2/24/23 at 7:03 AM with Nurse Aide #2 revealed she did not recall why she gave Resident #1 a bed bath on her scheduled shower day 12/21/22. Nurse Aide #2 stated staff had problems with completing their ADL care when the facility was understaffed and they completed the basic care of making sure the residents were dry, fed, and turned.

An interview on 2/24/23 at 11:39 AM with Nurse Aide #3 revealed she usually gave her showers and was not sure why she gave Resident #1 a bed bath instead of a shower on 12/7/22. Nurse Aide #3 did state she could have given Resident #1 a bed bath instead of a shower on 12/7/22 due to a lack of staffing. Nurse Aide #3 revealed Resident #1 was a 2 person lift to get up and if the facility was understaffed that day it would have been difficult to get to her shower.

An interview on 2/24/23 at 3:51 PM with the Director of Nursing (DON), Corporate Nurse Consultant, and Administrator revealed the nurse aides should be going to the nurses if they needed help to get showers completed. The Administrator stated the residents who requested a shower should be given a shower instead of a bed bath because that is their preference.

3. Resident #12 was admitted to the facility 6/18/21 with diagnoses that included traumatic brain injury, and quadriplegia (paralysis of all four limbs).

Review of the annual MDS dated 6/22/22 revealed Resident #12 was cognitively intact.

Review of Resident #12's active care plan, last reviewed 10/8/22 included a focus area for ADL

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 561	Continued From page 14	F 561		

self-care performance deficit.

Review of the master Shower Schedule revealed Resident #12 was to receive showers Tuesday and Thursday evenings.

Review of the December 2022 bathing documentation for Resident #12 revealed showers were given 12/2/22, 12/9/22, 12/12/22, 12/22/22, and 12/27/22. There was no documentation of any shower refusals.

Review of the December 2022 bathing documentation for Resident #12 revealed bed baths were given 12/3/22, 12/4/22, 12/5/22, 12/13/22, 12/14/22, 12/17/22, 12/18/22, 12/21/22, 12/24/22, 12/26/22, 12/28/22, and 12/31/22.

Review of the January 2023 bathing documentation for Resident #12 revealed showers were given 1/12/23 and 1/18/23. There was no documentation of any shower refusals.

Review of the January 2023 bathing documentation for Resident #12 revealed bed baths were given 1/2/23, 1/3/23, 1/4/23, 1/5/23, 1/6/23, 1/8/23, 1/10/23, 1/16/23, 1/22/23, 1/24/23, 1/26/23, and 1/28/23.

Review of the February 2023 bathing documentation for Resident #12 revealed one shower was given 2/21/22. There was no documentation of any shower refusals.

Review of the February 2023 bathing documentation for Resident #12 revealed bed baths were given 2/2/23, 2/6/23, 2/9/23, 2/10/23, 2/13/23, 2/14/23, 2/17/23, and 2/20/23.

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 561		F 561		

Continued From page 15

Review of the December 2022 through February 2023 progress notes for Resident #12 revealed no documentation of shower refusals.

An interview with Resident #12 on 2/20/23 at 11:11 AM revealed she was to get her showers Tuesday and Thursday but she only got 1 shower a week. Resident #12 stated she would get offered bed baths, but she preferred to get a shower.

An interview on 2/24/23 at 3:51 PM with the Director of Nursing (DON), Corporate Nurse Consultant, and Administrator revealed the nurse aides should be going to the nurses if they needed help to get showers completed. The Administrator stated the residents who requested a shower should be given a shower instead of a bed bath because that is their preference.

4. Resident #58 was admitted to the facility on 3/24/21 with diagnoses that included cerebral infarction, diabetes type 2, and muscle weakness.

Review of the quarterly MDS dated 11/10/22 revealed Resident #58 was cognitively intact.

Review of Resident #58's active care plan, last reviewed 9/27/22 included a focus area for ADL self-care performance deficit.

Review of the master Shower Schedule revealed Resident #58 was to receive showers Tuesday and Thursday evenings.

Review of the December 2022 bathing documentation for Resident #58 revealed showers were given 12/6/22, 12/12/22, 12/22/22, and 12/29/22. There was no documentation of

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 02/28/2023

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 561 Continued From page 16
any shower refusals.

Review of the December 2022 bathing documentation for Resident #58 revealed bed baths were given 12/4/22, 12/9/22, 12/13/22, 12/14/22, 12/21/22, and 12/24/22.

Review of the January 2023 bathing documentation for Resident #58 revealed showers were given 1/3/23, 1/10/23, 1/12/23, 1/17/23, 1/24/23, and 1/26/23. There was no documentation of any shower refusals.

Review of the January 2023 bathing documentation for Resident #58 revealed bed baths were given 1/4/23, 1/5/23, 1/6/23, 1/8/23, 1/16/23, 1/18/23, 1/22/23, and 1/30/23.

Review of the February 2023 bathing documentation for Resident #58 revealed 1 shower was given 2/21/23. There was no documentation of any shower refusals.

Review of the February 2023 bathing documentation for Resident #58 revealed bed baths were given 2/2/23, 2/6/23, 2/9/23, 2/13/23, 2/17/23, and 2/20/23.

Review of the December 2022 through February 2023 progress notes for Resident #58 revealed no documentation of shower refusals.

An interview with Resident #58 on 2/20/23 at 11:45 AM revealed she was to receive her showers on Tuesday and Thursdays. Resident #58 stated she would ask to get her showers, but did not get them. Resident #58 also stated she would get a washup in the bathroom, but that it was not worthwhile.

F 561

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561 Continued From page 17 F 561

An interview on 2/24/23 at 3:51 PM with the Director of Nursing (DON), Corporate Nurse Consultant, and Administrator revealed the nurse aides should be going to the nurses if they needed help to get showers completed. The Administrator stated the residents who requested a shower should be given a shower instead of a bed bath because that is their preference.

5. Resident #284 was admitted to the facility on 9/21/22 with diagnoses that included chronic respiratory failure with hypoxia (the absence of enough oxygen in the tissues to sustain bodily functions), chronic bronchitis, and diabetes type 2.

The quarterly MDS dated 2/2/23 revealed Resident #284 was cognitively intact.

Review of Resident #284's active care plan, last reviewed 9/27/22 included a focus area for ADL self-care performance deficit.

Review of the master Shower Schedule revealed Resident #284 was to receive showers Monday and Friday evenings.

Review of the December 2022 bathing documentation for Resident #284 revealed no showers were given. There was no documentation of any shower refusals.

Review of the December 2022 bathing documentation for Resident #284 revealed bed baths were given 12/2/22, 12/6/22, 12/7/22, 12/8/22, 12/9/22, 12/13/22, 12/14/22, 12/15/22, 12/17/22, 12/20/22, 12/21/22, 12/22/22, 12/27/22, 12/28/22, 12/29/22, and 12/31/22.

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 02/28/2023

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F 561	Continued From page 18 Review of the January 2023 bathing documentation for Resident #284 revealed showers were given 1/13/23, 1/18/23, 1/25/23, and 1/29/23. There was no documentation of any shower refusals. Review of the January 2023 bathing documentation for Resident #284 revealed bed baths were given 1/2/23, 1/3/23, 1/4/23, 1/11/23, 1/17/23, 1/19/23, 1/20/23, 1/21/23, 1/23/23, 1/24/23, 1/26/23, 1/28/23, and 1/31/23. Review of the February 2023 bathing documentation for Resident #284 revealed no showers were given. There was no documentation of any shower refusals. Review of the February 2023 bathing documentation for Resident #284 revealed bed baths were given 2/1/23, 2/2/23, 2/3/23, 2/4/23, 2/6/23, 2/11/23, 2/13/23, 2/17/23, and 2/21/23. Review of the December 2022 through February 2023 progress notes for Resident #284 revealed no documentation of shower refusals. An interview with Resident #284 on 2/20/23 at 1:13 PM revealed she only received a shower about once a month. Resident #284 stated she preferred to get showers and not bed baths. An interview on 2/22/23 at 2:10 PM with Nurse Aide #5 revealed if a resident refused a shower it would be documented and the nurse notified of the refusal. Nurse Aide #5 stated sometimes it was impossible to give the residents their showers when they had to take care of 17-20 residents or more.	F 561		

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561		F 561		

Continued From page 19

An interview on 2/24/23 at 9:01 AM with Nurse #4 revealed a bed bath was not a substitute for a shower, and it was expected showers were completed on shower days. Nurse #4 was not sure why Resident #1, Resident #12, Resident #58, and Resident #284 were not getting their showers.

An interview on 2/24/23 at 3:51 PM with the Director of Nursing (DON), Corporate Nurse Consultant, and Administrator revealed the nurse aides should be going to the nurses if they needed help to get showers completed. The Administrator stated the residents who requested a shower should be given a shower instead of a bed bath because that is their preference.
6. Resident #70 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis of the right side, stroke, debility, muscle weakness, and depression.

An admission Minimum Data Set for Resident #70 dated 2/1/23 revealed she was cognitively intact with no behaviors or rejection of care. The resident required extensive 1 person assist for bed mobility and extensive 2 person assist for transfers.

The care plan for Resident #70 dated 2/4/23 revealed Resident #70 had an activity of daily living (ADL) self-care performance deficit related to stroke and right hemiparesis. The interventions included Resident #70 required assistance by staff to move between surfaces.

During an interview on 02/20/23 at 10:54 AM Resident #70 revealed she needed help to get out of bed because of her stroke. On the weekends

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 02/28/2023

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F 561	Continued From page 20	F 561		

she had to stay in bed all day because there was not enough staff to get her up. She stated that residents that could not get up on their own were left in bed on the weekend. When she asked staff to help her get up on the weekend, she was told they were short staffed, or staff would say they were the only one on the unit. She further stated there were activities on the weekends that she and others would like to participate in, but she could not because she could not get up on her own. She explained that this occurred mostly on the weekend. During the week she had to wait to get up, but staff would eventually get her up. She stated on that day she was supposed to be going to therapy, but she had not been gotten up yet. She further stated the NA would get her up on that day, but it sometimes took them a while, "it's worse on the weekend".

During an interview on 2/23/23 at 12:56 PM Nurse Aide (NA) #7 revealed on this past weekend the facility was short staffed. She stated she cared for the residents on the East unit where Resident #70 resided, and she did not get Resident #70 out of bed. She explained she had approximately 20 residents to care for. When she had to care for that number of resident's it was difficult to complete all her duties including getting residents out of bed. She stated she did not recall resident #70 requesting to get out of bed.

During an interview on 2/23/23 at 2:25pm Resident #70 revealed she asked staff to get her out of bed the past weekend, but no one got her up, "they never get us up on the weekend". She stated she had only been gotten out of bed once on the weekend since she had been in the facility.

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 02/28/2023

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 561	Continued From page 21 An interview was conducted on 2/23/23 at 4:00 PM with Nurse #6. She revealed she worked the weekend and was the nurse for the East unit where Resident #70 resided. She stated staffing was low and it was challenging. She remembered Resident #70 did not get out of bed. She was not aware that the resident wanted to get up. She further stated if she knew that Resident #70 wanted to get out of bed, she would have assisted her. During an interview on 2/24/23 at 3:52 PM the Director of Nursing revealed that residents should be able to get out of bed when they like. If staff were busy, or needed help, they should ask for help from their teammates. During an interview on 02/27/23 at 1:31 PM the Regional Director of Clinical Services revealed if staff could not get residents up out of bed on the weekend, or get assistance to get that resident up, they should notify the DON. The DON was on-call on the weekends and could come in to assist if needed.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		3/24/23

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 02/28/2023

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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 578	Continued From page 22 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 2 of 32 residents reviewed (Residents #18 and #29). Findings included: 1. Resident #18 was admitted on 11/7/18.	F 578	1.By 3/23/23 the Nurse Managers reviewed the Physician’s orders, Portable DNR, and MOST form to ensure completion of advanced directives for Residents #18 and #29. By 3/23/23 the Nurse Managers revised the care plan to reflect current advanced directives for Residents #18 and #29.	

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 02/28/2023

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 578

Continued From page 23

A DNR (Do Not Resuscitate) form dated 11/2/22 for Resident #18 was located in the advance directive book at the nurses' station.

A review of Resident #18's medical record revealed a physician's order dated 11/2/22 for a DNR.

Resident #18's care plan dated 2/15/23 revealed her to be a full code.

The MDS Coordinator stated on 2/21/23 at 3:32 PM Resident #18's advance directive code status change should have occurred in real-time when the physician's order was signed. When the care plan was reviewed on 2/15/23, the advance directive code status should have been changed by the MDS coordinator who updated the care plan.

The Administrator was interviewed on 2/24/23 at 4:13 PM and stated Resident #18's advance directive should have been reflected on the care plan with a goal and interventions. The care plan should be updated quarterly or as needed.

2. Resident #29 was admitted to the facility on 09/21/21 with multiple diagnoses that included cerebral infarction (stroke) and heart failure.

The significant change Minimum Data Set (MDS) dated 12/02/22 assessed Resident #29 with moderate impairment in cognition.

Review of Resident #29's medical record revealed a physician's order dated 12/28/22 for a code status of Do Not Resuscitate (DNR).

Review of the Code Status book for residents kept at the nurses' station revealed Resident #29

F 578

2. All residents with advanced directives have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers reviewed the Physician's orders, Portable DNR, and MOST form to ensure completion of advanced directives for all current residents. By 3/23/23 the Nurse Managers revised the care plan to reflect current advanced directives for all current residents. Any opportunities identified were addressed immediately by the Director of Nursing.

3.By 3/23/23 the Nurse Managers re-educated all Nursing staff, including agency staff on the facility policy for advance directives. Beginning 3/23/23 the Nurse Managers were educated by the Director of Nursing on the responsibility of updating the care plan to reflect current advanced directives. Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff.

The Nurse Managers and Director of Nursing will review 10 resident records 3 times per week for 12 weeks to ensure the Physician order matches the Portable DNR and MOST forms and is reflected accurately in the care plan.

4.The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of Completion 3/24/23

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 24 had a DNR form in place effective 12/28/22. Review of Resident #4's comprehensive care plans, last revised 01/21/23, revealed a care plan with a focus of Advanced Directive - Full Code. Interventions included to review Resident #29's advanced directives quarterly and/or as needed. During an interview on 02/21/23 at 3:32 PM, MDS Nurse #1 explained when notified of a code status change for a resident, she first checked the resident's chart to ensure there was a physician's order and then updated the resident's advanced directive care plan. MDS Nurse #1 was not sure how the code status change for Resident #29 was missed and stated his advance directive care plan should have been updated on 12/28/22 when the physician order for DNR was received. During an interview on 02/24/23 at 3:54 PM, the Administrator stated Resident #29's advance directive care plan should have been updated when his code status changed and was most likely an oversight.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		3/24/23

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 02/28/2023

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F 582	Continued From page 25	F 582		

charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to 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 02/28/2023

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 582	Continued From page 26 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare Part A skilled services to 1 of 3 residents reviewed for beneficiary notification review (Resident #27). The Findings Included: Resident #27 was admitted to the facility on 01/11/22. A review of Resident #27's medical record revealed no evidence a NOMNC and SNF ABN were provided to her or her Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 10/31/22. Resident #27 remained in the facility. A joint interview was conducted with the Social Worker (SW) and Minimum Data Set (MDS) Nurse #1 on 02/22/23 at 9:36 AM. MDS Nurse #1 explained the Business Office Manager was responsible for issuing the SNF ABN when notified a resident had received a NOMNC. During an interview on 02/23/23 at 3:44 PM, the SW confirmed she was responsible for issuing residents or their RP a NOMNC when notified Medicare Part A services were ending. The SW stated she did not recall issuing Resident #27 a NOMNC and was unable to explain why the required NOMNC was not provided.	F 582	6. NOMNC-F582D 1. Resident #27 continues to reside in the facility receiving skilled nursing care. 2. All residents receiving Medicare Part A skilled services have the potential to be affected by this alleged deficient practice. By 3/23/23, the Administrator and Nurse Manager completed an audit of the CMS Notice of Medicare Non-coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) completed for Medicare Part A skilled residents for the past 30 days. Any residents that did not have NOMNC and SNF ABNs completed were reissued. Any opportunities identified were addressed by the Administrator. 3. By 3/23/23 the Business Office consultant re-educated the Business Office Manager and the Social Worker regarding the facility policy for issuing NOMNCs and SNF ABNs to residents prior to discharge from Medicare Part A skilled services. The Business Office manager will review and audit all NOMNCs and SNF ABNs issued to Medicare Part A skilled residents to ensure they are issued in accordance with facility policy prior to discharge from Medicare Part A skilled services. 4. The Business Office Manager will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.	

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 02/28/2023

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F 582	Continued From page 27 The Business Office Manager was no longer employed and unable to be interviewed. During an interview on 02/24/23 at 3:54 PM, the Administrator stated Resident #27 should have received a NOMNC and SNF ABN per regulatory guidelines prior to Medicare Part A services ending. The Administrator explained there had been a change in the Business Office Manager position which contributed to the breakdown in the process.	F 582	Date of Completion 3/24/23	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/24/23

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 02/28/2023

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F 584	Continued From page 28 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair jagged and splintered edges on the middle and lower portion of a bathroom door in the residents shared bathroom (room 107); failed to clean the air vents and filters of the air condition and heating units in resident rooms (rooms 102, 106, 108, and 109); failed to maintain walls in good repair in a resident's room (room 109-B) on 1 of 2 wings (West Wing). The facility failed to maintain a clean and sanitary side rail for a resident's bed (room 144-A); failed to appropriately label and store personal care equipment in residents shared bathrooms (rooms 145, 143, and 142); failed to maintain functioning overhead lights in residents bathrooms (rooms 142 and 145); failed to provide functioning soap dispensers in residents bathrooms (rooms 148 and 146); and failed to provide a resident a pillow in good condition (room 131-B) on 1 of 2 wings (West Wing).	F 584	5.Homelike Environment F584E 1. By 3/23/23 the Maintenance Director repaired the bathroom door in room 107, cleaned the air vents and filters of the air condition and heating units in resident rooms 102, 106, 108, and 109, repaired the walls in resident room 109-B, dusted the siderail on the bed in resident room 144A. By 3/23/23 the Nurse Manager labeled the personal care equipment in residents shared bathrooms in rooms 145, 143, and 142. By 3/23/23 the Maintenance Director replaced the light bulbs in the overhead lights in residents bathrooms in rooms 142 and 145 and replaced the soap dispensers in residents bathrooms in rooms 148 and 146. By 3/23/23 the Nurse Manager replaced the resident a pillow in room 131-B. 2. All residents have the potential to be affected by this alleged deficient practice.	

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 02/28/2023

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F 584

Continued From page 29

The findings included:

1. An observation on 02/20/23 at 3:07 PM of the bathroom door in room 107 revealed near the middle and lower section of the door there were two circular shaped areas where the wood was missing. Approximately 3 to 4 inches of the wood was missing, and the edges were jagged and splintered.

A second observation on 02/22/23 at 10:34 AM revealed no change in the condition of the bathroom door in room 107.

2. a. An observation on 02/20/23 at 11:32 AM revealed the air/heat unit in room 109 had a buildup of dust and debris inside the vents and a buildup of lint like debris covering the air filter.

A second observation on 02/22/23 at 10:49 AM revealed no change in the condition of the air/heat unit in room 109.

b. An observation on 02/20/23 at 2:53 PM revealed the air/heat unit in room 106 had a buildup of dust and debris inside the vents and a buildup of lint like debris covering the air filter.

A second observation made on 02/22/23 at 10:46 AM revealed no change in the condition of the air/hear unit vent or filter in room 106.

c. An observation on 02/21/23 at 8:39 AM revealed the air/heat unit in room 102 had a buildup of dust and debris inside the vents and a buildup of lint like debris covering the air filter.

A second observation on 02/22/23 at 11:03 AM revealed no change in the condition of the

F 584

By 3/23/23 the Maintenance Director and the Administrator reviewed all resident rooms and created a prioritized list of facility repairs.
3. By 3/23/23 the Administrator re-educated all staff, including agency staff on the facility process for notifying the Maintenance Director of needed repairs by making a notation in the Maintenance Log at each Nurses station.
Beginning 3/23/23 the Maintenance Director was educated by the Administrator on the responsibility of reviewing these repair requests daily and completing the repair or adding to the prioritized list. Beginning 3/23/23 the Administrator will ensure this education will be included in orientation for newly hired staff and agency staff.
The Administrator will review 5 resident rooms and shared bathrooms 3 times per weekly for 12 weeks to ensure requested repairs have been made and any new repair needs are identified and noted in the log.
4. The Administrator will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.
Date of Completion 3/24/23

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 02/28/2023

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F 584	Continued From page 30	F 584		

Continued From page 30
air/heat unit in room 102.

d. An observation on 02/21/23 at 3:48 PM revealed the air/heat unit in room 108 had a buildup of dust and debris inside the vents and a buildup of lint like debris covering the air filter.

A second observation on 02/22/23 at 10:47 AM revealed no change in the condition of the air/heat unit in room 108.

3. An observation made on 02/20/23 at 11:32 AM of room 109-B revealed behind the bed on the lower half of the wall was a large area of unpainted spackling and damaged sheetrock with deep gouges into the wall.

A second observation on 02/22/23 at 10:32 AM revealed no change in the condition of the wall behind the bed in Room 109.

During an interview on 02/23/23 at 10:08 AM the Maintenance Director revealed he was under the impression Housekeeping cleaned the air filters and vents on the units in resident rooms and didn't know maintenance was responsible for cleaning those on a regular basis until last week. The Maintenance Director observed the damage to the wall in room 109 and explained the resident would need to be out of the room for approximately two days and he had to wait for that to happen which caused a standstill for repairs when maintenance couldn't gain access to the room as needed. He confirmed he wasn't aware of the damaged area behind the bed in room 109 and stated the sheetrock and spackling needed to be repaired and painted. The Maintenance Director explained he used TELS (a maintenance software system) to monitor work

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 02/28/2023

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F 584	Continued From page 31	F 584		

orders and relied on staff to notify maintenance of any environment issues they identified. He explained staff could either verbally tell maintenance or write a note in the logbook kept at each nurse station that was checked in the morning.

An interview and observation were conducted on 02/23/23 at 10:38 AM with the Maintenance Assistant. The Maintenance Assistant revealed he was aware maintenance was responsible for cleaning the air condition and heating units in resident rooms. He explained a vacuum cleaner was used to remove dust and debris from the air vents and the filters were sprayed off then wash with hot water and air dried then replaced. The Maintenance Assistant stated he cleaned all the air condition and heating units in resident rooms monthly and it took approximately two days. The Maintenance Assistant observed the units in rooms 106 and 108 had a buildup of dust and debris in the air vent and lint like dust and debris covering the air filter. The Maintenance Assistant revealed he was aware the air condition and heating units on the West Wing were dirty and not been cleaned this month and stated the dust builds up quick.

An observation of room 107 and interview were conducted on 02/24/23 at 8:36 AM with the Maintenance Director. The Maintenance Director revealed he wasn't aware of the damaged areas on the bathroom door. The Maintenance Director stated he would smooth the wood and fix it so there wouldn't be jagged or splintered edges.

A joint interview was conducted on 02/24/23 at 5:38 PM with the Administrator, Director of Nursing, and the Corporate Nurse Consultant.

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 02/28/2023

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F 584	Continued From page 32	F 584		

The Administrator revealed the Maintenance Assistant cleaned the air filters in January, but it hadn't been done for February. The Corporate Nurse Consultant stated if cleaning once a month didn't keep the units clean maintenance may need to clean those more than once a month. The Administrator stated the environment concerns would be addressed and explained staff should be notifying maintenance of issues noted in the residents rooms and bathrooms and could do so either verbally or write a note for a work order.

4. An observation of the right side rail of the bed in room 144-A on 02/20/23 at 10:18 AM revealed dried brown material on the side rail. Additional observations of the right side rail of the bed in room 144-A on 02/21/23 at 9:04 AM, on 02/22/23 at 9:00 AM, on 02/23/23 at 10:21 AM, and on 02/24/23 at 8:09 AM revealed the dried brown material remained on the side rail.

An interview with the Director of Environmental Services on 02/23/23 at 10:32 AM revealed housekeeping staff worked 7 days a week and cleaned each resident room daily using a 7-step process. He explained the process included emptying the trash; checking/refilling paper towel dispensers; checking/refilling soap dispensers; dusting each surface; wiping down and cleaning all surfaces in the rooms, including resident beds; dust-mopping; and mopping the floors.

A follow-up interview with the Director of Environmental Services on 02/24/23 at 10:15 AM revealed he expected bed rails to be clean and free of debris.

An interview with the Administrator on 02/24/23 at

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 02/28/2023

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 584		F 584		

Continued From page 33
5:33 PM revealed side rails on resident beds should be clean and free of debris.

5. (a) An observation of the shared bathroom of Room 145 on 02/20/23 at 2:17 PM revealed 3 unlabeled and uncovered bath basins stacked inside each other sitting on the back of the toilet.

Additional observations of the shared bathroom of room 145 revealed the following:

-On 02/21/23 at 9:02 AM 3 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the back of the toilet.
-On 02/22/23 at 8:51 AM 2 covered and unlabeled bath basins were stacked inside each other and were sitting on the back of the toilet.
-On 02/23/23 at 10:19 AM 2 covered but unlabeled bath basins were stacked inside each other and were sitting on the back of the toilet.
-On 02/24/23 at 8:16 AM 3 covered and unlabeled bath basins were stacked inside each and were sitting inside another covered and unlabeled bath basin on the back of the toilet.

(b) An observation of the shared bathroom of Room 143 on 02/20/23 at 10:24 AM revealed 2 unlabeled and uncovered bath basins stacked inside each other sitting on the floor.

Additional observations of the shared bathroom of room 143 revealed the following:

-On 02/21/23 at 9:09 AM 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the back of the toilet.
-On 02/22/23 at 12:23 PM 2 covered and unlabeled bath basins were stacked inside each other and were sitting on the back of the toilet.

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 02/28/2023

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 584	Continued From page 34 -On 02/23/23 at 10:44 AM 2 covered and unlabeled bath basins were partially stacked inside each other and were sitting on the back of the toilet. -On 02/24/23 at 8:10 AM 2 covered and unlabeled bath basins were partially stacked inside each other and were sitting on the back of the toilet. (c) An observation of the shared bathroom of Room 142 on 02/20/23 at 10:41 AM revealed 2 unlabeled and uncovered bath basins stacked inside each other sitting in a wheelchair and an unlabeled and uncovered bath basin sitting on the floor. Additional observations of the shared bathroom of room 142 revealed the following: -On 02/21/23 at 9:18 AM 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting in a wheelchair and an unlabeled and uncovered bath basin was sitting on the floor. -On 02/22/23 at 8:56 AM revealed 2 unlabeled and uncovered bath basins were stacked inside each and were sitting in a wheelchair. -On 02/23/23 at 10:25 AM revealed 2 covered and unlabeled bath basins were stacked inside each other and were sitting in a wheelchair. -On 02/24/23 at 8:12 AM revealed 2 covered and unlabeled bath basins were stacked inside each other and were sitting on the floor beside the sink. An interview with the Director of Nursing (DON) on 02/24/23 at 2:11 PM revealed all bath basins should be labeled and covered, should not be stored on the floor, and should not be stacked inside each other. She stated it was the	F 584		

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 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 35 responsibility of nurse aides (NAs) to make sure personal care equipment was labeled, covered, and stored appropriately. 6. (a) An observation of the bathroom of room 142 on 02/20/23 at 10:41 AM revealed no functioning overhead light. Additional observations of the bathroom of room 142 on 02/21/23 at 9:18 AM, 02/22/23 at 8:56 AM and 02/23/23 at 10:25 AM revealed no functioning overhead light. (b) An observation of the bathroom of room 145 on 02/20/23 at 2:17 PM revealed no functioning overhead light. Additional observations of the bathroom of room 145 on 02/21/23 at 9:02 AM, 02/22/23 at 8:51 AM, and 02/23/23 at 10:19 AM revealed no functioning overhead light. An interview with the Maintenance Director on 02/23/23 at 3:24 PM revealed Monday through Friday he did a walk-through of all resident rooms on the east side of the building and the Director of Environmental Services did a walk-through of all resident rooms on the west side of the building to check for any issues that need to be addressed. He stated he also relied on other departments to report any issues with resident rooms, including burned out light bulbs. The Maintenance Director stated he only became aware of the bathroom light of room 145 not functioning on 02/23/23 and was not aware of the bathroom light of room 142 not functioning. He stated all bathroom lights should be in working order. An interview with the Administrator on 02/24/23 at 5:33 PM revealed all resident bathroom lights should be in working order.	F 584		

F 584 Continued From page 36 F 584

7. (a) A check of the soap dispenser in the bathroom of room 148 on 02/22/23 at 8:45 AM revealed no soap came out of the dispenser. An additional check of the soap dispenser of the bathroom of room 148 on 02/24/23 at 8:19 AM revealed no soap came out of the dispenser.

(b) A check of the soap dispenser in the bathroom of room 146 on 02/20/23 at 2:17 PM revealed no soap came out of the dispenser. Additional checks of the soap dispenser in the bathroom of room 146 at 02/22/23 at 8:48 AM, 02/23/23 at 9:58 AM, and 02/24/23 at 8:19 AM revealed no soap came out of the dispenser.

During an interview with the Director of Environmental Services on 02/24/23 at 10:15 AM he checked the soap dispenser in the bathroom or room 146 and confirmed there was no soap in the dispenser. He checked the soap in the dispenser of the bathroom of room 142 and it was full of soap but he was unable to get the soap to come out of the dispenser. The Director of Environmental Services stated soap dispensers should be checked/refilled daily and all soap dispensers should be in working order.

An interview with the Administrator on 02/24/23 at 5:33 PM revealed all soap dispensers should contain soap and should be in working order.
8. An observation of a resident's room (131-B) on 2/20/23 at 10:39 AM revealed the plastic covering on the pillow had multiple cracks, rips, and tears. The resident was resting in bed with her head on the pillow with the pillowcase covering half of the pillow.

On 2/21/23 at 9:51 AM the resident was resting in bed with her head on the same pillow, with the

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	345134	A. BUILDING ______ B. WING ______	C 02/28/2023

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F 584	Continued From page 37	F 584		

pillowcase covering the pillow. The resident had no visible skin irritations.

On 2/23/23 at 12:56 PM Nurse Aide #7 was interviewed and confirmed she was assigned to the resident in 131-B. She stated that the bed linens were changed every shower day or as needed when soiled. Nurse Aide #7 said when a pillow was in disrepair, she went to laundry to get a new pillow. She reported she did not know the pillow was damaged and did not know why the pillow was not replaced when the resident's linen was changed during the week.

The Housekeeping (HK) Manager was interviewed on 2/23/23 at 10:40 AM and stated that all facility staff were responsible for monitoring the pillows and notifying him when a pillow needed to be replaced. He said the facility kept a stash of pillows in the laundry room that were used to replace damaged pillows. The HK Manager reported that he had not been notified of damaged pillows during the current week.

A tour with the HK Manager on 2/23/23 at 10:43 AM of room 131-B revealed the damaged pillow remained on the bed with the resident laying on it. The HK manager removed the pillow and replaced it with an extra pillow found in the room. When the pillow was removed from the pillowcase, the bottom seam of the pillow was split, and the stuffing was hanging out of the pillow. The HK manager said the pillow should have been replaced.

The Administrator stated on 2/24/23 at 4:13 PM that the resident's pillow should have been replaced by facility staff when it was found damaged, and it was not done.

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F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that a resident was free from neglect when it failed to provide incontinence care for 1 of 3 residents reviewed for incontinence care (Resident #48). The reasonable person concept was applied to this deficiency. Individuals would expect to receive the care needed and would be upset if left in a wet bed. Findings included: Resident #48 was admitted to the facility 08/16/19 with diagnoses including cerebrovascular accident (abbreviated as CVA and meaning a stroke) and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 01/17/23 revealed Resident #48 was severely cognitively impaired, had no behaviors or	F 600	7.Neglect F600D 1. On 02/20/2023, the Charge Nurse and the Nurse Aide provided incontinence care and changed the bed linen for Resident #48. 2. All dependent residents have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers completed an observation of dependent residents to identify other residents with concerns related to neglecting ADL care. Any opportunities identified were addressed immediately by the Director of Nursing. 3. By 3/23/23 the Nurse Managers re-educated all facility staff, including agency staff on the facility policy for neglect of residents including the lack of ADL Care. Beginning 3/23/23 the Director of Nursing will ensure this education will	3/24/23

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F 600	Continued From page 39 rejection of care, and was always incontinent of bladder. Review of Resident #48's care plan last revised 01/18/23 revealed he was incontinent of bowel and bladder and interventions included checking him frequently and assisting with toileting as needed; providing incontinence briefs per manufacturer's recommendation; providing loose-fitting, easy to remove clothing; and providing peri-care (cleaning private areas) after each incontinent episode. An observation of Resident #48 on 02/20/23 at 10:16 AM revealed he was lying in bed with his eyes closed and a strong odor of urine was noted in his room. An observation of Nurse Aide (NA) #8 on 02/20/23 at 10:52 AM revealed she entered Resident #48's room and pulled back his top sheet. Lying in bed beside Resident #48 was a urine saturated incontinence brief. Resident #48 was partially lying on a bath blanket being used as a bed pad and the bath blanket contained a dried ring of urine. No bottom sheet was on Resident #48's bed and a large moist area was noted to his mattress below the bath blanket. An interview with NA #8 on 02/20/23 at 10:58 AM revealed she reported for work around 8:30 AM the morning of 02/20/23. She stated she checked Resident #48 shortly after arriving for her shift and noted he had been incontinent of urine. NA #8 stated she did not provide incontinence care to Resident #48 when she noted he was wet because breakfast trays arrived on the hall and she could not perform incontinence care while trays were on the hall.	F 600	be included in orientation for newly hired staff and agency staff. The Nurse Managers and Director of Nursing will observe 5 dependent residents 3 times per week for 12 weeks to ensure the residents are free from neglect . 4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations to maintain compliance. Date of Completion 3/24/23	

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F 600	Continued From page 40 She stated after breakfast was served, she began her incontinence round at room 139 and was working her way down the hall to Resident #48's room. NA #8 stated she did not ask another staff member for assistance with providing incontinence care to Resident #48. She stated she had not provided any incontinence care to Resident #48 on 02/20/23 until she was observed providing incontinence care at 10:52 AM. NA #8 confirmed there was a dried ring of urine on Resident #48's bath blanket. An interview with the Director of Nursing (DON) on 02/21/23 at 5:00 PM revealed NA #8 should have reported for work at 07:00 AM on 02/20/23, performed an incontinence round before breakfast, and performed an incontinence round after breakfast. She stated NAs could stop passing meals trays to provide incontinence care if needed. The DON stated NA #8 should have provided incontinence care when it was known Resident #48 was wet or asked another staff member for assistance. An interview with the Administrator on 02/21/23 at 5:06 PM revealed NA #8 should have provided incontinence care to Resident #48 at the time she discovered he was wet or she could have asked her peers for assistance with passing meal trays or providing incontinence care. She stated NA #8 could have notified Resident #48's nurse he had been incontinent and asked her for assistance with providing incontinence care.	F 600		
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	F 636		3/24/23

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F 636	Continued From page 41 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. (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.	F 636		

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F 636 Continued From page 42

F 636

§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 comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the assessment period) for 2 of 32 sampled residents (Residents #75 and #135).

Findings included:

1. Resident #75 was admitted to the facility on 12/07/22.

Review of Resident #75's medical record at revealed an admission MDS assessment with an ARD of 12/11/22 was marked as completed on 12/27/22.

During a telephone interview on 02/24/23 at 12:03 AM, MDS Nurse #2 explained she worked for the

*8.MDS timeliness F636D

1. On 12/27/2022 and 03/07/2023, the MDS Assessments for Residents #75 and #135 were submitted, lateness is known to MDS Nurse, Facility Department Heads and Regional/Corporate Supervisors.
2. By 03/23/2023, the RN Nurse Consultant and MDS Nurse completed an audit of current resident with recently completed MDS Assessments to ensure assessments were submitted in a timely manner per ARD guidelines.
3. On 3/16/2023, the RN Nurse Consultant provided education to the facility MDS Nurse on completing MDS assessments in a timely manner per ARD guidelines. Newly hired MDS Nurses will receive education during orientation and prior to working in role.

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F 636	Continued From page 43 facility remotely, usually in the evenings or weekends, on a part-time basis assisting with MDS assessments. MDS Nurse #2 verified Resident #75's admission MDS assessment dated 12/11/22 was not completed within the regulatory time frame but was not sure why. During an interview on 02/24/23 at 3:54 PM, the Administrator stated Resident #75's admission MDS assessment should have been completed within the regulatory time frame. 2. Resident #135 was admitted to the facility on 02/07/23. Review of Resident #135's medical record on 02/23/23 at 10:24 PM revealed an admission MDS assessment with an ARD of 02/14/23 had a status of "in progress." During a telephone interview on 02/24/23 at 12:03 AM, MDS Nurse #2 explained she worked for the facility remotely, usually in the evenings or weekends, on a part-time basis assisting with MDS assessments. MDS Nurse #2 verified Resident #135's admission MDS assessment dated 02/14/23 was late and not completed within the regulatory time frame because another contributor had not finished their sections of the MDS assessment. During an interview on 02/24/23 at 3:54 PM, the Administrator stated Resident #135's admission MDS assessment should have been completed within the regulatory time frame.	F 636	4. The Director of Nursing or designee will complete audits of the 5 residents 3 times a week for 12 weeks to ensure timely completion of MDS Assessment. The Director of Nursing will submit the results of audits to the QAPI committee monthly x 3 months and will make changes to the plan as necessary to maintain compliance with submitting MDS Assessments in a timely manner. Date of Compliance: 3/24/23	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/25/23

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F 641	Continued From page 44 §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 Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR) and hospice for 2 of 32 sampled residents reviewed for MDS accuracy (Resident #45 and #34). Findings included: 1. Review of Resident #45's medical record revealed a North Carolina Medicaid Long Term Care form (a preadmission form which describes a patient's medical condition and the amount of care they need when placed in a long term care facility) dated 10/18/21 that indicated Resident #45 had a time-limited Level II PASRR determination. Resident #45 was admitted to the facility on 11/03/21. Her diagnoses included schizoaffective disorder and major depressive disorder. The annual MDS assessment dated 11/03/22 indicated Resident #45 was not currently considered by the state Level II PASRR process to have a serious mental illness. During a telephone interview on 02/24/23 at 12:03 AM, MDS Nurse #2 reviewed the MDS annual assessment dated 11/03/22 for Resident #45 and confirmed it did not accurately reflect Resident #45 had a Level II PASRR, and it had been an oversight.	F 641	*9. MDS F641D-PASRR 1. On 11/22/2022, the MDS Nurse modified and resubmitted MDS Assessment for residents #45 and for Resident #34 on 02/19/2023 to accurately reflect the PASSAR 2 (resident #45) and discontinued Hospice status (resident #34). 2. By 03/23/2023, The RN Nurse Consultant and the RN MDS Nurse completed an audit of current residents with PASSR 2 and Hospice/Discontinued from Hospice to ensure most recent MDS assessments was properly coded to reflect the PASSR 2 and Hospice status. 3. By 03/23/2023 The RN Nurse Consultant provided education to the facility MDS Nurse and Social Worker on accurately coding residents with PSARR2 or Hospice/Discontinued Hospice when completing MDS Assessments (Admission, Annual, Readmission, Significant Change) within 14 days per Resident Assessment Instrument (RAI) guidelines. Newly hired MDS Nurses and Social Service Workers will receive education during orientation and prior to beginning work in said roles. 4. The Director of Nursing or designee will monitor submitted MDS assessments for accuracy of coding residents with PASSR2 or Hospice/Discontinuation of Hospice 3 times weekly for 12 weeks. The	

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F 641	Continued From page 45	F 641		

During a telephone interview on 02/27/23 at 12:52 PM, MDS Nurse #1 explained the Admissions Director or Social Worker notified MDS when a resident had a Level II PASRR determination and when made aware, it was marked on the MDS assessment. MDS Nurse #1 stated she was not made aware Resident #45 had a Level II PASRR determination which was why the MDS annual assessment dated 11/03/22 was not completed accurately.

During an interview on 02/24/23 at 3:54 PM, the Administrator stated Resident #45's annual MDS assessment dated 11/03/22 should have been accurately completed to reflect she had a Level II PASRR determination.
2. Resident #34 was admitted to the facility 02/14/22 with diagnoses including Parkinson's disease and non-Alzheimer's dementia.

Review of a hospice Discharge-Transfer Summary Report dated 11/21/22 revealed Resident #34 began receiving hospice services 03/11/22 and was discharged from hospice care 11/04/22.

The quarterly Minimum Data Set (MDS) dated 02/14/23 revealed Resident #34 received hospice services.

An interview with MDS Nurse #2 on 02/24/23 at 12:03 PM revealed she coded Resident #34's quarterly MDS dated 02/14/23 to reflect he was receiving hospice services. She explained she wasn't sure if Resident #34 was still receiving hospice services and asked a staff member who told her Resident #34 was still under hospice care, and she took him at his word. She

Director of Nursing will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly for 3 months and will make changes to the plan as necessary to maintain compliance with accurately coding resident MDS Assessment for PASRR2 and Hospice/Discontinuation of Hospice.
Date of Completion: 3/24/2023.

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F 641	Continued From page 46 confirmed that since Resident #34 was discharged from hospice on 11/04/22 he should not have been coded as receiving hospice. During an interview with the Administrator on 02/24/23 at 5:33 PM she stated Resident #34's quarterly MDS dated 02/14/23 should have been accurately completed and should not have indicated he was receiving hospice services since he had previously been discharged from hospice.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 3 residents reviewed	F 644	Coordination of PASRR F644D Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident	3/24/23

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F 644 Continued From page 47
with a Level II PASRR (Resident #45).

Findings included:

Resident #45 was admitted to the facility on 11/03/21. Her diagnoses included schizoaffective disorder and major depressive disorder.

Review of Resident #45's medical record revealed a North Carolina Medicaid Long Term Care form (a preadmission form which describes a patient's medical condition and the amount of care they need when placed in a long term care facility) dated 10/18/21 that indicated Resident #45 had a time-limited Level II PASRR ending in an "E".

Review of the North Carolina Skilled Nursing Facility PASRR authorization codes document revealed a PASRR ending in "E" indicated "Level II: 30-day rehabilitation services authorization only."

Review of Resident #45's medical record on 02/24/23 at 12:57 PM revealed no evidence a PASRR evaluation was requested or a new PASRR had been obtained.

During an interview on 02/24/23 at 2:04 PM, the Corporate Consultant stated she reviewed Resident #45's medical record and could not find any evidence a PASRR evaluation was requested for Resident #45's expired Level II PASRR.

During an interview on 02/24/23 at 3:54 PM, the Administrator explained the Social Worker was responsible for requesting PASRR evaluations prior to the expiration date and could not speak as to why it was not done. The Administrator

F 644

Review (PASRR) before the expiration date for 1 of 3 residents reviewed with a Level II PASRR (Resident #45).
1. On 3/20/2023 a PASRR review was completed and a New PASSR 2 for resident #45 was issued that indicated no expiration date.
2. On 3/16/2023, the RN Nurse Consultant provided education to the Social Worker on requesting PASSR reviews prior to PASSR expiration dates.
3. The Director of Nursing or designee will monitor that resident PASSRs are requested prior to the expiration dates 3 times weekly x 12 weeks.
4. The Director of Nursing will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly for 3 months and will make changes to the plan as necessary to maintain compliance with requesting PASSR prior to expiration date.
Date of Completion: 3/24/2023

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 02/28/2023

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F 644	Continued From page 48 explained they had recently completed an audit of current residents' Level II PASRR's and Resident #45's expired Level II PASRR just got missed.	F 644		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in physical status for 1 of 3 residents diagnosed with a mental health disorder (Resident #29). Findings included: Resident #29 was admitted to the facility on 11/03/21. His diagnoses included schizoaffective disorder. A PASRR determination notification letter dated 09/21/21 indicated Resident #29 had a Level 1 PASRR effective 09/21/21 with no expiration date and noted in part, "no further PASRR screening is required unless a significant change occurs with the individual's status." The North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry dated 02/21/23 revealed Resident #29 had a PASRR review on 09/21/21. There were no requests for re-evaluation after	F 646	*11. Sig Change MDS 646D Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident 1. 1. 1. Review (PASRR) re-evaluation after a significant change in physical status for 1 of 3 residents diagnosed with a mental health disorder (Resident #29) The facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in physical status for resident #45 diagnosed with a mental health disorder. A request for re-evaluation of PASRR status was sent in on 3/21/2023. 2. All current residents have the potential to be affected. All current residents that had a Significant Change In Status MDS with an ARD in last 30 days have been audited to determine if they have a mental health disorder or intellectual disability. Any resident identified as having a mental health disorder or intellectual disability will have a Preadmission Screening and	3/24/23

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F 646	Continued From page 49 09/21/21. The significant change Minimum Data Set (MDS) assessment dated 12/02/22 revealed Resident #29 was not currently considered by the state Level II PASRR process to have a serious mental illness. During an interview on 02/23/23 at 3:44 PM, the Social Worker (SW) confirmed she was responsible for requesting PASRR re-evaluations and was aware a PASRR request for re-evaluation needed to be submitted after a significant change in a resident's mental or physical status. The SW stated she was not informed Resident #29 had a significant change in status and confirmed she did not submit a request for a PASRR re-evaluation for Resident #29 after the significant change MDS assessment dated 12/02/22. During an interview on 02/24/23 at 3:54 PM, the Administrator explained the Social Worker was responsible for requesting PASRR reevaluations when needed and could not speak as to why it was not done. The Administrator stated a request should have been made to PASRR for an evaluation when Resident #29 had a significant change in condition.	F 646	Resident Review (PASRR) re-evaluation submitted to the State for review by 3/23/23. 3. The Social Worker was educated on 3/16/2023, by the RN Nurse Consultant on requesting a Preadmission Screening and Resident Review (PASRR) re-evaluation after a Significant Change In Status MDS for resident with a mental health disorder or intellectual disability per RAI Manual. All new employees will be educated on process of requesting PASSR with significant changes during orientation and prior to beginning work 4. The Director of Nursing or designee will complete audits of the 5 residents 3 times a week for 12 weeks to ensure a Preadmission Screening and Resident Review (PASRR) re-evaluation was conducted after a Significant Change In Status MDS for residents with a mental health disorder or intellectual disability. The Director of Nursing will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Date of Completion: 3/24/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		3/24/23

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F 656	Continued From page 50 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

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F 656 Continued From page 51

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan that addressed Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 3 sampled residents reviewed for PASRR (Resident #45).

Findings included:

Review of Resident #45's medical record revealed a North Carolina Medicaid Long Term Care form (a preadmission form which describes a patient's medical condition and the amount of care they need when placed in a long term care facility) dated 10/18/21 which indicated Resident #45 had a 30-day Level II PASRR determination.

Resident #45 was admitted to the facility on 11/03/21. Her diagnoses included schizoaffective disorder and major depressive disorder.

Review of Resident #45's active care plans, last reviewed/revised 01/21/23, revealed no care plan that addressed the Level II PASRR determination.

During a telephone interview on 02/27/23 at 12:52 PM, MDS Nurse #1 explained the Admissions Director or Social Worker notified MDS when a resident had a Level II PASRR. MDS Nurse #1 stated she was not made aware Resident #45 had a Level II PASRR determination which was why a care plan was not developed.

During an interview on 02/24/23 at 3:54 PM, the Administrator stated it was her expectation that residents with a Level II PASRR determination would have care plans developed that reflected

F 656

12. F656 Develop Care Plan 656D
1.On 2/24/2023, the MDS Nurse revised the care plan of Resident #45 to include the Level II PASRR with goals and interventions.
2. All residents with a Level II PASRR have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers and MDS Nurse conducted an audit of current care plans for all residents with a Level II PASRR and revised to include goals and interventions.
3. By 3/23/23 the MDS Nurse was re-educated by the Director of Nursing on the requirement for development of the care plan for residents with a Level II PASRR. Education will be provided to new employees during orientation and prior to beginning work. The Nurse Managers and Director of Nursing will review the care plans of 5 residents with a Level II PASRR 3 times per week for 12 weeks to ensure the care plan reflects the Level II PASRR.
4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.
Date of Completion 3/24/23

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F 656	Continued From page 52 their PASRR needs.	F 656		
F 677 SS=E	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 observations, record review, and resident and staff interviews the facility failed to provide incontinence care (Resident #48), nail care (Resident #487, Resident #61, Resident #54, and Resident #185), and a shave (Resident #487) for 5 of 14 dependent residents reviewed for activities of daily living (ADL). Findings included: 1. Resident #48 was admitted to the facility 08/16/19 with diagnoses including cerebrovascular accident (abbreviated as CVA and meaning a stroke) and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 01/17/23 revealed Resident #48 was severely cognitively impaired, had no behaviors or rejection of care, and was always incontinent of bladder. Review of Resident #48's care plan last revised 01/18/23 revealed he was incontinent of bowel and bladder and interventions included checking him frequently and assisting with toileting as needed; providing incontinence briefs per manufacturer's recommendation; providing	F 677	13. ADLs F677E 1. On 2/20/2023, the Charge Nurse and the Nurse Aide provided incontinence care, oral hygiene and changed the bed linen for Resident #48. On 2/22/2023 Nail care and shave was provided for resident #487. On 2/22/2023 nail care was provided for residents #54, #61. On 2/24/2023 nail care was provided for resident #185. 2. All dependent residents have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers completed an audit of dependent residents to identify other residents needing ADL care. Any opportunities identified were addressed immediately by the Director of Nursing. 3. By 3/23/23 the Nurse Managers re-educated all facility staff, including agency staff on the facility policy for completing ADLs for dependent residents. Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff. The Nurse Managers and Director of Nursing will observe 5 dependent	3/24/23

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F 677	Continued From page 53 loose-fitting, easy to remove clothing; and providing peri-care (cleaning private areas) after each incontinent episode. An observation of Resident #48 on 02/20/23 at 10:16 AM revealed he was lying in bed with his eyes closed and a strong odor of urine was noted in his room. An observation of Nurse Aide (NA) #8 on 02/20/23 at 10:52 AM revealed she entered Resident #48's room and pulled back his top sheet. Lying in bed beside Resident #48 was a urine saturated incontinence brief. Resident #48 was partially lying on a bath blanket being used as a bed pad and the bath blanket contained a dried ring of urine. No bottom sheet was on Resident #48's bed and a large moist area was noted to his mattress below the bath blanket. No redness or open areas were noted to Resident #34's skin. An interview with NA #8 on 02/20/23 at 10:58 AM revealed she reported for work around 8:30 AM the morning of 02/20/23. She stated she checked Resident #48 shortly after arriving for her shift and noted he had been incontinent of urine. NA #8 stated she did not provide incontinence care to Resident #48 when she noted he was wet because breakfast trays arrived on the hall and she could not perform incontinence care while trays were on the hall. She stated after breakfast was served, she began her incontinence round at room 139 and was working her way down the hall to Resident #48's room. NA #8 stated she did not ask another staff member for assistance with providing incontinence care to Resident #48. She stated she had not provided any incontinence care to	F 677	residents 3 times per week doe 12 weeks to ensure ADLs are completed. 4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of Completion 3/24/23	

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 677	Continued From page 54 Resident #48 on 02/20/23 until she was observed providing incontinence care at 10:52 AM. NA #8 confirmed there was a dried ring of urine on Resident #48's bath blanket. An interview with the Director of Nursing (DON) on 02/21/23 at 5:00 PM revealed NA #8 should have reported for work at 7:00 AM on 02/20/23, performed an incontinence round before breakfast, and performed an incontinence round after breakfast. She stated NAs could stop passing meals trays to provide incontinence care if needed. The DON stated NA #8 should have provided incontinence care when it was known Resident #48 was wet or asked another staff member for assistance. An interview with the Administrator on 02/21/23 at 5:06 PM revealed NA #8 should have provided incontinence care to Resident #48 at the time she discovered he was wet or she could have asked her peers for assistance with passing meal trays or providing incontinence care. She stated NA #8 could have notified Resident #48's nurse he had been incontinent and asked her for assistance with providing incontinence care. 2. Resident #487 was admitted to the facility on 2/2/23 with diagnoses that included end stage renal disease, heart failure, debility, and muscle weakness. An admission Minimum Data Set dated 2/9/23 for Resident #487 revealed he was cognitively intact with no behaviors or rejection of care. Resident #487 required extensive 2 person assist for personal hygiene. The care plan for Resident #487 updated on 2/14/23 revealed he had an activity of daily living	F 677		

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F 677	Continued From page 55	F 677		

(ADL) self-care performance deficit related to end stage renal disease, wounds, abdominal abscess, and heart failure. The interventions included the resident required assistance from staff for personal hygiene. Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.

An observation and interview were conducted on 2/21/23 at 11:08 AM. Resident #487 was observed with long jagged nails that extended approximately ¼ inch beyond his fingertips. His nails were observed with brown matter underneath. Resident #487's beard was long and appeared unshaved. Resident #487 revealed he had been in the facility for a few weeks and his nails had not been trimmed since he had been there. He further revealed he would like to have his nails trimmed. He also wanted to be shaved; he did not usually let his beard grow; he preferred a close shave.

An observation on 2/22/23 at 12:29pm revealed Resident #487 was in bed watching television, his nails were long with brown matter underneath and Resident #487 had not been shaved.

During an interview on 02/23/23 at 10:45 AM Nurse #5 revealed nurse aides (NA) and nurses provided nail care. Nail care was provided on an as needed basis and included cleaning and trimming. She stated if we see it needs to be done, we do it. Nurse aides could not trim nails for diabetics. If a resident was diabetic the NA should report it to her, and she would trim that resident's nails. Nurse #5 revealed shaving should be done as needed and on shower days by the NA.

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F 677	Continued From page 56	F 677		

An observation and interview were conducted with Nurse #5 on 2/23/23 at 10:50 AM. Resident #487's nails and beard were observed by Nurse #5, and she stated the resident's nails needed to be trimmed and cleaned and he needed to be shaved. Nurse #5 asked Resident #487 if he would like to be shaved. The resident stated yes, he would like to be shaved. He had his own electric razor beside his bed it just needed to be plugged in to charge. Nurse #5 stated she would let the NA know the resident needed his nails cleaned, trimmed, and he needed to be shaved.

During and observation and interview on 2/23/23 at 10:55 AM NA #6 revealed NA's provided nail care unless the resident was a diabetic. She stated she provided nail care when she recognized the resident needed it. She further stated that when she noticed her resident had a lot of hair on their face, she would offer to shave them. Resident #487 was observed by NA #6, and she stated his nails were long and needed to be trimmed, cleaned and he needed to be shaved. NA #6 further stated she did not notice the resident's beard or nails when she cared for him on 2/22/23 on the 3:00 PM - 11:00 PM shift.

During an interview on 2/24/23 at 3:52 PM the Director of Nursing revealed that residents should receive nail care with ADL care and staff should offer to shave residents on shower days.

3. Resident #61 was admitted to the facility on 2/1/23 with diagnoses that included stroke, respiratory failure, generalized weakness, and schizophrenia.

An admission Minimum Data Set for Resident #61 dated 2/8/23 revealed he was cognitively

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 02/28/2023

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F 677	Continued From page 57	F 677		

intact with no behaviors or rejection of care. Resident #61 required extensive 1 person assist with personal hygiene.

The care plan for Resident #61 updated on 2/13/23 revealed Resident #61 had an ADL self-care performance deficit related to respiratory failure, stroke, and schizophrenia. The interventions included check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #61 required assistance with personal hygiene.

An observation and interview were conducted on 2/20/23 at 11:45 AM. Resident #61's was in his room sitting on the edge of his bed. His nails were observed long and jagged with brown matter underneath. His fingernails extended approximately ½ inch beyond his fingertips. Resident #61 stated his nails were too long, but no one had offered to trim them since he arrive at the facility. He further stated he like to have them trimmed.

An observation on 2/21/23 at 11:15 AM revealed Resident #61's nails were long, jagged, and untrimmed.

An observation made on 2/22/23 at 8:40 AM revealed Resident #61's nails were long and jagged. His fingernails extended approximately ½ inch beyond his fingertips.

An observation and interview on 2/22/23 at 12:23 PM revealed Resident #61's nails were trimmed. Resident #61 stated an NA had come in and trimmed his nails.

During an interview on 2/22/23 at 2:00 PM NA #5

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 677	Continued From page 58	F 677		

revealed she provided nail care when she saw it needed to be done. She further revealed she noticed Resident #61's nails needed to be trimmed on that day. She stated that Resident #61's nails were long, so she trimmed them. She further stated she was very busy on the day before (2/21/23) and did not notice his nails. She explained she had last trimmed his nails about 3 weeks ago.

During an interview on 02/23/23 at 10:45 AM Nurse #5 revealed nurse aides and nurses provided nail care. Nail care was provided on an as needed basis and included cleaning and trimming. She stated if we see it needs to be done, we do it. Nurse aides could not trim nails for diabetics. If a resident was diabetic the NA should report it to her, and she would trim that resident's nails.

During an interview on 2/24/23 at 3:52 PM the Director of Nursing revealed that residents should receive nail care with ADL care.

4. Resident #54 was admitted to the facility on 1/27/23 with diagnoses that included lung cancer with metastasis to the liver and bone, stroke, heart failure, and respiratory failure.

An admission Minimum Data Set for Resident #54 dated 2/3/23 revealed he was cognitively intact with no behaviors or rejection of care. Resident #54 required extensive 1 person assist for personal hygiene.

The care plan for Resident #54 updated 2/4/23 revealed Resident #54 had an ADL self-care performance deficit related to cancer and its disease process. The interventions included

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F 677	Continued From page 59 provide assistance with ADL's as needed. An observation and interview were conducted on 2/20/23 at 11:55 AM. Resident #54 was laying in his bed watching television. His nails were observed long and extended approximately ¼ inch beyond his fingertips. His nails were observed with brown matter underneath. Resident #54 revealed staff had never trimmed his nails and he would like to have them trimmed. An observation on 2/21/23 at 11:20 AM revealed Resident #54's nails were long, jagged, untrimmed and had brown matter underneath. An observation made on 2/22/23 at 8:50 AM revealed Resident #54's nails were long, jagged and had brown matter underneath. An observation and interview on 2/22/23 at 12:30 PM revealed Resident #54's nails were trimmed and cleaned. Resident #54 stated an NA had come in and trimmed and cleaned his nails. During an interview on 2/22/23 at 2:00 PM NA #5 revealed she provided nail care when she saw it needed to be done. She further revealed she noticed Resident #54's nails needed to be trimmed and cleaned on that day. NA #5 stated Resident #54's nails were "long and dirty", so she trimmed and cleaned them. She further stated she was very busy on the day before (2/21/23) and did not notice his nails. She explained she had last trimmed his nails about 3 weeks ago. During an interview on 02/23/23 at 10:45 AM Nurse #5 revealed nurse aides and nurses provided nail care. Nail care was provided on an as needed basis and included cleaning and	F 677		

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 02/28/2023

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F 677	Continued From page 60	F 677		

trimming. She stated if we see it needs to be done, we do it. Nurse aides could not trim nails for diabetics. If a resident was diabetic the NA should report it to her, and she would trim that resident ' s nails.

During an interview on 2/24/23 at 3:52 PM the Director of Nursing revealed that residents should receive nail care with ADL care.
5. Resident #185 was admitted to the facility on 11/10/22 with diagnoses including heart failure, acute respiratory failure, and diabetes mellitus.

Review of the care plan initiated on 12/06/22 revealed Resident #185 had the potential and actual skin integrity impairment related to lymphedema (swelling caused by increased body fluids) affecting the bilateral lower extremities. Interventions included Resident #185 should avoid scratching and fingernails should be kept short.

Review of the quarterly Minimum Data Set dated 01/06/23 revealed Resident #185 was assessed as being cognitively intact with no rejection of care behaviors and required extensive assistance with personal hygiene and total assistance with bathing.

Review of Resident #185's shower days revealed bathing was scheduled on Tuesday and Thursday during day shift.

An observation on 02/20/23 at 2:27 PM revealed Resident #185 fingernails on both hands were extend pass the fingertips approximately 2 centimeters.

An interview and observation were conducted on

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 02/28/2023

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F 677		F 677		

Continued From page 61
02/22/23 at 10:06 AM with Resident #185. The length of Resident #185's fingernails had not changed. Resident #185 explained a shower was provided yesterday (02/21/23) but no staff offered to trim her fingernails. Resident #185 stated her nails were long and needed to be cut and filed. She wanted her nails trimmed because of the areas on her lower legs that itch, and she didn't want to scratch and cause an open sore. Resident #185 confirmed she got a shower twice a week and staff had mentioned they would like to trim her fingernails but haven't.

An observation and interview were conducted on 02/24/23 at 9:00 AM. There was no change in the length of Resident #185's fingernails and right thumb nail was broken and jagged. Resident #185 revealed she was bathed yesterday (02/23/23) but wasn't sure if she asked the Nurse Aid (NA) to cut her fingernails and stated her nails were long and needed trimmed.

An observation and interview were conducted on 02/24/23 at 9:45 AM with NA #9. There was no change in the length of Resident #185's fingernails. NA #9 confirmed she assisted Resident #185 with a bed bath on 02/23/23. NA #9 stated a bed bath included nail care either clipping or filing. NA #9 observed Resident #185's fingernails and confirmed the nails were long and needed to be trimmed. NA #9 stated she didn't notice and didn't offer to have Resident #185's fingernails trimmed nor did the resident request to have her fingernails trimmed.

During an interview on 02/23/23 at 10:45 AM Nurse #5 revealed NA staff and nurses provided nail care as needed. Nurse #5 stated NA staff couldn't trim fingernails for diabetics that was

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 02/28/2023

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F 677	Continued From page 62 done by the nurses. A joint interview was conducted on 02/24/23 at 5:33 PM with the Administrator, Director of Nursing, and Corporate Nurse Consultant. The Administrator stated nail care was included as part of the shower and bed bath and should be offered when needed. The Administrator revealed she wouldn't expect a resident would have to ask for basic care.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to supervise 1 of 4 residents reviewed for smoking (Resident #22). The findings included: Resident #22 was admitted to the facility on 11/26/21 with diagnoses that included chronic obstructive pulmonary disorder (COPD), and cognitive communication deficit. The annual Minimum Data Set (MDS) dated 12/13/22 revealed Resident #22 was cognitively intact and was coded for current tobacco use.	F 689	. Sup to prevent accidents-smoking F689D 1. Based on observations, record review, resident and staff interview the facility failed to supervise 1 of 4 residents reviewed for smoking (Resident #22). 2. All residents have the potential to be affected by the alleged deficient practice. An audit was completed to ensure that all residents' safe smoking assessments were accurate or corrected if needed on 2/21/23. The Smoking list was also updated to ensure that all residents who smoke were listed appropriately as	3/24/23

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 02/28/2023

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F 689 Continued From page 63

Review of the care plan dated 12/15/22 for Resident #22 revealed he was a supervised smoker and would not smoke without supervision. Interventions included to instruct the resident about the facility policy on smoking, locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if resident is suspected of violating the smoking policy, observe clothing and skin for signs of cigarette burns, and staff will supervise resident during smoking sessions for safety.

Review of the smoking assessment dated 12/15/22 revealed Resident #22 was a supervised smoker.

Review of the list of residents who smoked at the facility updated 12/16/22 revealed Resident #22 was listed as a supervised smoker.

An interview with Resident #22 on 2/20/23 at 3:15 PM revealed he smoked whenever he wanted to and kept his smoking supplies himself.

An observation on 2/20/23 at 3:40 PM revealed Resident #22 sitting outside in his wheelchair on the smoking patio smoking. No staff were present. Resident #22 was observed to finish smoking and put the cigarette out in the designated ashtray.

An interview on 2/22/23 at 2:10 PM with Nurse Aide #5 revealed all smokers needed to be supervised when they went out to smoke. Nurse Aide #5 stated the nurses kept the cigarettes and lighters at the nurse station and the residents would have to go to the nurse's station and ask for their supplies.

F 689

supervised or unsupervised. All staff were educated on the smoking policy including assessments and supervised smoking list on 2/21/23. All new staff including agency staff will be educated during orientation and prior to beginning work.

3. DON/ADON or Designee will audit all residents who smoke 3x week for 12 weeks to ensure all residents are being supervised as directed and if anyone has a change in status, a new assessment will be completed.

4. To monitor the effectiveness of the above action plan, the QAPI committee will evaluate the process monthly x3 months beginning 03/28/23.

Date of completion 3/24/2023

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 689	Continued From page 64	F 689		

An interview on 2/22/23 at 3:28 PM with Nurse Aide #1 revealed most of the residents at the facility were independent smokers.

An interview on 2/22/23 at 4:24 PM with Nurse #1 revealed there was a list of residents who were smokers, but she was not sure where that list was located. Nurse #1 stated there was an assessment that was completed on admission that would determine if a resident was independent or supervised for smoking.

An interview on 2/23/23 at 3:00 PM with the Director of Nursing (DON) revealed staff kept the smoking supplies at the nurse's station on the West Side. The DON stated Resident #22 was a supervised smoker and staff should be going out with him when he smoked. The DON also stated he had been caught smoking in his room and had to be a supervised smoker.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)	F 712		3/24/23

§483.30(c) Frequency of physician visits
§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

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 02/28/2023

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F 712	Continued From page 65 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician visits were alternated with the Family Nurse Practitioner's visits every 60 days for 3 of 3 sampled residents reviewed for physician visits (Residents #3, #39 and #16). Findings included: 1. Resident #3 was admitted to the facility on 07/18/21. Her diagnoses included cerebral infarction (stroke), hypertension, and dysphagia (trouble swallowing). The significant change Minimum Data Set (MDS) dated 11/03/22 indicated Resident #3 had moderate impairment in cognition. Review of Resident #3's Electronic Medical Record (EMR) revealed she was seen by the Medical Director on 03/03/22 and 04/07/22. There were no other progress notes of physician visits conducted by the Medical Director. Review of Resident #3's EMR revealed she was seen by the Family Nurse Practitioner (FNP) on 05/12/22, 05/30/22, 06/20/22, 06/23/22, 07/25/22, 08/22/22, 08/29/22, 09/22/22, 10/20/22, 11/17/22, 12/12/22, 01/10/23, and 02/02/23. During a telephone interview on 02/23/23 at 4:47	F 712	15. Physician visits F712E 1. Residents #3, #39, and #16 were visited by the Physician on 3/7/2023(#3), 2/28/2023 (#16) and3/14/2023 (#39). 2. All residents have the potential to be affected by this alleged deficient practice. By 3/23/23 the Nurse Managers and Medical Records Director audited all current residents to identify the last visit completed by the Physician. The Administrator notified the Physician of required visits to be completed by 3/23/2023. 3. By 3/23/23 the Administrator educated the Physician Nurse Practitioners on the requirement of Physician visits according to F712. All long term residents will have a Physician visit within the last 60 days by 3/23/23. All new admissions will have a visit within the first 30 days by 3/23/23. The Nurse Manager and Medical Records Director will complete an audit of 10 residents weekly for 12 weeks to ensure Physicians visits have been completed. Beginning 3/23/23 the Administrator will ensure this education will be included in orientation for newly hired Physicians and Nurse Practitioners. 4. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee	

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	345134	A. BUILDING ______ B. WING ______	C 02/28/2023

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F 712	Continued From page 66	F 712		

PM, the Medical Director explained he and the FNP kept track of when residents needed to be seen for regulatory visits and facility staff notified them when residents needed to be seen for acute visits. The Medical Director stated Resident #3 was seen monthly by the FNP, who was an extension of his practice, and based on his understanding of the regulation he did not need to alternate regulatory visits with the FNP.

A joint interview was conducted with the Director of Nursing (DON), Administrator, and Corporate Consultant on 02/24/23 at 3:54 PM. The Administrator and Corporate Consultant both stated the Medical Director should be alternating resident visits with the FNP per regulatory guidelines.

2. Resident #39 was admitted to the facility on 12/13/17. Her diagnoses included adult failure to thrive and dementia without behavioral disturbance.

The quarterly Minimum Data Set (MDS) dated 12/29/22 indicated Resident #39 had severe impairment in cognition.

Review of Resident #39's Electronic Medical Record (EMR) revealed she was seen by the Medical Director on 03/17/22, 04/22/22, and 05/17/22. There were no other progress notes of physician visits conducted by the Medical Director.

Review of Resident #39's EMR revealed she was seen by the Family Nurse Practitioner (FNP) on 06/20/22, 07/21/22, 08/22/22, 09/19/22, 10/20/22, 11/21/22, 12/19/22, 01/12/23, and 02/09/23. During a telephone interview on 02/23/23 at 4:47

meeting and the committee will make recommendations.
Date of Completion 3/24/23

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 02/28/2023

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F 712	Continued From page 67 PM, the Medical Director explained he and the FNP kept track of when residents needed to be seen for regulatory visits and facility staff notified them when residents needed to be seen for acute visits. The Medical Director stated Resident #39 was seen monthly by the FNP, who was an extension of his practice, and based on his understanding of the regulation he did not need to alternate regulatory visits with the FNP. A joint interview was conducted with the Director of Nursing (DON), Administrator, and Corporate Consultant on 02/24/23 at 3:54 PM. The Administrator and Corporate Consultant both stated the Medical Director should be alternating resident visits with the FNP per regulatory guidelines. 3. Resident #16 was admitted to the facility on 06/28/21 with diagnoses including hypertension, heart failure, dementia, and debility. Review of the quarterly Minimum Data Set dated 02/01/23 revealed Resident #16 was assessed as having moderately impaired cognition and received antidepressant, antianxiety, and diuretic medications. Review of Resident #16's medical records revealed the physician progress notes for the most recent visits by the Medical Director (MD) were dated 03/16/22 and 04/19/22. The medical records revealed the dates the Family Nurse Practitioner (FNP) saw Resident #16 were consecutively each month from 05/16/22 through 02/06/23. During a telephone interview on 02/23/23 at 4:47 PM the MD explained him and the FNP kept track	F 712		

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	345134	A. BUILDING ______ B. WING ______	C 02/28/2023

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F 712	Continued From page 68 of when residents needed to be seen for their regulatory visits. The MD stated the FNP was an extension of his practice and would reach out to him if there were any issues and per their contract and his understanding of the Centers for Medicare and Medicaid Services (CMS) regulation for regulatory physician visits he didn't have to alternate visits with the FNP. A joint interview was conducted on 02/24/23 at 3:54 PM with the Administrator, Corporate Nurse Consultant and Director of Nursing. The Administrator and Corporate Nurse Consultant were aware of the CMS regulation for regulatory physician visits and stated the MD should be alternating visits with the FNP. During an interview on 02/28/23 at 9:38 AM the Assistant Director of Nursing confirmed the MD hadn't seen Resident #16 since 04/2022.	F 712		
F 725 SS=E	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	F 725		3/24/23

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 02/28/2023

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 725 Continued From page 69

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.

§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 observations, record review, resident, family and staff interviews, the facility failed to provide sufficient nursing staff resulting in residents not having their choices honored for bathing and not receiving transfer assistance when requested for 6 of 8 sampled residents (Residents #135, #1, #12, #58, #284, and #70).

Findings included:

This tag is cross referenced to:

F561: Based on record review, observations, resident and staff interviews, the facility failed to provide residents with their preferred method of bathing (Residents #135, #1, #12, #58, and #284) and failed to accommodate a resident's request to be assisted out of bed (Resident #70) for 6 of 8 residents reviewed for choices and dignity.

During a telephone interview on 02/24/23 at 2:18 PM, Medication Aide (MA) #1 revealed since the previous survey, she had been assisting with coordinating the nursing staff schedule. MA #1 explained she used staffing agencies as needed

F 725

16. Staffing F725E
Based on observations, record review, resident, family and staff interviews, the facility failed to provide sufficient nursing staff resulting in residents not having their choices honored for bathing and not receiving transfer assistance when requested for 6 of 8 sampled residents (Residents #135, #1, #12, #58, #284, and #70)
1. BY 3/23/2023, Residents #1, #12, #58, #135, and #284 have had their preferences for bath and receiving transfer assistance out of bed noted on Kardex. Residents will continue to have preferences honored and care charted in medical records.
2. On 3/16/2023, The Administrator, Director of Nursing, and Staffing Cordinator completed review of current staffing levels to determine sufficient staffing needs to ensure resident preferences are honored. As a result of this review, additional monitoring by DON, ADON and Nurse Managers 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 02/28/2023

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F 725	Continued From page 70 to supplement the nursing staff schedule and tried to have a minimum of 7 to 8 Nurse Aides (NA) for the day shift, 7 NA for the evening shift, and 5 NA on the night shift. MA #1 stated for a while, she was able to "pack the building" with staff, including a shower team, and only recently was instructed to "scale back" on staffing. MA #1 stated on most days she was able to meet the preferred minimums for each shift and if there were call-outs, she would reach out to staffing agencies, call other staff or filled in herself in order to get the shift covered. MA #1 stated she was unaware of staff having issues with not getting resident care provided due to lack of staff. During an interview on 02/24/23 at 2:27 PM, the Director of Nursing (DON) revealed the number of staff scheduled per shift was based on the current resident census and MA #1 was very good to try and ensure they had the preferred minimums of 7 to 8 NA on the day shift, 7 NA on the evening shift and 5 NA on the night shift. The DON stated there was a recent change in corporate structure and they were given new staffing recommendations which included replacing agency staff with facility hired staff. She explained they have advertised job openings on social media, reached out to local schools, posted a banner outside the facility, and held job fairs but finding applicants had been difficult. The DON stated they still used staffing agencies to supplement the nursing staff schedule; however, agency staff would sign up for a shift and then cancel at the last minute making it a challenge to get the shift covered. The DON stated due to staffing challenges, there were times when the preferred staffing minimums were not met. A joint interview was conducted with the DON,	F 725	ensure sufficient staffing to maintain honoring preferences of residents. 3. By 3/23/2023, the RN Nurse Consultant provided education to the Administrator, DON, Staffing Coordinator on maintaining sufficient staff to ensure resident preferences for bathing and transfer assistance is provided. Staffing levels will be reviewed in staff meetings by DON or ADON and Staffing Coordinator to ensure sufficient staff is scheduled. The Director of Nursing or designee will audit 5 residents 3 times a week for 12 weeks to ensure resident preferences are being honored. 4. The Director of Nursing will bring the audit results to the Quality Assurance Process Improvement Committee monthly for 3 months and make changes to the plan as necessary to maintain compliance with sufficient staffing. Date of completion: 3/24/2023	

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F 725	Continued From page 71 Administrator and Corporate Consultant on 02/24/23 at 3:54 PM. The Corporate Consultant explained the number of nursing staff scheduled was based off the current resident census and she was not aware of staff not being able to provide resident care due to being short-staffed. She stated they offered bonuses to staff for picking up extra shifts when needed and if unable to get the shift covered other staff, such as Medical Records and Central Supply, could fill in to ensure the facility was adequately staffed. During a telephone interview on 02/27/23 at 4:07 PM, the Administrator revealed she was unaware of any staffing concerns at the facility and explained on any given day, including the weekends, there was enough staff scheduled to ensure resident care was provided. She explained if for some reason the facility was short-staffed and the NAs were having trouble getting their work completed, they could have notified her or the DON and she would have approved overtime and/or getting additional agency staff to come in and assist.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		3/24/23

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 02/28/2023

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F 758	Continued From page 72 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacy Consultant, Nurse Practitioner (NP), and staff	F 758	17. Unnecessary meds no GDR F758D Based on record review and Pharmacy	

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F 758	Continued From page 73 interviews the facility failed to attempt a gradual dose reduction (GDR) of antipsychotic ordered 07/27/22 and antidepressant medication ordered 03/12/22 for 1 of 5 residents reviewed for unnecessary medication (Resident #34). Findings included: Resident #34 was admitted to the facility 02/14/22 with diagnoses including non-Alzheimer's dementia and encephalopathy (a disturbance in brain functioning). Review of Resident #34's orders revealed an order dated 03/12/22 for Mirtazapine (an antidepressant) 30 milligrams (mg) at bedtime for encephalopathy. Resident #34 also had an order dated 07/27/22 for Quetiapine Fumarate (an antipsychotic) 25 mg 1 tablet twice a day for agitation. Review of Resident #34's Medication Administration Records (MARs) from March 2022 through February 2023 revealed he received Mirtazapine and Quetiapine Fumarate as ordered. The quarterly Minimum Data Set (MDS) dated 02/14/23 revealed Resident #34 was severely cognitively impaired and had verbal behaviors 1 to 3 days during the look back period. The MDS indicated Resident #34 received antidepressant and antipsychotic medications 7 out of 7 days during the look back period, received antipsychotics on a routine basis, a GDR had not been attempted, and the Physician had not documented a GDR as clinically contraindicated. An interview with the NP on 02/23/23 at 2:48 PM	F 758	Consultant, Nurse Practitioner (NP), and staff interviews the facility failed to attempt a gradual dose reduction (GDR) of antipsychotic ordered 07/27/22 and antidepressant medication ordered 03/12/22 for 1 of 5 residents reviewed for unnecessary medication (Resident #34). 1. On 2/23/2023, the Nurse Practitioner reviewed medications for resident #34 and Mirtazapine 30mg was decreased to 15mg daily. On 3/08/2023, the MD reviewed medications and ordered to discontinue Quetiapine Fumarate 25 mg twice a day. 2. All resident with orders for psychotropic medications are at risk for this deficiency. By 3/23/2023, an audit of residents receiving psychotropic medications was conducted to determine if a Gradual Dose Reduction had been addressed by providers. Providers were notified to include reviewing psychotropic medication use for Gradual Dose Reductions during routine resident visits. 3. On 3/21/2023, education was provided to the Medical Director, the Nurse Practitioners, and the Pharmacy Consulting Pharmacist on on-going monitoring and implementation of Gradual Dose Reductions for residents receiving psychotropic medications. The DON or designee will Audit 5 residents receiving psychotropic medications for Gradual Dose Reductions or documentation that a Gradual Dose Reduction is not indicated 3 times a week for 12 weeks to ensure psychotropic medications are considered for Gradual Dose Reductions.	

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F 758	Continued From page 74 revealed Resident #34 was taking Mirtazapine as an appetite stimulant and Quetiapine Fumarate for agitation. She stated she just hadn't thought about doing a GDR of Mirtazapine or Quetiapine Fumarate for Resident #34, but he would be appropriate for a GDR for both medications because his appetite was fine and he was recently discharged from hospice. The NP stated pharmacy had not prompted her to consider a GDR for either medication. An interview with the Pharmacy Consultant on 02/24/23 at 9:57 AM revealed a GDR should be suggested every 6 months for psychotropic medications (medications that cause changes in awareness, mood, feelings, or behavior) and she confirmed she did not ask the NP or Physician to consider a GDR for Mirtazapine or Quetiapine Fumarate. The Pharmacy Consultant stated she usually read through the resident's progress notes to see if a GDR should be suggested and it looked like Resident #34 still had some behaviors, so she did not suggest a GDR. An interview with the Administrator, Director of Nursing (DON), and Corporate Nurse Consultant on 02/24/23 at 05:33 PM revealed the pharmacy should have prompted the NP or Physician to consider a GDR every 6 months for antidepressant and antipsychotic medications.	F 758	4. The Director of Nursing will bring audit result to the Quality Assurance Process Improvement committee meeting monthly for 3 months and changes to the plan will be made as necessary to ensure compliance with Gradual Dose Reduction requirements. Date of Completion: 3/24/2023	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		3/24/23

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F 761	Continued From page 75 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for of 1 of 4 medication carts (East A medication storage cart) and they failed to ensure medications were under direct observation by the administering nurse who left medications unattended at the bedside for 1 of 2 residents (Resident #1) reviewed for medication storage. Findings included: 1. A continuous observation of the East A medication cart on 02/24/23 from 11:12 AM until 11:29 AM revealed there were 7 medication cards lying on top of the medication cart and Nurse #8 was not in view of the medication cart. During the	F 761	. Drug storage F761D 1. On 2/20/2023, the Medication Aide and the Charge Nurse collected the medications at the bedside, reviewed the physician orders and administered the medications to resident #186 as ordered by the physician. The Nurse Manager provided one on one education to the Medication Aide on 2/20/2023 regarding medication administration including the requirement to observe the resident swallow the medication prior to leaving the resident room. On 2/24/2023 the medication cart on East A was locked by the Charge Nurse. 2. All residents receiving medications have the potential to be affected by this	

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F 761	Continued From page 76	F 761		

observation 1 resident in a wheelchair propelled by the medication cart, 1 resident using a rolling walker walked by the medication cart, and 4 staff members walked by the medication cart. No residents or staff members noticed the unattended medications. The medications were within reach of every person that passed by the East A medication cart on 02/24/23 from 11:12 AM to 11:29 AM.

Medication blister cards containing the following were left unattended on the East A medication cart on 02/24/23:

1 tablet of Chlorthalidone 25 milligrams (a blood pressure medication)
3 tablets of Amitriptyline 50 milligrams (an antidepressant)
1 tablet of Ondansetron 4 milligrams (a medication for nausea)
1 tablet of Bumetanide 1 milligram (a diuretic)
4 tablets of Eliquis 5 milligrams (a blood thinner)
1 tablet of Folic Acid 1 milligram
5 tablets of Ondansetron 4 milligrams

On 02/24/23 at 11:29 AM Nurse #8 returned to the East A medication cart. During an interview with Nurse #8 at the same time and date, she confirmed she was assigned to the East A medication cart. Nurse #8 stated she placed the medication blister cards on top of the East A medication cart to remind her to order refills of the medications from pharmacy and then left the medication cart to speak with a state surveyor. She stated she should not have left unattended medications on top of the medication cart.

An interview with the Director of Nursing (DON) on 02/24/23 at 5:33 PM revealed medications

alleged deficient practice. By 3/23/23 the Nurse Managers conducted a review of all resident rooms to ensure no medications were available at the bedside. By 3/23/23 the Nurse Managers audited all medication carts to ensure unattended carts are locked. Any opportunities identified were addressed immediately by the Director of Nursing.
3. By 3/23/23 the Nurse Managers re-educated all Licensed Nurse and Medication Aides, including agency staff on the facility policy for medication administration including the requirement to ensure the medication cart is locked prior to leaving it unattended and to observe the resident swallow the medication prior to leaving the room.
Beginning 3/23/23 the Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff.
The Nurse Managers and Director of Nursing will observe 5 Licensed Nurses or Medication Aides 3 times per week for 12 weeks to ensure there are no medications left at bedside and residents are observed swallowing medications prior to leaving the room.
4.The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations and changes as necessary.
Date of Completion: 3/24/2023

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F 761	Continued From page 77	F 761		

should not be left unattended on a medication cart. She stated medications could be re-ordered from the pharmacy through the electronic medication record (EMAR) and did not have to be removed from the medication cart to be re-ordered.

2. Resident #1 was admitted to the facility 7/31/15 with diagnoses that included age-related cognitive decline.

Review of the quarterly Minimum Data Set (MDS) dated 12/26/22 revealed Resident #1 was cognitively intact.

Review of the medical record revealed Resident #1 had not been assessed for self-administration of medications since 2/3/16. That assessment revealed Resident #1 had no interest in self-administering medications.

An observation of Resident #1's bedside table on 2/20/23 at 2:05 PM revealed 1 blue, 1 orange, and 3 white pills in a medication cup.

An interview with Resident #1 on 2/20/23 at 2:05 PM revealed those were her medications from yesterday, 2/19/23. Resident #1 stated staff did not observe her take her medications and she could throw them in the trash if she wanted to.

An interview with Medication Aide #1 on 2/20/23 at 2:10 PM revealed the medications were probably from 2nd shift yesterday. The Medication Aide #1 stated she did not see the medications in the cup at the bedside that morning. She also stated the nursing staff should not leave medications at the bedside.

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F 761	Continued From page 78 An interview with the Director of Nursing (DON) on 2/20/23 at 3:02 PM revealed she believed the medications that were left at the bedside in Resident #1's room were from 2nd shift the day before. The DON stated no medications should be left at the bedside. The DON revealed if a resident expressed a desire to administer their own medications, they would need to be assessed for safety, get a physician's order saying the resident could have the medication at the bedside, and the resident would need to keep the medication safely locked up. The DON stated Resident #1 could not self-administer her medications.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		3/24/23

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F 812	Continued From page 79 Based on observations and staff interviews the facility failed to date and label opened food and remove expired food from 1 of 3 reach-in refrigerators. This practice had the potential to affect food served to residents. Findings included: On 2/20/23 at 9:57 AM an observation of the kitchen reach-in cooler #3 revealed one 5-quart square plastic container located on the top shelf that was approximately 1/8 full of grape jelly. The container was covered with plastic wrap and did not contain a label or use by date. A quart size food storage plastic bag contained sliced deli meat on the bottom shelf that did not contain a label or use by date and an open bag of pre-cut slaw mix was missing a label and use by date. Additionally, the same reach-in refrigerator contained a head of cabbage with dried and yellow outer shell. The Dietary Manager (DM) stated in an interview on 2/20/23 at 12:46 PM that the food items missing labels and use by dates should have been dated and labeled before placed into the reach-in refrigerator. The cabbage head should have been thrown away when the cook checked the food storage areas and refrigerators at the beginning of his shift. The DM stated she checked the food storage and refrigerators every morning she worked. The food storage and refrigerated areas had not yet been checked and should have been by the cook and herself. The Administrator stated in an interview on 2/24/23 at 4:46 PM that when a food item was opened for use it should be dated and labeled before storing and expired or spoiled food should	F 812	19. Food storage F812E 1. Facility failed to store, prepare/serve sanitary food in kitchen area by not labeling, dating and sealing open food items in refrigerator/cooler. On 2/20/2023 the container with grape jelly, the storage bag with sliced deli meat, and the open bag of slaw mix was disposed of. The head of cabbage was also disposed of on 2/20/2023. 2. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted by 3/23/23 to ensure that all unlabeled, dated and unsealed containers were removed from refrigerators/coolers. By 3/23/23 the Dietary Manager re-educated Dietary staff on safe food handling practices including labeling, dating and sealing open food items prior to storing in the refrigerator/cooler. All new employees and agency staff will be educated during orientation and prior to beginning work. 3. The Administrator and Dietary Manager will monitor refrigerators/coolers in the kitchen for safe food storage 3 times per week for 12 weeks. 4. The Dietary Manager will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of Completion 3/24/23	

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F 812	Continued From page 80 be disposed of.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to	F 867		3/24/23

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F 867	Continued From page 81	F 867		

adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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	345134	A. BUILDING ______ B. WING ______	C 02/28/2023

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F 867	Continued From page 82 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and	F 867	20. QAPI F867E 1. By 3/23/23, the Quality Assurance	

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F 867	Continued From page 83 Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint investigation survey completed on 11/22/21 and a complaint investigation survey completed on 02/17/22. This was for one repeat deficiency in the area of activities of daily living provided for dependent residents originally cited on 11/22/21 during a recertification and complaint investigation survey and on 02/17/22 during a complaint investigation survey. In addition, there were four repeat deficiencies in the areas of comprehensive assessments and timing, accuracy of assessments, free of accident hazards/supervision/devices, and sufficient nursing staff that were originally cited on 11/22/21 during a recertification and complaint investigation survey and/or complaint investigation survey on 02/17/22. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F636: During the recertification and complaint investigation survey of 02/28/23, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (abbreviated as ARD and referring to the last day of the assessment period) for 2 of 32 sampled residents (Residents #75 and #135). During complaint investigation survey of 02/17/22,	F 867	Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F636 timely MDS assessments, F641 accurate MDS assessments, F689 Free of accidents/hazards/supervision and F729 Staffing. 2. By 3/23/23 the Director of Operations and Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F636 timely MDS assessments, F641 accurate MDS assessments, F689 Free of accidents/hazards/supervision and F729 Staffing. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds. 3.By 3/23/23 the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings for 12 weeks, the	

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F 867	Continued From page 84	F 867		

the facility failed to complete annual MDS assessments within 14 days of the ARD.

F641: During the recertification and complaint investigation survey of 02/28/23, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR) and hospice for 2 of 32 sampled residents reviewed for MDS accuracy (Resident #45 and #34).

During the recertification and complaint investigation survey of 11/22/21, the facility failed to accurately code MDS assessments in the area of smoking.

During the complaint investigation survey of 02/17/22, the facility failed to accurately code MDS assessments in the area of pressure ulcers.

F677: During the recertification and complaint investigation survey of 02/28/23, the facility failed to provide incontinence care (Resident #48), nail care (Resident #487, Resident #61, Resident #54, and Resident #185), and a shave (Resident #487) for 6 of 14 dependent residents reviewed for activities of daily living (ADL).

During the recertification and complaint investigation survey of 11/22/21, the facility failed to provide nail care to residents dependent on staff for ADL assistance.

During the complaint investigation survey of 02/17/22, the facility failed to provide incontinence care to residents dependent on staff for ADL assistance.

F689: During the recertification and complaint

QAPI committee will continue to meet monthly.
By 3/23/23 the Director of Operations or Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.
4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies.
Date of Completion 3/24/23

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F 867	Continued From page 85 investigation survey of 02/28/23, the facility failed to supervise 1 of 4 residents reviewed for smoking (Resident #22). During the recertification and complaint investigation survey of 11/22/21, the facility failed to provide enteral feedings and pleasure foods only to a resident assessed as unsafe for consuming fluids by mouth and failed to complete and document resident quarterly smoking assessments. F725: During the recertification and complaint investigation survey of 02/28/23, the facility failed to provide sufficient nursing staff resulting in residents not having their choices honored for bathing and not receiving transfer assistance when requested for 6 of 8 sampled residents (Residents #135, #1, #12, #58, #284, and #70). During the complaint investigation survey of 02/17/22, the facility failed to have sufficient nursing staff to provide incontinence care and pressure ulcer care. During a telephone interview on 02/27/23 at 4:07 PM, the Administrator revealed she started her employment in December 2021 and could not speak as to what processes were put into place following the recertification survey in November 2021 or why the concerns identified continued to be an issue on subsequent recertification and/or complaint investigation surveys. The Administrator explained the QAPI committee met the third Thursday of each month and each department head brought concerns identified from the month prior for the committee to discuss and develop plans on how to address. The Administrator stated on any given day, including	F 867		

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F 867	Continued From page 86 the weekends, there was enough staff scheduled to ensure resident care was provided and felt staff were just not communicating if they were having trouble getting their work done as no staff had reported not being able to provide resident care due to lack of staff.	F 867		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to ensure the call light annunciator panel located at the nurses' station functioned to identify the room number and sound an alarm and failed to ensure the light above the room entry door worked when the call light at the bedside and bathroom were engaged for 1 of 17 residents (Resident #16) reviewed for call lights on 1 of 2 wings (West Wing). The findings included: Resident #16 was admitted on 06/28/21 with diagnoses including debility and heart failure. Review of quarterly Minimum Data Set dated 02/01/23 revealed Resident #16 was assessed as having moderately impaired cognition and was	F 919	21. Call Lights F919D 1. Based on observations, resident, and staff interviews, the facility failed to ensure the call light annunciator panel located at the nurses' station functioned to identify the room number and sound an alarm and failed to ensure the light above the room entry door worked when the call light at the bedside and bathroom were engaged for resident (Resident #16). 2. All residents have the potential to be affected by the alleged deficient practice. By 2/23/23 the Maintenance Director and the Administrator audited all bathroom call lights to ensure they were all working properly. The Maintenance Director repaired the bathroom call light for	3/24/23

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F 919

Continued From page 87

independent with bed mobility and needed supervision with transfers and extensive assistance with toilet use.

Review of the care plan focus area for activities of daily living revised on 07/09/22 described Resident #16 as having a self-care deficit related to an intolerance to activity due to diagnoses. Interventions put in place included encourage Resident #16 to use the call bell and call for assistance.

An observation of the call lights for Resident #16 was made on 02/20/23 at 2:30 PM. The call light in the bathroom and at the bedside were engaged. The light above the room entry door didn't work and there was no sound of an alarm to indicate either of the call lights were engaged.

An observation made on 02/22/23 at 9:58 AM revealed when the bathroom call light for Resident #16 was engaged the light above the entry door didn't work and the call light annunciator panel didn't sound an alarm or light the room number to indicate it was engaged.

During an interview and observation on 02/22/23 at 10:39 AM Resident #16 revealed she often performed her own activities of daily living task including toileting herself. Resident #16 explained she would self-transfer from the wheelchair to the toilet and rarely used the call light. Resident #16 was able to locate and engage the call light at the bedside. When engaged the light above the room entry door didn't work and the call light annunciator panel at the nurses' station did not light or sound an alarm to indicate Resident #16 had engaged the bedside call light.

F 919

resident #16 on 2/23/23. The call light annunciator panel and call lights were all repaired by 3/23/23.

3. By 3/23/23 the Administrator re-educated all staff, including agency staff on the facility process for notifying the Maintenance Director of needed repairs on call lights by making a notation in the Maintenance Log at each Nurses station. Beginning 3/23/23 the Maintenance Director was educated by the Administrator on the responsibility of reviewing these repair requests daily and completing the repair or adding to the prioritized list. Beginning 3/23/23 the Administrator will ensure this education will be included in orientation for newly hired staff and agency staff.

The Administrator will review 5 resident rooms and shared bathrooms 3 times per week for 12 weeks to ensure the call light system is working properly.

4. The Administrator will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of Completion 3/24/23

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F 919	Continued From page 88 An interview was conducted on 02/23/23 at 12:02 PM with the Maintenance Director. The Maintenance Director explained there was a power surge early in the week either on 02/20/23 or 02/21/23 when the floors were being buffed. The Maintenance Director stated he just found out about the power surge but wasn't aware the call light annunciator panel or light above Resident #16's entry door was affected. The Maintenance Director explained he used TELS (a web-based maintenance software) that included random call light checks and described he checked 8 resident rooms to ensure the call lights in the bathroom and at the beside functioned and stated those checks were done each month but had no documentation to show it was done. An observation and interview were conducted with the Maintenance Director on 02/24/23 at 8:36 AM. The Maintenance Director revealed he relied on staff to report environment issues and there was a maintenance logbook kept at each nurse station for them to do so and was checked each morning. Observation of the call light in the bathroom of Resident #16 revealed when it was engaged the light above the entry door worked. The call light annunciator panel at the nurses' station identified Resident #16 room number and an alarm sounded. The call light at the bedside was engaged and the light above the entry door and the call light annunciator panel at the nurses' station did not work and no alarm sounded to identify Resident #16 call light at the bedside was engaged. The Maintenance Director revealed he replaced the bulb above the entry door and the pull station/call light box in the bathroom but did not at the bedside. An interview was conducted on 02/24/23 at 9:02	F 919		

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F 919	Continued From page 89 AM with Nurse Aide (NA) #7. NA #7 explained she either verbally told maintenance or wrote a work order to inform them of environment issues. NA #7 revealed she was made aware the call light didn't work in Resident #16's bathroom due to a power surge but was unsure of the date. NA #7 explained Resident #16 does toilet herself and staff knew to go check the room. A joint interview was conducted on 02/24/23 at 5:38 PM with the Administrator, Director of Nursing, and Corporate Nurse Consultant. The Administrator revealed staff should notify the maintenance when there were issues noted in a resident's room and bathrooms and could do so either verbally or write a work order in the maintenance book kept at each nurse station.	F 919		