STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 An unannounced recertification survey was conducted on 8/29/22 to 9/1/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EZ8O11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 8/29/22 to 9/1/22. Event ID #EZ8O11. 19 of the 64 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00191375, NC00185021, NC00185233, NC00188926, NC00191914, NC00183934, NC00189407, NC00188437, NC00190985, NC00190524, NC00188982, NC00191540, NC00187777, NC00185504, NC00188586, NC00185127, NC00190338, NC0018382, NC00184368, NC00181553, NC00188389, NC188785, NC00189083, NC00189167, NC00189228, and NC00192463.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		9/29/22

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

Electronically Signed | 09/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 550	Continued From page 1 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 promote dignity by not providing a privacy cover over an urinary catheter drainage bag for one resident (Resident #52). This occurred for 1 of 6 residents reviewed for dignity. Findings included:	F 550	F550 1. Resident #52 privacy cover was placed over the urinary catheter on 8/31/22 by the licensed nurse. 2. An audit was completed on September 26, 2022, by the DON or designee of the current residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 550	Continued From page 2 Resident #52 was admitted to the facility on 7/14/2021 with a diagnosis of uropathy requiring a suprapubic catheter. Review of Resident #52's quarterly Minimum Data Set dated 7/27/2022 showed that she was alert and oriented. It also stated resident had a suprapubic catheter. On 8/29/2022 at 11:10 AM, Resident #52 was observed from the hallway lying in her bed. An urinary catheter bag was visible from the hallway and noted to be hanging from the side of the bed and filled with urine. Several staff members and a visitor were observed walking past the open door. During an interview with Resident #52 on 8/29/2022 at 11:15 AM, stated that she would prefer the whole building not walk by and see her urine in a bag hanging on the bed. On 8/29/2022 at 12:30 PM, Resident #52 was observed form the hallway lying in her bed. The catheter drainage bag contained yellow urine and remained uncovered. On 8/30/2022 at 10:50 AM, Resident #52 was observed form the hallway lying in her bed. The catheter drainage bag contained yellow urine and remained uncovered. During an interview with Nurse #4 on 8/31/2022 at 2:10 PM, she stated that they always put a privacy cover over the bags upon admission. She stated that Resident #52 had just returned to the facility and that is probably just got forgotten. She added that she noticed it and put a privacy cover over the bag before she left the facility that	F 550	have urinary catheters to ensure that privacy covers are in place as required. 3. The nursing staff to include agency staff were in serviced by September 29, 2022, by the Staff Development Coordinator or designee related to ensuring privacy covers are in place over urinary catheters. New hires and agency staff will not be allowed to work until the education is completed. 4. The Director of Nursing (DON) or designee will complete audits of at least 5 residents with urinary catheters weekly for 4 weeks and monthly for 2 months to ensure privacy covers continue to be in place over urinary catheters. The DON will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 550	Continued From page 3 afternoon. During an interview with Director of Nursing on 8/31/2022 at 10:26 AM, she stated that nursing staff should be aware that catheter bags should not be visible from the hallway. She added that a bag cover should always be used to maintain resident's privacy and dignity.	F 550		
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. §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	F 578		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 4 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 obtain a physician ' s order for Do Not Resuscitate (DNR) for 1 of 1 resident reviewed for advanced directives (Resident #234). The findings included: Resident #234 was admitted to the facility on 7/29/22 and expired in the facility on 7/31/22. A review of Resident #234 ' s medical record revealed no physician's order to identify the residents code status as DNR. Further review of the medical record revealed a Stop sign document that indicated Resident #234 was a DNR. The document had an effective date of 7/29/22 (Resident #234 ' s admission date) but was not scanned into the electronic health record until 8/5/22, after Resident #234 was discharged from the facility. On 9/1/22 at 1:12 PM, an interview was conducted with Nurse #1 who stated the	F 578	F578 1. Resident #234 expired on 7/31/22. 2. An audit was completed on September 27, 2022, by the DON or designee of the current residents' code status to ensure physician orders are obtained and documented in the medical record. 3. The licensed nurses to include agency licensed nurses were in serviced by September 29, 2022, by the Staff Development Coordinator/ designee related to ensuring that physician orders for resident code status are obtained and documented in the medical record. New hires and agency licensed nurses will not be allowed to work until the education is completed. 4. The Director of Nursing (DON) or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure resident code	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 5 admitting nurse was supposed to review code status, allergies, medications and diet on admission. Nurse #1 stated most residents came in with the Stop sign documented but if they did not the physician will fill one out on the next visit. On 9/1/22 at 2:15 PM, an interview was conducted with the Director of Nursing (DON). She stated the admitting nurse was responsible for entering the residents code status and calling the physician for orders. She stated she went over it with the nurses frequently and expected the code status to be identified on admission and a physician's order obtained.	F 578	status orders are obtained and documented in the medical record. The DON or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 582 SS=B	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 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	F 582		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 582	Continued From page 6 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 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 facility residents with CMS-10123 Notice of Medicare non-coverage (NOMNC) prior to discharge from Medicare services for 3 of 3 residents reviewed for discharge documentation (Resident #481, Resident #40, and Resident #480).	F 582	F582 1. Residents #481, #40, and #480 were issued Notice of Medicare non-coverage (NOMNC) on August 14, 2022, by Social Worker. 2. An audit was completed on September 28, 20222 by the Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 582	Continued From page 7 Findings included: 1. Resident #481 was admitted to the facility 4/29/2022 and discharged to another facility on 5/4/2022. A review of the medical record revealed Resident #481 had not received a NOMNC form prior to discharge. An interview was conducted with the Social Worker (SW) on 9/1/2022 at 10:44 AM. The SW reported she was not aware a NOMNC form should have been provided to Resident #481 upon discharge to the other facility. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported he expected all residents to be provided with the appropriate notices upon their discharge from the facility or from therapy services. 2. Resident #40 was admitted to the facility on 7/13/2022 and discharged by physical therapy on 8/16/2022. Resident #40 remained in the facility. A review of the medical record revealed Resident #40 had not received a NOMNC form prior to discharge from therapy services. An interview was conducted with the SW on 9/1/2022 at 10:44 AM. The SW reported she was not aware a NOMNC form should have been provided to Resident #40 upon discharge from therapy services. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported he expected all residents to be provided with the appropriate notices upon their discharge from therapy services.	F 582	Worker of the current residents' that require NOMNC to ensure NOMNCs have been issued as required. 3. The Business office manager (BOM) and Social Work were in serviced on September 27, 2022, by the Administrator related to ensuring that NOMNC are being issued as required. New hire BOMs will not be allowed to work until the education is completed. 4. The Administrator or designee will complete audits of at least 5 residents weekly for 4 weeks and monthly for 2 months to ensure resident NOMNCs are being issued as required. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 582	Continued From page 8 3. Resident #480 was admitted to the facility on 2/1/2022 and discharged home 3/17/2022. A review of the medical record revealed Resident #480 had not received a NOMNC form prior to discharge. An interview was conducted with the SW on 9/1/2022 at 10:44 AM. The SW reported she was not aware a NOMNC form should have been provided to Resident #480 upon discharge to home. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported he expected all residents to be provided with the appropriate notices upon their discharge from the facility.	F 582		
F 584 SS=D	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	F 584		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 9 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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, resident and staff interviews, the facility failed to maintain a clean and homelike environment by not ensuring Room #222 had a working toilet for at least 3 days during the survey, not ensuring a clean resident room (Room 117A) and failed to label and cover urinals for 3 residents use in a shared bathroom (Rooms 114 and 115) for 3 of 47 rooms on 2 of 2 halls reviewed for a clean, comfortable, and homelike environment. 1. Resident #58 was admitted on 10/19/2021. Her recent quarterly Minimum Data Set (MDS) dated 8/30/22 showed she was moderately	F 584	F584 1. Room #222 toilet was repaired on August 29, 2022, by the Maintenance Director. Room 117A was cleaned on September 1, 2022, by the housekeeper. The urinals in Room 114 and Room 115 shared bathrooms were discarded on August 31, 2022 and replaced and urinals were labeled by Nurse #2. 2. An audit was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 10	F 584		

cognitively impaired, required supervision with prompting for activities of daily living, and was continent of bowel and bladder.

On 8/29/2022 at 10:30 AM, an observation was made a shared bathroom between two rooms with a printer-generated paper sign that read "no water do not use" on the bathroom door of Room #222.

On 8/29/2022 at 10:35 AM, Resident #58 stated a staff member put up the sign the previous day. She stated she didn't know what was wrong but the toilet wasn't flushing right. She stated that a staff member told her someone would look at it soon. She was not redirected to another toilet to use in the meantime.

On 8/30/2022 at 9:15 AM, Resident #58's bathroom door still had the sign on the door.

On 8/30/2022 at 9:20 AM, Resident #58 stated she was still using the toilet and flushing it, but it wasn't going down like it was supposed to do and stated that the toilet was starting to smell.

On 8/31/2022 at 10:35 AM, the shared toilet still had the sign on the door and Resident #58 stated she was starting to use the toilet next door because no one used that one.

During an interview with maintenance on 8/31/2022 at 10:45 AM, he stated he was unaware of any broken toilets. He stated the staff will put in maintenance requests online and he can access it right from his phone. He stated if there had been a request, he would have fixed it right away. He stated that there was a leak so someone had turned off the water almost

September 26, 2022, by the DON or designee of the current residents' room to ensure that a comfortable and homelike environment is being maintained in the facility to include toilets are working properly, rooms are clean, and urinals are labeled.

3. The nursing staff to include agency nursing staff, housekeeping staff and the maintenance staff were in serviced by September 29, 2022, by the Administrator or Director of Nursing (DON) or designee related to ensuring that a comfortable and homelike environment is being maintained in the facility to include toilets are working properly, rooms are clean, and urinals are labeled. New hire staff will not be allowed to work until the education is completed.

4. The Administrator or designee will complete audits of at least 8 rooms weekly for 4 weeks and monthly for 2 months to ensure a comfortable and homelike environment is being maintained.

The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.

Date of Compliance: September 29, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 11	F 584		

completely. He stated he fixed it and it was in working now.

During an interview with the unit manager on 8/31/2022 at 11:15 AM, she stated she was unaware that there was a broken toilet. She stated any staff member should be able to put in a maintenance request.

During an interview with the Director of Nursing on 9/1/2022, she stated that any staff member should be able to enter a request for maintenance to check and repair anything in the facility. She added that housekeeping can let any staff member know and they should be able to enter that request for them.

2. On 8/29/22 at 11:07 AM, an observation of Room 117A revealed several dried liquid spots on the wall behind the bed and on the wall next to the sink. The area behind the trash can in the room was heavily soiled with a dried brown liquid substance that had run down the wall. The floor had crumbs and dust along the wall behind the bed and there was an area that was heavily soiled with a dried dark substance and dried tan colored substance on the floor under the head of the bed.

On 8/30/22 at 10:45 AM, Room 117A continue to have several dried liquid spots on the wall behind the bed and on the wall next to the sink. The area behind the trash can in the room was still heavily soiled with a dried brown liquid substance that had run down the wall. The floor still had crumbs and dust along the wall behind the bed and there was still an area that was heavily soiled with a dried dark substance and dried tan colored tube feeding built up on the floor under the head of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 12	F 584		

On 9/1/22 at 2:15 PM, an observation of Room 117A revealed several dried liquid spots remained on the wall behind the bed and on the wall next to the sink. The area behind the trash can in the room was still heavily soiled with a dried brown liquid substance that had run down the wall. The floor still had crumbs and dust along the wall behind the bed and there was still an area that was heavily soiled with a dried dark substance and dried tan colored tube feeding built up on the floor under the head of the bed.

On 9/1/22 at 2:15 PM, an interview was conducted in Room 117 with Housekeeper #1. Housekeeper #1 stated he usually cleaned the walls in the rooms on the evening round after lunch. He stated he had not cleaned Room 117 yet. When Housekeeper #1 was informed the areas of concern were present since 8/29/22, he stated he must not have seen it. He stated he was responsible for cleaning all of the rooms on the 100 hall and it was a lot to get to in an 8 hour day.

On 9/1/22 at 2:30 PM, the Housekeeping Director was interviewed in Room 117A with Housekeeper #1 present. She observed the areas and stated resident rooms were cleaned daily to include the walls and floors. She added Housekeeper #1 should have noticed the areas on the walls and floor and taken care of them.

3. Observations were made on 08/29/2022 at 8:39 AM, 08/30/2022 at 10:02 AM and on 08/31/2022 at 2:59 PM of the shared bathroom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 584	Continued From page 13 located between rooms 114 and 115 revealed three unlabeled urinals were observed in the bathroom stored on the back of the toilet. An interview with Nurse Aide (NA) #4 was conducted on 08/29/2022 at 10:40 AM. The NA stated three of the four residents who shared the bathroom were able to utilize the bathroom on their own. She said the three residents emptied their urinals in the bathroom independently. The NA was unable to say which residents had left their urinals in the bathroom. She further stated urinals should be stored in labeled bags in the bathroom or at resident's bedside. An interview with Nurse #2 was conducted on 08/31/2022 at 12:57 PM. Nurse #2 stated she regularly cared for the residents on the hall 100 and urinals should be labeled and covered. During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation of staff to label and cover urinals.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 623	Continued From page 14	F 623		

discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 623	Continued From page 15	F 623		

and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 623	Continued From page 16 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notification for a resident representative and the ombudsman for a resident who was transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #49). Findings included: Resident #49 was admitted to the facility 6/25/2022. Resident #49 was discharged to the hospital on 6/27/2022 and readmitted to the facility 7/21/2022. Resident #49 was discharged to the hospital on 8/23/2022 and readmitted to the facility on 8/24/2022. Resident #49 was discharged to the hospital on 8/29/2022 and was hospitalized during the dates of the survey. a. Review of Resident #49 ' s medical record revealed no written communication to the family related to Resident #49 ' s hospitalizations were scanned into the record. An interview was conducted by phone with the family member of Resident #49 on 8/29/2022 at 2:45 PM. The family member reported she had been told Resident #49 was going to the hospital, but she was not provided written information. The Business Office Manager (BOM) was interviewed on 9/1/2022 at 2:00 PM. The BOM reported that the admissions coordinator was responsible for providing family members with	F 623	F623 1. Resident #49 family was provided written notification of discharges to the hospital by Social Services. 2. An audit was completed on September 26, 2022, by social services of the current residents' who have been discharged to the hospital in the last 30 days and written notification was provided to the responsible parties. 3. The Social Service Director was educated on September 26, 2022, by the Administrator related to ensuring that written notification of hospital discharges is being provided to resident responsible parties. New hire social service will not be allowed to work until the education is completed. 4. The Administrator or designee will complete audits of residents discharged to the hospital weekly for 4 weeks and monthly for 2 months to ensure written notifications of hospital discharges are being sent to responsible parties as required. The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 623	Continued From page 17 written notices of hospitalization. The BOM reported the facility had not had anyone in the admissions coordinator position since 6/24/2022 and she thought the medical records staff were supposed to call residents who were hospitalized. The BOM reported the medical records staff member was out sick and not available for interview. b. The Social Worker (SW) was interviewed on 9/1/2022 at 2:29 PM. The SW reported she did not send a list of discharges to the county ombudsman. The SW reported she was aware she should provide the ombudsman with a list of discharged residents. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported the admissions coordinator had quit without notice on 6/24/2022. The Administrator explained the admissions coordinator was responsible to call residents or their family members when the resident was discharged to the hospital. The Administrator reported without the admission coordinator, the medical records staff was calling family members, but medical records staff was out sick. The Administrator reported he expected a written notice of hospitalization to be provided to residents or their family members when the resident left the facility for an unplanned hospitalization. The Administrator reported he was not aware SW was not providing a list of discharges to the county ombudsman.	F 623	3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that	F 637		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 637	Continued From page 18 there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to complete a significant change assessment for 1 of 1 sampled resident (Resident #77) reviewed for rehabilitation services. Findings included: Resident #77 was originally admitted to the facility on 3/11/22 and re-admitted on 5/17/22 with diagnoses which included pathological hip fracture, fall, and adult failure to thrive. The admission Minimum Data Set (MDS) dated 3/15/22 indicated Resident #77 was cognitively intact, required extensive assistance with bed mobility, transfers occurred 1-2 times, and had no falls since admission. Review of the clinical records revealed Resident #77 had an unwitnessed fall in his room on 5/12/22. The on-call physician was notified, and Resident #77 was sent to the hospital for evaluation.	F 637	F637 1. Resident #77 Significant change assessment was completed on September 1, 2022 by the Minimum Data Set (MDS) licensed nurse. 2. An audit was completed on September 28, 2022 by MDS licensed nurse of the current residents who might require significant change assessments and any missing assessment were completed on September 28, 2022. 3. The MDS nurse was educated on September 26, 2022 by the Regional MDS consultant according to the Resident Assessment Instrument (RAI) guideline to ensure that significant change assessments are being completed as required. New hire MDS nurses will not be allowed to work until the education is completed. 4. The Director of Nursing or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 637	Continued From page 19 The hospital's discharge summary dated 5/17/22 revealed Resident #77 was diagnosed with left hip with nondisplaced closed fractures due to fall. The resident was re-admitted to the facility on 5/17/22. The medical records indicated on his return from the hospital, Resident #77 continued to receive physical therapy from 5/18/22 through 6/22/22 to address functional decline and attention to midline, fall risk prevention, provide patient, family and caregiver education and mitigate barrier to a safe transition. A quarterly MDS dated 5/27/22 indicated Resident #77 was moderately, cognitively impaired, required extensive assistance with bed mobility and transfers, and 1-fall with no injury. During an interview on 9/01/22 at 9:07 a.m., the MDS Coordinator acknowledged when Resident #77 returned from the hospital after the fall resulting in a fracture, a significant change MDS should have been completed on 5/27/22, not a quarterly.	F 637	months to ensure significant change assessments have been completed as required. The Director or Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record reviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92	F 638	F638 1. Residents #24, #432, and #6 were reviewed on September 26, 2022 by the	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 638	Continued From page 20 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 3 of 27 residents (Residents 24, #432, and #6) reviewed for timely completion of quarterly MDS assessments. Findings included: 1.Resident # 24 was admitted to the facility on 06/14/19. Resident #24 most recent quarterly MDS assessment with an Assessment Reference Date (ARD) of 04/13/22 was marked as completed late on 05/05/22 which was more than 14 days after the ARD date. The previous ARD date was 01/11/22. On 09/01/22 at 12:20 PM the MDS nurse was interviewed, and she explained she had been out of work for a period of time and as the only MDS nurse she got behind and was not able to complete MDS assessments as required. An interview with the Nursing Home Administrator (NHA) conducted on 09/01/22 at 1:44PM revealed that he hired a new MDS nurse to work as needed and the new MDS nurse was to begin orientation during the next week. 2. Resident # 432 was admitted to the facility on 12/13/19. Resident #432's most recent quarterly MDS assessment had an ARD date of 03/24/22 was marked as completed late on 05/01/22 which was more than 14 days after the ARD date. The previous ARD date was 12/01/21.	F 638	Minimum Data Set (MDS) licensed nurse related to the late completion of quarterly MDS. 2. An audit was completed on September 28, 2022 by the MDS licensed nurse of the current residents to ensure quarterly MDS assessments are being completed timely. 3. The MDS nurse was educated on September 26, 2022 by the Regional MDS consultant related to ensuring that quarterly MDS assessments are being completed timely. New hire MDS nurses will not be allowed to work until the education is completed. 4. The Director of Nursing or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure that quarterly MDS assessments continue to be completed timely. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 638	Continued From page 21	F 638		

On 09/01/22 at 12:20 PM the MDS nurse was interviewed, and she explained she had been out of work for a period of time and as the only MDS nurse she got behind and was not able to complete MDSs as required.

An interview with the NHA conducted on 09/01/22 at 1:44PM revealed that he hired a new MDS nurse to work as needed and the new MDS nurse was to begin orientation during the next week.
3. Resident #6 was admitted to the facility on 8/30/18 with diagnoses that included, in part, chronic obstructive pulmonary disease and diabetes.

The quarterly MDS assessment with an ARD of 5/31/22 was reviewed and revealed the assessment was signed as completed on 7/1/22. The previous MDS ARD was 2/28/22.

An interview was completed with the MDS Nurse and Clinical Reimbursement Coordinator on 8/31/22 at 2:58 PM. The MDS Nurse verified she completed the quarterly assessment for Resident #6 and stated the assessment should have been signed as completed on 6/13/22. She explained she was the only MDS Nurse in the building and had gotten behind when she helped with other responsibilities in the facility due to COVID outbreaks with residents and staff. The Clinical Reimbursement Coordinator shared MDS assessments fell behind for "about a month" and the regional team assisted with completing past due assessments and care plans.

During an interview with the Administrator on 9/1/2022 at 3:37 PM, he explained the facility had only one MDS nurse to complete all MDS assessments, and she was unable to keep up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 638	Continued From page 22 with the volume of assessments. The Administrator reported a new MDS nurse had been hired to assist with the assessments and that nurse would start the following week.	F 638		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of dental (Residents #3, #34 and #43) and tube feeding (Resident #47) for 4 of 4 residents reviewed for resident assessments. Findings included: 1. Resident #34 was admitted to the facility on 10/30/2019. Review of Resident #34's annual minimum data set assessment dated 10/07/2021 revealed in section L dental was marked no for obvious or likely cavity or broken teeth. He was cognitively intact. During an interview on 08/29/22 at 12:32 PM with Resident #34 he was observed to have brown, missing, and broken upper teeth. Some teeth were brown to the gum line. He denied pain during the interview. He stated he thought they checked his teeth one time in the years since his admission	F 641	F641 1. Residents #3, #34, and #43 Minimum Data Set (MDS) assessments were corrected in the area of dental on September 28, 2022, by the MDS nurse. Resident #47 MDS assessment was corrected in the area of tube feeding on September 28, 2022, by the MDS nurse 2. An audit was completed on September 28, 2022, by the MDS licensed nurse of the MDS assessments completed in the last 60 days to ensure that MDS assessments are being completed accurately in the identified areas of dental and tube feedings. 3. The MDS nurse was educated on September 26, 2022, by the Regional MDS consultant according to the Resident Assessment Instrument (RAI)guideline to ensure that MDS assessments are being completed accurately. New hire MDS nurses will not be allowed to work until the education is completed.	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 23 In an interview on 08/31/22 at 8:35 AM the Corporate Nurse Consultant stated she was unable to find a dental consult for Resident #34. An interview with the MDS Nurse was conducted on 08/31/22 at 9:22 AM. She revealed she had worked at the facility for 12 years and had been in the MDS position for three years. She further revealed she had marked Resident #34's MDS section L no for obvious or likely cavity or broken teeth. She explained it was the admitting nurse's responsibility to assess a resident's dental status during completion of the admission assessment UDA (user defined assessment). She further explained when she accessed a resident's MDS she refreshed everything, and it pulled the data to the MDS from the UDA. She stated the MDS guidelines instructed her to look at a resident's teeth and mouth during her MDS assessment. She further stated she used the assessment information from the UDA and did not visually assess Resident #34's dental status on admission. On 08/31/22 at 9:35 AM the MDS Nurse observed Resident #34's teeth. She stated, "I can't make the decision if a tooth is broken, it could be decayed". After she observed Resident 34's teeth she said she would code that he had missing teeth. During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation that the MDS Nurse would ensure that the minimum data set assessments were correct and if inaccurate	F 641	4. The Director of Nursing/ designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure that MDS assessments continue to be completed accurately. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 24	F 641		

documentation was identified by the MDS Nurse then it should be corrected, and the physician should be notified of any concerns.

2. Resident #3 was admitted to the facility on 11/23/2021.

Review of Resident #3's annual MDS assessment dated 02/25/2022 revealed in section L dental was marked no for obvious or likely cavity or broken teeth. He had impaired cognition.

During an interview on 08/30/22 at 10:02 AM with Resident #3 he was observed to have missing, brown, and broken teeth. He revealed he had not been seen by a dentist since admission. He wiggled one of the front bottom teeth and explained it had been loose for some time. He stated he had reported the loose tooth but could not remember when or to whom he had reported it. He further stated he had not reported the concern again.

In an interview on 08/31/22 at 8:35 AM the Corporate Nurse Consultant stated she was unable to find a dental consult for Resident #3.

An interview with the MDS Nurse was conducted on 08/31/22 at 9:22 AM. She revealed she had worked at the facility for 12 years and had been in the MDS position for three years. She further revealed she had marked Resident #3's MDS section L no for obvious or likely cavity or broken teeth. She explained it was the admitting nurse's responsibility to assess a resident's dental status during completion of the admission assessment UDA (user defined assessment). She further explained when she accessed a resident's MDS she refreshed everything, and it pulled the data to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 25	F 641		

the MDS from the UDA. She stated the MDS guidelines instructed her to look at a resident's teeth and mouth during her MDS assessment. She further stated she used the assessment information from the UDA and did not visually assess Resident #3's dental status on admission.

On 08/31/22 at 9:45AM the MDS Nurse observed Resident #3's teeth. After she observed his teeth, she said she would code that he had missing teeth.

During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation that the MDS Nurse would ensure that the minimum data set assessments were correct and if inaccurate documentation was identified by the MDS Nurse then it should be corrected, and the physician should be notified of any concerns.

3. Resident #43 was admitted to the facility on 7/14/2022 with diagnoses to include end stage renal disease. The admission Minimum Data Set (MDS) assessment dated 7/21/2022 assessed Resident #43 to be cognitively intact. The MDS assessed Resident #43 to have no broken teeth or obvious decay.

The admission assessment for Resident #43 dated 7/14/2022 did not document broken teeth or obvious decay.

Resident #43 was observed on 8/29/2022 at 12:38 PM. It was noted Resident #49 was missing multiple teeth, and the teeth he had were dark. Resident #43 was interviewed at the time of the observation, and he reported he had been losing teeth for "a while", but he did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 26	F 641		

dental pain. Resident #49 reported he did not remember anyone looking into his mouth or offering him dental services.

An interview with the MDS Nurse was conducted on 08/31/22 at 9:22 AM. The MDS nurse revealed she had coded Resident #43 as having no broken teeth or obvious decay. The MDS nurse explained it was the admitting nurse's responsibility to assess a resident's dental status during completion of the admission assessment. The MDS nurse reported when she completed a resident MDS it pulled the data from the admission assessment. She stated the MDS guidelines instructed her to look at a resident's teeth and mouth during her MDS assessment. She explained she used the assessment information from the admission assessment and did not visually assess Resident #43's dental status on admission.

The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported Resident #43 ' s MDS was not coded correctly because the MDS did not perform an oral examination. The Administrator reported it was his expectation that MDS assessments were coded correctly.

4. Resident #47 was admitted to the facility on 3/9/22 with diagnoses to include gastrostomy tube.

A physician ' s order dated 5/9/22 revealed Resident #47 was NPO (nothing by mouth).

A quarterly Minimum Data Set (MDS) assessment dated 7/25/22 revealed Resident #47 had a feeding tube. The MDS also indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 641	Continued From page 27 Resident #47 received mechanically altered diet. On 9/1/22 at 8:53 AM, the MDS Nurse was interviewed. She stated she just started completing section K on the assessment and thought she should code the tube feeding as mechanically altered because it was a liquid. She added she now understood that it was not accurate. On 9/1/22 at 3:57 PM, an interview was conducted with the Administrator who stated it was his expectation that the MDS be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 28 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. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop comprehensive care plans for 1 of 5 sampled residents reviewed for nutrition (Resident #77) and 1 of 1 sampled resident (Resident #43) reviewed for discharge planning. Findings included: 1. Resident #77 was originally admitted to the facility on 3/11/22 and re-admitted on 5/17/22 with diagnoses which included severe protein-calorie malnutrition, dysphagia, abnormal weight loss, and adult failure to thrive. The physician's order dated 7/25/22 revealed the resident was to receive an 8-ounce house	F 656	F656 1. Residents #77 comprehensive care plan for nutrition was completed by the Minimum Data Set (MDS) nurse on September 28, 2022. Resident #43 comprehensive care plan for discharge was completed by the MDS nurse on September 28, 2022. 2. An audit was completed on September 28, 2022, by the MDS licensed nurse of the comprehensive care plan to ensure comprehensive care plans for nutrition and discharge are being completed as required. 3. The MDS nurse was educated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 29 supplement (Ensure Plus as available) with meals for protein-calorie malnutrition. A physician's order dated 7/25/22 indicated Resident #77 was to receive a frozen nutritional treat three times each day related to his diagnoses of severe protein-calorie malnutrition, adult failure to thrive, and abnormal weight loss. The quarterly Minimum Data Set (MDS) dated 8/19/22 indicated Resident #77 was moderately, cognitively impaired, required supervision with eating, weighed 84 pounds, had no significant weight loss or gain, and received a therapeutic/mechanically altered diet. There was no nutrition care plan with interventions for Resident #77's diagnoses of severe protein-calorie malnutrition and abnormal weight loss. The most recent weight documented in the clinical records on 8/24/22 indicated Resident #77 weighed 87 pounds. On 8/29/22 at 1:16 p.m., Resident #77 was observed in his room, feeding himself lunch of mechanical soft texture. The resident was drinking a four-ounce strawberry shake. The resident's meal ticket indicated the resident was to receive a magic cup (frozen nutritional treat) with his meal. There was no magic cup on his meal tray. The resident stated he always received a strawberry shake (which he enjoyed) with every lunch and supper. The resident consumed one hundred percent of the 4-ounce strawberry shake but consumed less than twenty-five percent of his meal of mechanical soft texture.	F 656	September 26, 2022, by the Regional MDS consultant related to ensuring that comprehensive care plans are being completed for nutrition and discharges. New hire MDS nurses will not be allowed to work until the education is completed. 4. The MDS or designee will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure comprehensive care plans continue to be completed accurately. The MDS or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 30	F 656		

During a telephone interview on 8/31/22 at 9:45 a.m., the Registered Dietitian (RD) stated Resident #77 had been losing weight since admission and his weight was currently stable, but still low. She stated the current interventions to prevent further weight loss for the resident included fortified foods, magic cup (for protein and calories) with his breakfast, lunch, and supper, house supplement (2-strawberry shakes (8-ounces of Ensure or Ensure Plus) with meals and in-between meals, 2.5mg (milligrams) dronabinol medication (used as an appetite stimulant) twice each day, 2(4-ounce) strawberry shakes and a magic cup with each meal, and weekly weights. When questioned about the resident receiving the 4-ounce shake instead of the 4-ounce magic cup as ordered, the RD stated not receiving the supplements and/or receiving the supplements in the amounts as ordered may contribute to the resident's lack of weight gain.

Resident #77 was observed in his room with his lunch meal tray on 8/31/22 at 1:15 p.m. The food items on the meal tray included 1-(4 ounce) strawberry shake. There was no magic cup (frozen nutritional treat) on the resident's meal tray.

During an interview on 8/31/22 at 1:25 p.m., NA#6 (nursing assistant) stated Resident #77 was able to feed himself. She revealed Resident #77 received a 4-ounce strawberry shake with all his meals but did not receive a receive a magic cup.

During an interview on 8/31/22 at 10:45 a.m., the MDS Coordinator stated Nutrition was not independently/specifically addressed in Resident #77's Care Plan but should have been and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 656	Continued From page 31 be immediately addressed. 2. Resident #43 was admitted to the facility on 7/14/2022 with diagnoses to include end stage renal disease. The admission Minimum Data Set (MDS) assessment dated 7/21/2022 assessed Resident #43 to be cognitively intact. The MDS was coded to indicate Resident #43 had no discharge plans and was going to be staying in the facility for long-term care. The care plans dated 7/15/2022 for Resident #43 revealed no care plan was in place that addressed his long-term care status. The Social Worker (SW) was interviewed on 9/1/2022 at 10:16 AM. The SW reported that Resident #43 had told her on admission he wanted to go home, but once he had been at the facility it was determined that would not be safe. The SW reported that Resident #43 was not able to discharge home and he would be staying at the facility for long-term care. The SW reported the MDS coding would trigger a care plan related to long-term care and she was not aware the MDS did not trigger the care plan. The SW further reported she was not aware a care plan that addressed long-term care needed to be included in the comprehensive care plan. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported he was not aware the SW had not developed a long-term care plan for Resident #43 and he expected all residents to have a care plan that addressed their discharge plan or their need for continued long-term care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 657	Continued From page 32 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to review and update the comprehensive care plan for falls for 1 of 1 sampled resident (Resident #77) reviewed for rehabilitation services. Findings included:	F 657	F657 1. Residents #77 comprehensive care plan for falls was reviewed and updated by the Minimum Data Set (MDS) nurse on September 28, 2022. 2. An audit was completed on September 28, 2022, by the MDS nurse of the comprehensive care plans for the last	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 657	Continued From page 33 Resident #77 was originally admitted to the facility on 3/11/22 and re-admitted on 5/17/22 with diagnoses which included pathological hip fracture, fall, and adult failure to thrive. The care plan dated 3/30/22 revealed Resident #77 was at risk for falls related to deconditioning, gait/balance problems, and a hip fracture with repair from a fall prior to admission to facility. Interventions included ensure resident's call light was within reach and encourage the resident to use it for assistance as needed and the resident needed prompt response to all requests for assistance. Review of the clinical records revealed Resident #77 had an unwitnessed fall in his room on 5/12/22. The on-call physician was notified, and Resident #77 was sent to the hospital for evaluation. The hospital's discharge summary dated 5/17/22 revealed Resident #77 was diagnosed with a left hip nondisplaced closed fractures due to fall. The resident was re-admitted to the facility on 5/17/22. A quarterly MDS dated 5/27/22 indicated Resident #77 was moderately, cognitively impaired, required extensive assistance with bed mobility and transfers, and 1-fall with no injury. During an interview on 9/1/22 at 9:07 a.m., the MDS Coordinator was unable to recall why she did not update Resident #77's care plan after his fall on 5/12/22. She stated the resident's care plan interventions should have been updated.	F 657	60 days to ensure comprehensive care plans for falls are being reviewed and updated as required. 3. The MDS nurse was educated on September 26, 2022, by the Regional MDS consultant related to ensuring that comprehensive care plans for falls are being reviewed and updated. New hire MDS nurses will not be allowed to work until the education is completed. 4. The Director of Nursing or designee will complete audits of current residents that have fallen each week for 4 weeks and monthly for 2 months to ensure comprehensive care plans for falls continue to be reviewed and updated. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 658	Continued From page 34 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately complete a skin assessment for 1 of 4 residents reviewed for pressure ulcers (Resident #47). The findings included: Resident #47 was admitted to the facility on 3/9/22 with diagnoses to include diabetes mellitus type 2. A quarterly Minimum Data Set (MDS) assessment dated 7/25/22 revealed Resident #47 required extensive to total assistance with activities of daily living and was at risk for pressure ulcers. Resident #47 had a diabetic foot ulcer and a pressure ulcer to his sacrum. A record review revealed no orders for treatments to bilateral lower extremities. On 8/29/22 at 11:15 AM, Resident #47 was observed in his bed. His lower legs were exposed and revealed open areas and scabbed areas to his right and left lower legs. Resident #47 also had dry, scaly areas to both feet. A record review revealed a skin assessment dated 8/29/22 by the Treatment Nurse revealed Resident #47 had intact skin.	F 658	F658 1. Residents #47 skin assessment was completed on September 26, 2022, by the charged nurse. 2. New Skin assessments of the current residents were completed on September 28/2022 by the Director of Nursing (DON)/ designee to ensure skin assessments have been completed accurately. 3. The licensed nurses will be educated by September 29, 2022, by the Director of Nursing or designee related to ensuring that skin assessments are being completed accurately on admission, weekly, and prn. New hire licensed nurses will not be allowed to work until the education is completed. 4. The Director of Nursing or designee will complete audits of at least 10 current residents weekly for 4 weeks and monthly for 2 months to ensure skin assessment continue to be completed accurately. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 658	Continued From page 35 On 8/31/22 at 1:39 PM, an interview was conducted with the Treatment Nurse in Resident #47 ' s room. She stated Resident #47 no longer had any wounds. She stated she could not recall if she did the skin assessment on 8/29/22 for Resident #47. She stated she didn ' t think she did. When Resident #47 ' s lower extremities and feet were observed by the Treatment Nurse, she stated those were things that needed to be on the skin assessment so they could be monitored. A follow up interview was conducted with the Treatment Nurse on 9/1/22 at 2:15 PM. She stated she did complete the skin assessment for Resident #47 on 8/29/22 but she must have mis-clicked when she completed his skin assessment On 9/1/22 at 2:15 PM, the Director of Nursing was interviewed and stated skin assessments should be completed accurately.	F 658	3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to provide a shave and nail care for 2 of 6 residents reviewed for activities of daily living (ADLs) (Residents #47 and #77). The findings included:	F 677	F677 1. Residents #47 and #77 were shaved and nail care provided on September 26, 2022, by the charged nurse. 2. An audit of was completed of the current residents on September 27, 2022, by DON or designee to ensure residents	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 677	Continued From page 36 1. Resident #47 was admitted to the facility on 3/9/22 with diagnoses to include failure to thrive, right and left arm dysarthria following cerebral infarction. A quarterly Minimum Data Set assessment dated 7/25/22 revealed Resident #47 was rarely understood, and a Brief Interview for Mental Status revealed severe cognitive impairment. Resident #47 required extensive to total assistance for his ADLs. On 8/29/22 at 11:09 AM, Resident #47 was observed lying in his bed with approximately an inch of facial hair growth. Resident #47 was asked if he liked his facial hair, and he began rubbing his face and stated "no". Resident #47 was asked if he wanted to be shaved and he stated "yes". On 8/30/22 at 10:45 AM, Resident #47 was observed in bed and still was not shaved. On 8/31/22 at 11:06 AM, Resident #47 was observed in bed and still was not shaved. On 8/31/22 at 11:10 AM, NA #6 was interviewed in Resident #47 ' s room. She stated she worked with Resident #47 the day before and was also assigned to him today. She stated Resident #47 refused to be shaved yesterday. Resident #47 immediately yelled out, "no, no". The surveyor asked Resident #47 if he was offered a shave yesterday and he stated "no". NA #6 stated she did not report Resident #47 ' s refusal to the nurse. On 9/1/22 at 2:15 PM, the Director of Nursing was interviewed. She stated residents should be	F 677	have been shaved and nail care provided. 3. The nursing staff will be educated by September 28, 2022, by the Director of Nursing/designee related to ensuring that residents are being shaved and nail care provided. New hire nursing staff will not be allowed to work until the education is completed. 4. The Director of Nursing/ designee will complete audits of at least 10 current residents weekly for 4 weeks and monthly for 2 months to ensue residents continue to be shaved and nail care is being provided. The Director of Nursing will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 677	Continued From page 37	F 677		

shaved as often as they liked.

2. Resident #77 was originally admitted to the facility on 3/11/22 and re-admitted on 5/17/22 with diagnoses which included pathological hip fracture, fall, severe protein-calorie malnutrition, abnormal weight loss, and adult failure to thrive.

The care Plan dated 7/5/22 revealed Resident #77 had an activities of daily living (ADL) self-care performance deficit related to activity intolerance, fatigue, impaired balance, limited mobility, limited range of motion, musculoskeletal impairment, pain, and hip fracture. Interventions included for staff to check nails' length, trim and clean on bath day and as necessary.

The quarterly Minimum Data Set (MDS) dated 8/19/22 indicated Resident #77 was moderately, cognitively impaired, required limited assistance with transfers, extensive assistance with dressing, hygiene and toileting, and was totally dependent on staff for bathing. The resident was also frequently incontinent of bladder and totally incontinent of bowels.

During an observation on 8/29/22 at 3:50 p.m., Resident #77 was awake and reclining in his bed. The resident's fingernails on both hands were dirty with dark brown substance beneath his nails and surrounding the cuticles. Also, gray colored hairs extended from the inside of the resident's nostrils.

On 8/30/22 at 3:57 p.m., the resident was observed watching the television from his bed; both hands were lying on top of the bed linen. The resident's fingernails were dirty with dark brown substance beneath the nails and along the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 677	Continued From page 38 sides of nails and cuticles. The hair continued to protrude from the resident's nostrils. On 8/31/22 at 11:15 a.m., the door to the resident's room was closed. When this surveyor knocked on the door of the room, a nursing assistant called out, she was providing care to the resident. On 8/31/22 at 1:25 p.m., NA#6 revealed Resident #77 required assistance with all ADLs except feeding. She stated the resident was also total dependent on staff for incontinent care of bowel and bladder. During a meal observation on 8/31/22 at 1:15 p.m., Resident #77 was in his room feeding himself lunch. The resident's fingernails were dirty with dark brown substance beneath his nails and the surrounding cuticles. The hair continued to protrude from the resident's nostrils. An interview with Resident #77 was conducted on 8/31/22 at 1:18 p.m. The resident stated he would not mind having someone with a steady hand trim the hair from his nose.	F 677		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 39 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, interview with the Registered Dietician (RD), and record reviews, the facility failed to provide a nutritional supplement as ordered by the physician to address weight loss for 3 of 6 residents (Residents #48, #77 and #8) reviewed for nutrition. Findings included: 1. Resident #48 was admitted to the facility on 1/25/22 with diagnoses that included, in part, gastroesophageal reflux disease, dysphagia and Alzheimer's disease. The resident's April-August 2022 weights documented in the electronic record were as follows: 4/13/22 weight= 105.2 pounds 5/3/22 weight= 99.4 pounds 5/11/22 weight= 98 pounds 5/18/22 weight= 99.4 pounds 6/1/22 weight= 99.2 pounds 7/6/22 weight= 95.2 pounds	F 692	F692 1. Residents #48, #77 and #8 orders for nutritional supplement were reviewed by the Director of Nursing on September 27, 2022, as well as following up with the dietary manager to ensure supplements are being provided as ordered Registered Dietitian will input all orders into PCC and will place all diet order in tray card system and input any changes to diet orders in the tray cards system. 2. An audit was completed of the dietary recommendations for the last 60 days of the current residents on September 27, 2022, by DON or designee to ensure nutritional supplement recommendation orders are being followed and dietary is ensured supplements are being provided as ordered. 3. The nursing staff will be educated by September 29, 2022, by the Director of Nursing or designee related to ensuring that residents are receiving the ordered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 40 7/19/22 weight= 93.8 pounds 8/3/22 weight= 91 pounds 8/16/22 weight= 93 pounds A physician order dated 5/25/22 read, "Frozen nutritional treat with meals for significant weight loss/underweight status." A physician progress note written 7/5/22 by Physician #1 revealed Resident #48 had protein calorie malnutrition and stated, "Continue with the supplements ...Anticipate continued weight loss due to progression of his Huntington's, as well as Alzheimer's." The quarterly Minimum Data Set (MDS) assessment dated 7/25/22 revealed Resident #48 had severe cognitive impairment. He required supervision with eating, was on a mechanically altered diet and a therapeutic diet. He was 73 inches tall and weighed 94 pounds. The MDS further indicated Resident #48 had a weight loss of 5% or more in the last month or a 10% weight loss in the last six months. A nutrition care plan updated 8/8/22 indicated a goal that the resident would have no unrecognized weight gain/loss and a care plan approach included, "Provide and serve diet as ordered, and RD to evaluate and make diet change recommendations as needed." On 8/30/22 at 1:41 PM, Resident #48 was observed as he ate lunch in his room. The resident fed himself and consumed all his lunch. No frozen nutritional treat was observed on the lunch tray, nor was one offered to Resident #48 during the meal.	F 692	nutritional supplements. New hire nursing staff will not be allowed to work until the education is completed. The dietary staff was educated by September 29, 2022, by DON or designee ensure nutritional supplements are being provided as ordered. The Dietary Manager was educated by September 29, 2022, by DON or designee to ensure all Registered Dietitian recommendations are carried out 4. The Director of Nursing or designee will complete audits of at least 8 current residents weekly for 4 weeks and monthly for 2 months to ensue residents continue to receive dietary supplements as ordered. Registered Dietitian recommendations will be reviewed weekly by DON or designee to ensure all recommendations have been implemented. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 41	F 692		

Resident #48 was observed during breakfast on 8/31/22 at 8:44 AM. Nurse Aide (NA) #5 delivered the meal tray to the resident's room, set up the tray and assisted Resident #48 to an upright position in bed before she exited the room. The resident fed himself. An observation of the meal ticket on the tray revealed Resident #48 received a puree diet with no restrictions. No other information was listed on the meal ticket. No frozen nutritional treat was observed on the tray, nor was one offered to Resident #48 during the meal.

An interview was completed with NA #5 on 8/31/22 at 10:35 AM. She shared it was her first day working with Resident #48. She indicated she delivered the breakfast tray to Resident #48 and said the tray consisted of food and beverage, and no frozen nutritional treat was on the tray when she delivered it to the resident's room. NA #5 confirmed she had not offered a frozen nutritional treat to the resident.

In an interview with the Dietary Manager on 8/30/22 at 3:05 PM, she explained if a nutritional supplement was ordered by the RD, it was communicated to the Dietary Manager via electronic mail and she added the information to the resident's profile in her computer system which then printed out on the meal ticket and the supplement was added to the meal tray. During the interview, the Dietary Manager reviewed her computer system and stated Resident #48 was on a puree diet with thin liquids and was not noted to be on any nutritional supplements. She added if she was not notified of new nutritional supplement orders, then the information was not added to the tray ticket.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 42	F 692		

A phone interview was completed with the RD on 8/31/22 at 9:38 AM. She stated Resident #48 had lost weight since his admission, but his weight had recently stabilized, although she considered it to still be in a lower weight range. She added the resident's weight loss was anticipated due to his medical diagnoses, but she still wanted to raise his weight some with the supplement. She verified on 5/25/22 she recommended a frozen nutritional supplement be sent to the resident with all three meals. She explained when she made a recommendation, she wrote the information on a recommendation log and sent it to the Administrator, Director of Nursing (DON) and Dietary Manager. She then entered the supplement orders into the electronic health record. The RD expressed the facility should have carried out her supplement order and the frozen nutritional treat should have been added to Resident #48's meal tray.

In an interview with the DON on 8/31/22 at 10:08 AM, she explained when the RD made recommendations, the RD entered the orders into the electronic health record and then sent copies of the recommendations to the DON, Administrator and Dietary Manager. The DON said the Dietary Manager should have followed the RD's recommendations and made sure Resident #48 received the nutritional supplement that was ordered by the RD or physician. She added, from her observations, the resident fed himself and ate well and she thought his weight loss was attributed to the disease process.

2. Resident #77 was originally admitted to the facility on 3/11/22 and re-admitted on 5/17/22 with diagnoses which included severe protein-calorie malnutrition, dysphagia, abnormal weight loss,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 43	F 692		

and adult failure to thrive.

The physician's order dated 5/26/22 revealed Resident #77 was to receive a regular diet of a mechanical, soft-ground meat texture with regular, thin liquids.

The quarterly Minimum Data Set (MDS) dated 5/27/22 indicated Resident #77 was moderately, cognitively impaired, required supervision with eating, weighed 93 pounds, had no significant weight loss or gain, and received a therapeutic/mechanically altered diet.

The physician's order dated 7/25/22 revealed the resident was to receive an 8-ounce house supplement (Ensure Plus as available) with meals for protein-calorie malnutrition.

A physician's order dated 7/25/22 indicated Resident #77 was to receive a frozen nutritional treat three times each day related to his diagnoses of severe protein-calorie malnutrition, adult failure to thrive, and abnormal weight loss.

The quarterly MDS dated 8/19/22 indicated Resident #77 was moderately, cognitively impaired, required supervision with eating, weighed 84 pounds, had no significant weight loss or gain, and received a therapeutic/mechanically altered diet.

The most recent weight documented in the clinical records on 8/24/22 indicated Resident #77 weighed 87 pounds.

On 8/29/22 at 1:16 p.m., Resident #77 was observed in his room, feeding himself lunch of mechanical soft texture. The resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 44	F 692		

drinking a four-ounce strawberry shake. The resident's meal ticket indicated the resident was to receive a magic cup (frozen nutritional treat) with his meal. There was no magic cup on his meal tray. The resident stated he always received a strawberry shake (which he enjoyed) with every lunch and supper. The resident consumed one hundred percent of the 4-ounce strawberry shake but consumed less than twenty-five percent of his meal of mechanical soft texture.

During a telephone interview on 8/31/22 at 9:45 a.m., the Registered Dietitian (RD) stated Resident #77 had been losing weight since admission and his weight was currently stable, but still low. She stated the current interventions to prevent further weight loss for the resident included fortified foods, magic cup (for protein and calories) with his breakfast, lunch, and supper, house supplement (2-strawberry shakes (8-ounces of Ensure or Ensure Plus) with meals and in-between meals, 2.5mg (milligrams) dronabinol medication (used as an appetite stimulant) twice each day, 2(4-ounce) strawberry shakes and a magic cup with each meal, and weekly weights. When questioned about the resident receiving the 4-ounce shake instead of the 4-ounce magic cup as ordered, the RD stated not receiving the supplements and/or receiving the supplements in the amounts as ordered may contribute to the resident's lack of weight gain.

On 8/31/22 at 2:42 p.m., Nurse #1 revealed Resident #77 received Ensure (nutritional supplement) at breakfast, lunch, and supper from his nurse or medication aide.

Resident #77 was observed in his room with his lunch meal tray on 8/31/22 at 1:15 p.m. The food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 45	F 692		

items on the meal tray included 1-(4 ounce) strawberry shake. There was no magic cup (frozen nutritional treat) on the resident's meal tray.

During an interview on 8/31/22 at 1:25 p.m., NA#6 (nursing assistant) stated Resident #77 was able to feed himself. She revealed he enjoyed sweets and snack foods. NA#6 stated the resident received Ensure (supplement) from the nurse during medication administration. She also revealed Resident #77 received a 4-ounce strawberry shake with all his meals but did not receive a receive a magic cup. She acknowledged that when serving the resident his meal trays she never noticed magic cup documented on the resident's meal card.

On 8/31/22 at 1:48 p.m., the Dietary Manager stated the dietary department was having difficulty obtaining the physician ordered frozen nutrition treat since Monday (8/29/22) but substituted the supplement with the 4-ounce nutritional shake.

The review of the Nutrition Facts sheet of the 118 grams (4-ounce) strawberry shake provided by the Dietary Manager revealed the shake contained 200 calories: 6 grams of protein and 5 grams of fat. The Nutrition Facts sheet of the 118 grams (4-ounce) supplement nutritional treat revealed it contained 300 calories: 9 grams of protein and 12 grams of total fat.

3. Resident #2 was readmitted to the facility on 8/3/22 with diagnoses to include hemiplegia following a cerebrovascular accident, diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 46	F 692		

mellitus type 2, anemia and congestive heart failure.

A quarterly Minimum Data Set (MDS) assessment dated 6/3/22 revealed Resident #8 had moderately impaired cognition. Resident #8 was independent with meals after set up, was 64 inches tall and weighed 120 pounds. Resident #8 had a weight loss and was on a therapeutic diet.

A review of the care plan revised on 4/27/22 revealed a focus area of anemia. Interventions included give resident supplements as ordered, monitor intake and alert dietician if consumption is poor for more than 48 hours.

Weights for Resident #8 for the previous 6 months were documented as follows: 3/4/22 127.8 pounds, 4/13/22 130.2 pounds, 5/6/22 120 pounds, 6/3/22 120 pounds, 7/8/22 115 pounds and 8/5/22 116.2 pounds.

A review of the physician ' s orders included frozen nutritional treat twice a day for weight loss, dated 8/11/22.

A review of the August 2022 Medication Administration Record indicated Resident #8 was to receive the frozen nutritional treat at lunch and dinner.

A note by the Registered Dietician (RD) dated 8/10/2022 at 2:12 PM included: 56-year-old female re-admitted 8/3/2022 with cerebral infarction metabolic encephalopathy, hemiplegia/hemiparesis affecting dominant side, diabetes mellitus type 2 and iron deficiency anemia. Resident is on a mechanical soft diet with thin liquids consuming 51-100% average by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 47	F 692		

mouth intake of meals. One meal refusal reported since re-admission. Diet texture downgraded since last assessment. Independent/supervision with meals. No trouble chewing/swallowing. Height 64 inches, current body weight 119 pounds (8/8/2022) with a normal BMI of 20.4. Significant weight loss present over 180 days but weight has been fairly stable since 5/6/2022. Weight fluctuations anticipated related to CHF and re-hospitalizations. No open pressure wounds. Estimated energy needs based on current body weight of 119 pounds: 1620 kilocalories, 54 grams of protein and 1620 milliliters fluid. RD recommendations: 1. Add fortified foods to diet order due to significant weight loss, 2. Add frozen nutritional treats BID with lunch and dinner meals due to significant weight loss and 3. Add 8 oz of House Supplement (Ensure High PRO as available) three times a day due to significant weight loss.

On 8/29/21 at 1:20 PM, an observation of Resident #8 ' s lunch tray did not include a frozen nutritional treat. A review of the tray card did not include a frozen nutritional treat supplement.

An interview with Resident #8 on 8/29/21 at 1:21 PM revealed she did not know about the frozen nutritional treat. Resident #8 added she sometimes got an Ensure but she could not drink it all the time.

On 8/31/22 at 1:19 PM, an observation of Resident #8 ' s lunch tray did not include a frozen nutritional treat. Resident #8 had eaten approximately 75% of her meal.

On 9/1/22 at 12:50 PM, an observation of Resident #8 ' s lunch tray did not include a frozen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 692	Continued From page 48 nutritional treat. Resident #8 had visitors that brought food in from the outside for her to eat. On 9/1/22 at 1:10 PM an interview was conducted with NA #3 who stated the nurses give out the supplements unless it came out on the meal tray and then it would be listed on the tray card. On 08/31/22 at 09:38 AM, the RD was interviewed. During the interview, the RD stated when she assesses the residents, she fills out a log for recommendations that she sends via email to the Administrator, the Director of Nursing (DON), and the Dietary Manager. The RD stated she also puts the orders for supplements into the computer and after that the facility staff are responsible for carrying out the orders. The RD added the frozen nutritional treat should be sent out on the meal tray. On 8/31/22 at 1:48 PM, the Dietary Manager was interviewed and stated the facility was out of the frozen nutritional treat since 8/29/22. On 8/31/22 at 10:08 AM, the DON was interviewed. She stated when the RD made recommendations, she put the orders in herself and sends copies to her, the Administrator, and the Dietary Manager. The DON stated she then checks to make sure the orders are in, and the Dietary Manager should make sure the resident receives the supplement.	F 692		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 732	Continued From page 49 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to post the Daily Staffing Form that reflected the current facility census for 26 of the 30 days reviewed for	F 732	F732 1. The Director of Nursing provided education on September 26, 2022, with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 732	Continued From page 50 sufficient staffing. The facility also failed to post the Daily Staffing Form prior to the beginning of first shift for 3 out of 4 days observed during survey. Findings included: An observation was made upon entry to the facility on 8/29/2022 at 9:35 AM of the daily staff posting in the lobby of the front entrance. The posting was dated 8/28/2022. A second observation at 9:45 AM showed it had been replaced with the current date and was completely filled out. On 8/30/22, the daily staff posting was not posted in the front lobby entrance until 8:20 AM. On 8/31/22, the daily staff posting was not posted in the front lobby entrance until 9:45 AM. During a review of 30 days of staff schedules and daily postings on 8/31/22 at 11:15 AM, there was not a census for the facility documented on 26 of 30 days reviewed. Facility scheduler was out sick from the facility and not available for interview. During an interview with the Director of Nursing on 9/1/22 at 11:21 AM, she stated she was aware that the daily staff posting should be posted daily at the beginning of first shift which was 7:00am-3:00pm. She also stated she was aware the daily facility census is required for the form and that the scheduler in charge of doing that was new to the job.	F 732	the facility scheduler related to ensuring that the Daily Staffing form is posted at the beginning of the shift and reflects the daily census. 2. An audit of the Daily Staffing forms for the last 30 days was completed on September 27, 2022, by DON or designee to ensure Daily Staffing forms have been updated to reflect the daily census. 3. The receptionist in additional to the facility scheduler will be educated by September 28, 2022 by the Director of Nursing or designee related to ensuring that the Daily Staffing form is posted at the beginning of the shift and reflects the current daily census. New hire schedulers and receptionist will not be allowed to work until the education is completed. 4. The Administrator or designee will review the daily staffing posting form during the facility morning meeting to ensure posting are completed and reflect the daily census weekly for 4 weeks and monthly for 2 months The Administrator or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 755	Continued From page 51 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Consultant Pharmacist interviews, the facility failed to acquire and administer an intravenous (IV) antibiotic for a newly admitted resident with acute pancreatitis	F 755	F755 1. Resident # 280 was discharged on September 21, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 755	Continued From page 52 (Resident #280) resulting in four missed doses of medication. This occurred for 1 of 2 residents reviewed for pharmacy services. Findings included: Resident #280 was admitted to the facility the afternoon of 9/11/2021 with diagnosis of acute pancreatitis (inflammation of the pancreas) and cirrhosis of the liver. Review of the hospital physician discharge orders dated 9/11/2021 showed order for piperacillin-tazoctam (antibiotic used to treat bacterial infections) 3.375 grams in sodium chloride 0.9% 100 milliliters-infuse into the vein every 8 hours over 4 hours for 8 days. Nurse #5 was the admission nurse who signed off and ordered medication from the pharmacy. Multiple attempts to contact Nurse #5, who was from an agency and no longer worked at the facility, were unsuccessful. Review of Resident #280's September 2021 medication administration record (MAR) showed the IV antibiotic was not entered on the MAR until 9/12/2021 and Resident #280 did not receive the first dose until the 8:00 AM on 9/13/2021. This resulted in the resident missing a total of 4 doses. All three doses due on 9/12/2021 were marked as unavailable by Nurse #5. Review of Resident #280's progress notes showed an entry by Nurse #5 on 9/11/2021 and stated she was awaiting arrival of medication from pharmacy. On 9/12/2021, Nurse #5 documented twice she had checked on medication and was still awaiting its arrival from	F 755	2. An audit of the intravenous (IV) antibiotics for the last 30 days was completed on September 28, 2022, by the Director of Nursing or designee and any identified concerns were addressed as required. 3. The licensed nurses to include agency licensed nurses will be educated by September 28, 20222 related to ensuring IV antibiotics are being administered as orders. New hire licensed nurses to include agency licensed nurses will not be allowed to work until the education has been completed. 4. The Director of Nursing or designee will review the physician IV orders and the medication administration records during morning clinical review to ensure IV medications are being administered as ordered for 4 weeks and monthly for 2 months. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 755	Continued From page 53	F 755		

the pharmacy. Attempts to contact the pharmacy were not included in the progress notes.

During an interview with the Consultant Pharmacist on 8/31/2022, she stated that the facility had certain IV and oral medications on hand and, per her records, they had three doses of Resident #280's prescribed antibiotic on hand on 9/11/2021. She stated every nurse, agency or not, should be able to access that medication. She stated the medication is stored in a lock container in the medication room of the facility. She stated they did not receive the medication until the afternoon of 9/12/22 and it was sent to the facility in their evening delivery.

During an interview with the Director of Nursing on 9/1/2022 she stated there was a notebook at each nurse's station that listed the prescription medications that the facility had on hand in the locked medication bin located in the medication storage room and every nurse who comes into the facility should be aware of that information. She stated that was included in orientation for new hires and agency nurses. She also stated when the pharmacy was delayed in sending a medication, the nurse should see if it was stocked at the facility to avoid a delay in residents receiving doses as ordered. She stated she was not aware of that omission and there should not have been that delay in Resident #280 receiving the prescribed antibiotic.

During an interview with the facility practitioner on 8/29/2022 at 2:20 PM, she stated that Resident #280 did not have a bad outcome as a result of the medication administration delay and was discharged home with family two weeks after admission. She stated that all nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 755	Continued From page 54 should be aware of medications that the facility keeps on hand.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Consultant Pharmacist interviews, the facility failed to acquire and administer an intravenous (IV) antibiotic for a newly admitted resident with acute pancreatitis (Resident #280) resulting in four missed doses of medication, and failed to administer 1 dose of an anticoagulant for the treatment of atrial fibrillation (Resident #43). This occurred for 2 of 2 residents reviewed for medication errors. Findings included: 1. Resident #280 was admitted to the facility the afternoon of 9/11/2021 with diagnosis of acute pancreatitis (inflammation of the pancreas) and cirrhosis of the liver. Review of the hospital physician discharge orders dated 9/11/2021 showed order for piperacillin-tazoctam (antibiotic used to treat bacterial infections) 3.375 grams in sodium chloride 0.9% 100 milliliters-infuse into the vein every 8 hours over 4 hours for 8 days. Nurse #5 was the admission nurse who signed off and ordered medication from the pharmacy. Multiple attempts to contact Nurse #5, who was from an agency and no longer worked at the	F 760	F760 1. Resident # 280 was discharged on 9/21/21. The Director of Nurse notified Resident #43 physician and resident representative on September 26, 2022 related to the missed dose of the anticoagulant. 2. An audit of the intravenous (IV) antibiotics and the anticoagulants for the last 30 days was completed on September 28, 2022, by the Director of Nursing and any identified concerns were addressed as required. 3. The licensed nurses to include agency licensed nurses will be educated by September 28, 2022 related to ensuring IV antibiotics and anticoagulants are being administered as orders by Director of Nursing or designee. New hire licensed nurses to include agency licensed nurses will not be allowed to work until the education has been completed.	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 760	Continued From page 55 facility, were unsuccessful. Review of Resident #280's September 2021 medication administration record (MAR) showed the IV antibiotic was not entered on the MAR until 9/12/2021 and Resident #280 did not receive the first dose until the 8:00 AM on 9/13/2021. This resulted in the resident missing a total of 4 doses. All three doses due on 9/12/2021 were marked as unavailable by Nurse #5. Review of Resident #280's progress notes showed an entry by Nurse #5 on 9/11/2021 and stated she was awaiting arrival of medication from pharmacy. On 9/12/2021, Nurse #5 documented twice she had checked on medication and was still awaiting its arrival from the pharmacy. Attempts to contact the pharmacy were not included in the progress notes. During an interview with the Consultant Pharmacist on 8/31/2022, she stated that the facility had certain IV and oral medications on hand and, per her records, they had three doses of Resident #280's prescribed antibiotic on hand on 9/11/2021. She stated every nurse, agency or not, should be able to access that medication. She stated the medication is stored in a lock container in the medication room of the facility. The pharmacist stated they received the order for the antibiotic on 9/11/22 and it would have come in the early morning delivery on 9/12/22 if they had it in stock. She stated they did not receive the medication until the afternoon of 9/12/22 and it was sent to the facility in their evening delivery. During an interview with the Director of Nursing on 9/1/2022 she stated there was a notebook at each nurse's station that listed the prescription	F 760	4. The Director of Nursing or designee will review the IV orders, the anticoagulant orders and the medication administration records during morning clinical review to ensure IV and anticoagulant medications are being administered as ordered for 4 weeks and monthly for 2 months. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 760	Continued From page 56	F 760		

medications that the facility had on hand in the locked medication bin located in the medication storage room and every nurse who comes into the facility should be aware of that information. She stated that was included in orientation for new hires and agency nurses. She also stated when the pharmacy was delayed in sending a medication, the nurse should see if it was stocked at the facility to avoid a delay in residents receiving doses as ordered. She stated she was not aware of that omission and there should not have been that delay in Resident #280 receiving the prescribed antibiotic.

During an interview with the facility practitioner on 8/29/2022 at 2:20 PM, she stated that Resident #280 did not have a bad outcome as a result of the medication administration delay and was discharged home with family two weeks after admission. She stated that all nursing staff should be aware of medications that the facility keeps on hand.

2. The stock medication list (no date) was reviewed. It was noted apixaban 2.5 milligrams (mg) was available in the stock medications.

Resident #43 was admitted to the facility on 6/25/2022 with diagnoses to include diabetes and atrial fibrillation.

Admission orders for Resident #43 dated 6/25/2022 included an order for apixaban (a blood thinner) 2.5 mg by mouth twice daily.

The nursing notes for Resident #43 were reviewed. A note dated 6/25/2022 at 5:16 PM written by Nurse #4 indicated apixaban 2.5 mg had not been administered "until received from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 760	Continued From page 57	F 760		

pharmacy."

The Medication Administration Record (MAR) for Resident #43 was reviewed. The MAR documented Resident #43 received apixaban 2.5 mg on 6/26/2022 at 9:00 AM.

An interview was conducted with Nurse #7 on 9/1/2022 at 11:40 AM. Nurse #7 reported when a resident was admitted to the facility, there were stock medications available to administer to the resident. Nurse #7 reported each nursing station had a list of the medications.

A medication aide (MA) #1 was interviewed on 9/1/2022 at 11:53 AM. MA #1 reported the facility had stock medications. MA #1 reported she checked the stock medication list and if there was not a specific medication, she called the pharmacy to ask for a stat (very fast) delivery of the medication.

Nurse #4 was not available for interview.

The Director of Nursing (DON) was interviewed on 9/1/2022 at 2:57 PM. The DON reported she had provided the nurses and MA with in-services and education related to the availability of stock medications. The DON explained she had typed up a comprehensive list of the medications and had at least one copy at each nursing station. The DON reported she was not aware Resident #43 had not received a dose of apixaban when he was admitted to the facility. The DON reported it was her expectation that all nurses and medication aides were familiar with the list of stock medications.

The Administrator was interviewed on 9/1/2022 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 760	Continued From page 58 3:37 PM. The Administrator reported the DON had provided education and in-services to staff nurses and MA related to stock medications and he did not know why the admitting nurse for Resident #43 had not gotten the apixaban from the stock medications. The Administrator reported he expected nurses to administer available medications to new admissions.	F 760		
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 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:	F 761		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 761	Continued From page 59 Based on observations, record reviews, and staff interviews, the facility failed to discard expired insulin and date opened insulin for 1 of 2 medication carts observed (100 hall cart). Findings included: a. The 100-hall cart was observed on 8/30/2022 at 1:56 PM with Nurse #1. A quick-acting insulin pen for with an open date 6/22/2022 labeled with Resident #4 ' s name was noted and available for use. The insulin pen was labeled with instructions to "discard after 28 days". Nurse #1 was interviewed at the time of the observation. Nurse #1 reported the insulin pen should have been discarded after 28 days. Nurse #1 reported she thought night shift nurses were responsible for checking for expired medications, but all nurses should be mindful of discarding expired insulin. Resident #4 ' s medical record was reviewed. Physician orders dated 1/21/2022 for sliding scale Humalog (quick-acting insulin) before meals and at bedtime for blood sugar results over 200. The medication adminstration record was reviewed for Resident #4 and she had received Humalog 4 units on 8/30/2022 at 8:00 AM for a blood sugar result of 292. The facility physician (MD) was interviewed on 8/30/2022 at 2:57 PM. The MD reported the expired insulin pen would not harm the resident, but it might be less effective at controlling blood glucose levels. b. A vial of long-acting insulin was noted in the	F 761	F761 1. The identified insulin on the 100-hall cart was discarded on August 30, 2022, by the charge nurse. 2. An audit of the facility medication carts was completed on September 27, 2022, by DON or Designee and any expired and not dated insulin was discarded. 3. The licensed nurses to include agency licensed nurses will be educated by September 28, 2022 related to ensuring expired insulin is discarded and open insulin is dated by Director of Nursing or designee. New hire licensed nurses to include agency licensed nurses will not be allowed to work until the education has been completed. 4. The Director of Nursing or designee will check the facility medication carts weekly for 4 weeks and monthly for 2 months to ensure expired insulin is being discarded and open insulin is dated. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 761	Continued From page 60 medication cart, open and available for use. The vial was not dated with the date opened. Nurse #1 was interviewed at the time of the observation. Nurse #1 reported nurses should label all insulin when they opened it. The Director of Nursing (DON) was interviewed on 9/1/2022 at 2:57 PM. The DON reported the pharmacy had been at the facility on 8/29/2022 to check all the medication carts and the pharmacist should have noticed the Humalog insulin was expired and the long-acting insulin was not dated when it was opened. The DON reported all nursing staff should be discarding expired insulin and dating opened insulin. The Administrator was interviewed on 9/1/2022 at 3:37 PM. The Administrator reported the pharmacy came to the facility monthly to check the medication carts and they missed the expired insulin and the undated insulin. The Administrator reported he expected nursing staff to follow standards for discarding and labeling medications.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 791	Continued From page 61 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide dental services for 3 of 6 residents reviewed for dental services (Residents #3, #34 and #43). Findings included:	F 791	F791 1. Residents #3, #34, and #43 were reviewed by the Director of Nursing on September 1, 2022, and scheduled for dental appointments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 791	Continued From page 62 1. Resident #34 was admitted to the facility on 10/30/2019 with his most recent readmission date being 01/19/2021. His active diagnoses included hypertension, chronic obstructive pulmonary disease, and dementia. Review of Resident #34's annual minimum data set assessment dated 10/07/2021 revealed in section L dental was marked no for obvious or likely cavity or broken teeth. The medical record was reviewed and no orders or referral for dental care or a dentist assessment were noted. Resident #34 was observed on 08/29/2022 at 12:32 PM. He had missing, broken, and brown teeth on his top jaw and had missing teeth on the bottom jaw. He denied pain during the interview but revealed in the past it had hurt when he bit down. He stated he thought they checked his teeth one time in the years since his admission. In an interview on 08/31/22 at 8:35 AM the Corporate Nurse Consultant stated she was only able to find a dental consult for one of the three residents requested. There was no consult for Resident #34. On 08/31/22 at 8:45 AM the Social Worker provided a dental consult for Resident #34 dated 08/31/22. She also provided fax confirmation that the dental consult was faxed to Access Dental on 08/31/22 at 8:38 AM. During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation that the facility identified dental issues and provided	F 791	2. An audit of the current residents was completed on September 26, 2022, by DON or designee to ensure that identified residents that need dental follow up have been scheduled for dental appointments. 3. The licensed nurses to include agency licensed nurses will be educated by September 28, 2022 related to ensuring residents are being schedule for dental appointment follow up as needed. New hire licensed nurses to include agency licensed nurses will not be allowed to work until the education has been completed. 4. The Director of Nursing or designee will review at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure residents are receiving dental follow up as required. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 791	Continued From page 63	F 791		

services as appropriate.

2. Resident #3 was admitted to the facility on 11/23/2021. His active diagnoses included chronic obstructive pulmonary disease, altered mental status, atrial fibrillation, hypertension, failure to thrive, peripheral vascular disease, mild cognitive impairment, esophageal reflux disease, protein calorie malnutrition and cirrhosis of the liver.

Review of Resident #3's annual minimum data set assessment dated 02/25/2022 revealed in section L dental was marked no for obvious or likely cavity or broken teeth.

The medical record was reviewed and no orders or referral for dental care or a dentist assessment were noted.

Resident #3 was interviewed on 08/30/22 at 10:02 AM. Resident #3 had missing, brown, and broken teeth. He revealed he had not been seen by a dentist since admission. He wiggled one of the front bottom teeth and explained it had been loose for some time. He stated he had reported the loose tooth but could not remember when or to whom he had reported it. He further stated he had not reported the concern again.
In an interview on 08/31/22 at 8:35 AM the Corporate Nurse Consultant stated she was only able to find a dental consult for one of the three residents requested. There was no consult for Resident #3.

On 08/31/22 at 8:45 AM the Social Worker provided a dental consult for Resident #3 dated 8/31/22. She also provided fax confirmation that the dental consult was faxed to Access Dental on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 791	Continued From page 64 8/31/22 at 8:38 AM. During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation that the facility identified dental issues and provided services as appropriate. 3. Resident #43 was admitted to the facility on 7/14/2022 with diagnoses to include end stage renal disease. The admission Minimum Data Set (MDS) assessment dated 7/21/2022 assessed Resident #43 to be cognitively intact. The MDS assessed Resident #43 to have no broken teeth or obvious decay. The admission assessment for Resident #43 dated 7/14/2022 did not document broken teeth or obvious decay. Resident #43's medical record was reviewed. No referrals for dental services were noted. Resident #43 was observed on 8/29/2022 at 12:38 PM. It was noted Resident #49 was missing multiple teeth, and the teeth he had were dark. Resident #43 was interviewed at the time of the observation, and he reported he had been losing teeth for "a while", but he did not have dental pain. Resident #49 reported he did not remember anyone looking into his mouth or offering him dental services. An interview was conducted on 08/31/22 at 8:35 AM with the Corporate Nurse Consultant and she reported there was no dental consult for Resident #43.	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 791	Continued From page 65 The Social Worker (SW) was interviewed on 9/1/2022 at 10:16 AM. The SW reported she was not aware that Resident #43 had missing and obviously decayed teeth. The SW reported Resident #43 had not requested a dental consultation, and she would talk to him about it. During an interview on 09/01/2022 at 3:00 PM the Administrator and the Corporate Nurse Consultant stated it was their expectation that the facility identified dental issues and provided services as appropriate.	F 791		
F 812 SS=F	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: Based on observations and staff interviews, the	F 812	F812	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 812	Continued From page 66 facility failed to ensure a potentially hazardous sandwich made with eggs and mayonnaise was stored within safe temperature range at or below 41 degrees Fahrenheit to prevent the potential for food borne illness; failed to ensure the wash and final rinse cycles of the dishwashing machine operated at the manufacturer's recommended temperatures; by not maintaining the food service equipment in clean and debris-free condition; and, failed to ensure the food items stored in the snack/nourishment refrigerators in 1 of 2 residents' nourishment rooms (100 hall nourishment room) were clean, and food items not provided by the facility were dated and labeled. These practices had the potential to affect food served to residents. Findings included: 1. During a kitchen observation with the dietary manager (DM) on 8/29/22 at 10:38 a.m., there were 2-large, resealable plastic bags containing a sandwich, an oatmeal cookie, and a can of soda on the shelf in the walk-in cooler. The DM identified the sandwiches as egg salad and revealed the bagged lunches were for residents who go out of the facility to their dialysis appointments. She stated there were 8 or 9 dialysis residents in the facility and dietary prepared each dialysis resident with a resealable plastic bag containing a sandwich, 2-snacks, and a juice or diet soda to carry with them to dialysis. The DM revealed the facility receptionist would collect the sealed lunch bags from the kitchen every morning and give one to each resident as they left the facility for dialysis center.	F 812	1. The identified egg/ mayonnaise sandwiches were discarded on August 29, 2002, by the dietary manager. The dishwashing machine was checked on August 29, 2022, by the maintenance director to ensure it was operating at the manufacturer’s recommended temperatures. The 100-hall nourishment room refrigerator was cleaned on August 31, 2022, by Environmental Services Manager and unlabeled and not dated food was discarded. Broken tile was repaired by Maintenance on September 28, 2022. Grease was changed on August 30, 2022 by dietary associate. Wall was repaired by Maintenance on September 28, 2022. Lids were cleaned by dietary associates on September 2, 2022. Lid was labeled on September 2, 2022 with rice. Plate warmer was cleaned on September 2, 2022 by dietary associates. 2. A facility nourishment room refrigerator on each unit was cleaned and unlabeled and not dated food was discarded on August 31, 2022, by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 812	Continued From page 67 During an interview on 8/31/22 at 8:50 a.m., Resident #17 revealed he went to the dialysis center three times a week after breakfast and usually ate his packed lunch at 12:30 p.m. while at the dialysis center. He stated that the dietary department supplied him with a packed lunch in a resealable plastic bag which included a sandwich which was always egg salad (his preference), a drink, and snacks. When asked if the packed lunch was refrigerated at the dialysis center due to the mayonnaise-based sandwich, he responded no, the lunch remained in his tote bag (observed in a non-insulated tote bag without an ice pack on back of Resident #17's wheelchair) until he was ready to eat it. An interview with the facility's receptionist on 8/31/22 at 9:20 a.m. revealed 4-residents were scheduled for dialysis this day (Wednesday): 2-residents were to leave the facility at 9:15 a.m. for their 10:15 a.m., dialysis appointment and 2-residents were to leave the facility at 10:15 a.m. for their 11:15 a.m. appointments at the dialysis center. She stated at 9:00 a.m. she collected the 4-resealable, plastic bags of lunches from the dietary department and stores the bagged lunches in a file cabinet next to her desk for each dialysis resident to take with them to the dialysis center. As a demonstration, the receptionist removed from the file cabinet (not temperature controlled) next to her desk 2-large, sealed plastic bags, each consisting of a sandwich, a soda, an oatmeal cookie and a bag of snack crackers. The receptionist revealed she monitored the temperature of the sandwiches by touching the lunch bag to ensuring the sandwiches remained cool. She also stated that after four hours any lunch bags remaining in her file cabinet were returned to the kitchen.	F 812	Environmental Services Manager. 3. The nursing staff to include agency nursing staff will be educated by September 28, 2022 related to ensuring facility nourishment room refrigerators are being cleaned and food labeled and dated. New hire nursing staff to include agency nursing staff will not be allowed to work until the education has been completed. Dietary staff will be reeducated by September 28, 2022 by the Administrator or designee related to ensuring that the dishwashing machine is operating at the manufacture's recommended temperature. Dietary staff will be reeducated by September 28, 2022 by the Administrator or designee related to ensuring that the work orders need to be placed for repairs needed in kitchen, cleaning of lids, labeling lids, and cleaning plate warmer. 4. The Director of Nursing or designee will check the nourishment room refrigerators weekly for 4 weeks and monthly for 2 months to ensure nourishment room refrigerators continue to be clean and food is dated and labeled as required. The dietary manager or designee will complete an audit of the dishwashing machine 3 times weekly for 4 weeks and monthly for 2 months to ensure dishwashing temperatures continue to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 812	Continued From page 68 2. During three observations of the operation of the high temperature dishwashing machine in the kitchen on 8/29/22 from 10:21 a.m. to 10:35 a.m., the water temperatures during the wash cycle ranged from 154 degrees Fahrenheit to 174 degrees Fahrenheit; and the water temperatures during the rinse cycle were 174 degrees Fahrenheit during the first two observations and 176 degrees Fahrenheit during the third observation. The dietary staff revealed the wash and rinse temperature gauges were checked three times every day during the dishwashing operation. The dietary staff indicated the wash temperature should read 160 degrees Fahrenheit and the rinse temperature should read 180 degrees Fahrenheit. However, the dietary staff continued to send dishware through the dish machine when the rinse temperature read less than 180 degrees Fahrenheit then stacked the dishware on the storage racks and the meal trays at the food service tray line, ready for use. This surveyor informed the DM the rinse cycle was not meeting the required rinse temperature of 180 degrees Fahrenheit or above and the meal trays, plates, bowls, and silverware observed during the three observations would have to be rewashed. The DM directed the staff to stop the dishwashing machine and stated she would contact the dishwasher service technician. She revealed the service technician conducted monthly checks of the water temperature cycles on the machine every month and his last visit was a couple of weeks prior. 3. During the kitchen tour on 8/29/22 from 10:38	F 812	remain at the recommended temperatures. The dietary manager or designee will complete an audit of the kitchen floor tiles, kitchen walls, grease is fresh, lids are clean, lids are labeled, and plate warmer is clean 3 times weekly for 4 weeks and monthly for 2 months to ensure all areas are in compliance. The Director of Nursing or designee and dietary manager or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 812	Continued From page 69	F 812		

a.m. to 10:53 a.m., the following was observed: broken and missing floor tiles at the door of the walk-in cooler; dark black/brown grease in the deep fryer which the DM revealed was last used three days prior; badly scuffed/scratched wall next to the 3-compartment sink; the lids of the 3-bins (sugar, flour, rice) were stained with brown, sticky substances, and 1 of the bins filled with brown rice was not labeled.

The inside bottom of both sides of the double plate warmer contained food debris and there was a large piece of a broken plate in the bottom of one side of the warmer. The DM revealed the plate warmer was last taken apart and cleaned approximately one and half weeks ago.

4. On 8/31/22 at 11:00 a.m., an observation of 1 of 2 nourishment rooms was conducted. The outside of the refrigerator/freezer was dirty with brown and dark gray stains and old pieces of tape. The inside of the refrigerator had no light, and one bottom vegetable bin contained a free-flowing, yellow colored liquid. The following items were observed in the refrigerator and not labeled with a resident's name, room number, and date stored: 3-4 resealed bottles of water, 1(16 ounce) resealed bottle of diet soda, 1-packaged pre-cooked breakfast sandwich, and 2(12 ounce) cans of grape soda. The freezer section had no thermometer, 6-flavored freeze pops that were not labeled with a resident's name, room number and date stored, and 1-travel thermos not labeled with a resident's name, room number and date stored. On a shelf of the ice cart there was an uncovered ice scoop next to the scoop holder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 70	F 867		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 4/22/21. This was for 14 deficiencies that were cited in the areas of Resident Rights/Exercise of Rights (F550), Safe/Clean/Comfortable/Homelike Environment (F584), Request/Refuse/Discontinue Treatment; Formulate Advance Directives (F578), Medicaid/Medicare Coverage/Liability Notice (F582), Notice Requirements Before Transfer/Discharge (F623), Quarterly Assessments At Least Every 3 Months (F638), Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plan (F656), Care Plan Timing and Revision (F657), ADL Care Provided for Dependent Residents (F677), Posted Nurse Staffing Information (F732), Residents are free of Significant Medication Errors (F760), Label/Store Drugs and Biologicals (F761) and Influenza and Pneumococcal Immunizations (F883) cited on 4/22/21 and recited on the current recertification and complaint survey of 9/1/22. The duplicate citations during two federal surveys of record	F 867	F867 1. Quality Assessment and Assurance (QAA) Committee was held on September 27, 2022, by the Administrator related to the 14 deficiencies that were recited. 2. The current residents are at risk related to this deficient practice. 3. The interdisciplinary team was educated on September 27, 2022, by the Regional Director of Operation related to ensuring the QAA Committee maintain and implement processes to monitor interventions to maintain compliance in areas of previously identified deficiencies. 4. The Administrator will be responsible for monitoring the Quality Improvement Plan process monthly for 3 months to ensure that the facility remains in compliance for identified deficiencies. The Administrator will report findings of the audits in the monthly Quality Assurance Performance Improvement	9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 71 shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: 1. F550 - Based on observations and staff interviews, the facility failed to promote dignity by not providing a privacy cover over an urinary catheter drainage bag for one resident (Resident #52). This occurred for 1 of 6 residents reviewed for dignity. During the recertification and complaint survey of 4/22/21 and a complaint investigation of 3/5/21 the facility failed to promote dignity by not providing a cover for a urinary drainage bag for 1 of 3 residents that were reviewed for dignity. An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice. The Administrator stated they are currently working on big ticket items like stripping and waxing the floors. He stated there was a corporate renovation going on. They are focused now on employee education, falls, environmental issues, advance directive audits, medication administration, Minimum Data Set assessments and PASSR audits. 2. F584 - Based on observations, resident and	F 867	(QAPI) meeting for at least 3 months for review to ensure compliance. Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 72	F 867		

staff interviews, the facility failed to maintain a sanitary and homelike environment by not ensuring Room #222 had a working toilet for at least 3 days of the survey, not ensuring a clean resident room (Room 117A) and failed to bag and label urinals for multiple residents use in a shared bathroom (Rooms 114 and 115) for 3 of 47 rooms reviewed for a sanitary and homelike environment.

During the recertification and complaint investigation survey of 11/8/19 and a complaint investigation of 8/24/20, the facility failed to maintain a clean and safe environment by failure to maintain a clean floor, clean walls or prevent electrical wires from being accessible in 3 of 18 rooms (rooms 220, 104 and 123) reviewed for environment.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice. The Administrator stated they are currently working on big ticket items like stripping and waxing the floors. He stated there was a corporate renovation going on.

3. F578 - Based on record review and staff interviews, the facility failed obtain a physician ' s order for Do Not Resuscitate (DNR) for 1 of 1 resident reviewed for advanced directives (Resident #234).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 73	F 867		

During the recertification and complaint investigation survey of 4/22/21, the facility failed obtain an order and document the resident ' s advanced directives in the resident ' s electronic medical record (EMR) for 1 of 21 residents (Resident #58) reviewed for advanced directives.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice. The Administrator stated they are currently working on big ticket items like stripping and waxing the floors.

4. F582 - Based on record review and staff interviews, the facility failed to provide facility residents with CMS-10123 Notice of Medicare non-coverage (NOMNC) prior to discharge from Medicare services for 3 of 3 residents reviewed for discharge documentation (Resident #481, Resident #40, and Resident #480).

During the complaint investigation survey of 11/8/19, the facility failed to provide facility residents with CMS-10055 Skilled Nursing Advanced Beneficiary Notice (SNFABN) prior to discharge from Medicare services for 1 of 2 residents reviewed for discharge documentation (Resident #172).

An interview with the Administrator and Corporate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 74	F 867		

Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice. The Administrator stated they are currently working on big ticket items like stripping and waxing the floors.

5. F623 - Based on record reviews and staff interviews, the facility failed to provide written notification for a resident representative and the ombudsman for a resident who was transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #49).

During the recertification and complaint investigation survey of 4/22/21, the facility failed to notify the emergency contact of a discharge from the facility for 1 of 3 residents reviewed for discharge (Resident #68).

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

6. F638 - Based on staff interviews and medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 75	F 867		

record reviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 3 of 27 residents (Residents 24, 432 and 6) reviewed for timely completion of quarterly MDS assessments.

During the recertification and complaint investigation survey of 11/8/19, the facility failed to complete a resident assessment within 14 days of the Assessment Reference Date (ARD) for 2 of 14 (Resident #47 and Resident #52) reviewed for timely completion of Minimum Data Set (MDS) assessments.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

7. F641 - Based on observations, resident and staff interviews, and record review the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of dental (Residents #3, #34 and #43) and tube feeding (Resident #47) for 4 of 4 residents reviewed for resident assessments.

During the recertification and complaint investigation survey of 4/22/21 and a complaint investigation survey of 2/12/20, the facility to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 76	F 867		

accurately code the Minimum Data Set (MDS) assessment for pressure ulcers for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #43).

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice. The Administrator stated MDS assessments was one of the areas that were being audited.

8. F656 - Based on record reviews and staff interviews, the facility failed to develop comprehensive care plans for 1 of 5 sampled residents reviewed for nutrition (Resident #77) and 1 of 1 sampled resident (Resident #43) reviewed for discharge planning.

During the recertification and complaint investigation survey of 4/22/21, the facility failed to develop and implement a comprehensive care plan for one of two residents (Resident #58) reviewed for care plans.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 77	F 867		

the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

9. F657 - Based on record reviews and staff interview, the facility failed to review and update the comprehensive care plan for falls for 1 of 1 sampled resident (Resident #77) reviewed for rehabilitation services.

During the recertification and complaint investigation survey of 4/22/21, the facility failed to revise a care plan after completion of a quarterly assessment for 1 of 5 care plans reviewed for accidents (Resident #7).

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

10. F677 - Based on observations, record reviews and resident and staff interviews, the facility failed to provide a shave and nail care for 2 of 6 residents reviewed for activities of daily living (ADLs) (Residents #47 and #77).

During the recertification and complaint investigation survey of 4/22/21, the facility failed to provide nail care (Resident #8 and Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 78	F 867		

#54), failed to provide a scheduled shower (Resident #8), failed to clean ear wax from a residents ear (Resident #54) and failed to ensure residents facial hair was groomed (Resident #8 and Resident #54). This was for 2 of 6 residents reviewed for Activities of Daily Living (ADLs) or personal hygiene.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

11. F732 - Based on observations, record review and staff interview, the facility failed to post the Daily Staffing Form that reflected the current facility census for 26 of the 30 days reviewed for sufficient staffing. The facility also failed to post the Daily Staffing Form prior to the beginning of first shift for 3 out of 4 days observed during survey.

During the recertification and complaint investigation survey of 4/22/21, the facility failed to post accurate staffing information as compared to the Staff Schedule/ Assignment Sheets for 7 days of the 7 days reviewed.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 79	F 867		

administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

12. F760 - Based on record review and staff and Consultant Pharmacist interviews, the facility failed to acquire and administer an intravenous (IV) antibiotic for a newly admitted resident with acute pancreatitis (Resident #280) resulting in four missed doses of medication, and failed to administer 1 dose of an anticoagulant for the treatment of atrial fibrillation (Resident #43). This occurred for 2 of 2 residents reviewed for medication errors.

During the recertification and complaint investigation of 4/22/21, the facility failed to prevent significant medication errors for 1 of 8 residents reviewed for medication administration (Resident #42). The facility administered heart medication, insulin, blood thinner, blood pressure and diabetic medications to Resident #42 after Resident #68 ' s medications were transcribed in error for Resident #42. The facility failed to administer prescribed antipsychotic medication, heart medication, pain medication, tremor medication and insulin to Resident #42. Resident #42 had the high likelihood of additional adverse consequences to the medications he received that were not intended for him. Resident #42 experienced low blood sugar levels and increased tremors.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 80	F 867		

the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

13. F761 - Based on observations, record reviews, and staff interviews, the facility failed to discard expired insulin and date opened insulin for 1 of 2 medication carts observed (100 hall cart).

During the recertification and complaint investigation survey of 4/22/21, the facility failed to remove expired promethazine rectal suppositories (medication used for nausea/vomiting) and expired lansoprazole liquid (medication used for heartburn) in 1 of 2 medication storage rooms.

An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.

14. F883 - Based on record reviews and staff interviews, the facility failed to offer or administer the pneumococcal vaccine or the influenza

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 867	Continued From page 81 vaccine and failed to include documentation that the residents or the resident representative was provided education regarding the benefits and potential side effects of the pneumococcal vaccine and the influenza vaccine immunizations for 5 of 15 residents reviewed for immunization (Resident #'s 29, 42, 55, 56 and 57). During the recertification and complaint investigation survey of 4/22/21, the facility failed to administer the vaccine and provide the resident and their representative with education regarding the benefits and potential side effects of the pneumococcal immunization for 1 of 5 residents reviewed for immunizations (Resident #63). An interview with the Administrator and Corporate Nurse Consultant on 9/1/22 at 3:57 PM revealed the QAA committee met monthly. The Administrator stated the facility has several administrative staff that are new to the facility who are still in their 90-day window and he had planned to distribute the plan of correction from the last survey. The Corporate Nurse Consultant stated most of the people from last year's survey are gone but there are multiple plans in place to correct deficient practice.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		9/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 82 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 83 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to offer or administer the pneumococcal vaccine or the influenza vaccine and failed to include documentation that the residents or the resident representative was provided education regarding the benefits and potential side effects of the pneumococcal vaccine and the influenza vaccine immunizations for 5 of 5 residents reviewed for immunization (Residents #29,#42,#55, #56 and Resident #57). Findings included: The facility policy titled "Pneumococcal Vaccine (Series)" dated 11/01/2020, stated in part, the resident's medical record will include documentation that indicates at a minimum the following: The resident or resident representative was provided education regarding the benefits and potential side effects of pneumococcal immunization and the resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. The facility policy titled "Influenza Vaccination" dated 11/01/2020, stated in part, the influenza vaccine would be routinely offered annually from October 1st through March 31st and the resident's medical record will include documentation that the resident or resident representative was provided education regarding	F 883	F883 1. Resident #57 is no longer in the facility. Residents #29, #42, #55, #56 were evaluated for the influenza and pneumococcal vaccine to include documentation and education of the risk, benefits, and potential side effects on September 26, 2022, by the DON or designee. Resident #29, #42,#55, and #56 are up to date with the pneumococcal vaccine. Resident #29, #42, #55, and #56 will be given the influenza(f/U) vaccine starting Oct. 1, 2022. The signed f/u/pneumonia vaccine consent which includes risk/benefit side effect education and the vaccine information sheet were signed by resident/resident representative and scanned into the medical record. 2. An audit will be completed by September 28, 2022 by the Director of Nursing or designee of the current residents to ensure education and documentation of the risk, benefits and the potential side effects has been provided for the influzenza and the pneumococcal vaccine when the vaccines are offered. The Director of Nursing (DON) also reviewed the medical record to ensure that the vaccine consent form,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 84 the benefits and potential side effects of immunization and the resident received or did not receive the immunization due to medical contraindication or refusal. 1.Resident #29 was admitted to the facility on 11/02/2017. The quarterly Minimum Data Set (MDS) dated 06/09/2022revealed Resident #29 had no cognitive impairment. The MDS indicated the influenza vaccine had been received for the recent influenza season and the pneumococcal vaccine was up to date. The immunization history record for Resident #29 revealed he received the pneumococcal vaccine on 06/24/2021 and the influenza vaccine on 11/29/2021. A review of Resident #29's medical record revealed there was no documentation to indicate whether the resident or his representative received education regarding the pneumococcal vaccine or the influenza vaccine and there was no signed consent to receive or refuse the immunizations. The Director of Nursing (DON)/Infection Prevention Nurse was interviewed on 09/01/2022 at 1:05 PM regarding pneumococcal vaccine and influenza vaccine documentation and administration. The DON revealed she did not know that vaccine education had to be documented in EMRs and she believed that the consents had been scanned into each resident's EMR. 2.Resident #42 was admitted to the facility on	F 883	vaccine information sheet and declination sheet (if required) are signed and scanned into the medical record. 3. The Director of Nursing or designee will educate the licensed nurses to include agency licensed nurses by September 28, 2022 related to ensuring that residents are being provided education and completing the documentation of the risk, benefits, and the potential side effects of the influenza and pneumococcal vaccine when the vaccine is offered and the vaccine consent form, vaccine information sheet or declination sheet if required are scanned into the medical record as required. New hires and agency licensed nurses will require to complete this education prior to working in the facility. 4. The Director of Nursing or designee will complete an audit weekly for 4 weeks and monthly for 2 months to ensure documentation and education continues to be provided for residents that are offered/ receiving the influenza and pneumococcal vaccine to include that the signed vaccine consent form, vaccination information sheet, and declination sheet if required continues to be scanned into the medical record. The Director of Nursing or designee will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 85 07/08/2022. The quarterly MDS dated 07/20/2022 revealed Resident #42 had no cognitive impairment. The MDS indicated the influenza vaccine had been received for the recent influenza season and the pneumococcal vaccine was up to date. The immunization history record for Resident #42 revealed she received the pneumococcal vaccine on 06/24/2021 and the influenza vaccine on 11/29/2021. A review of Resident #42's medical record revealed there was no documentation to indicate whether the resident or her representative received education regarding the pneumococcal vaccine or the influenza vaccine and there was no signed consent to receive or refuse the immunizations. The Director of Nursing (DON)/Infection Prevention Nurse was interviewed on 09/01/2022 at 1:05 PM regarding pneumococcal vaccine and influenza vaccine documentation and administration. The DON revealed she did not know that vaccine education had to be documented in EMRs and she believed that the consents had been scanned into each resident's EMR. 3.Resident # 55 was admitted to the facility on 10/15/2017. Review of the annual MDS dated 08/01/2022 revealed Resident #55 had severe cognitive impairment and indicated the influenza vaccine had been received for the recent influenza	F 883	Date of Compliance: September 29, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 86	F 883		

season and the pneumococcal vaccine was up to date.

The immunization history record for Resident #55 revealed she received the pneumococcal vaccine on 06/24/2021 and the influenza vaccine on 11/29/2021.

A review of Resident #55's medical record revealed there was no documentation to indicate whether the resident or her representative received education regarding the pneumococcal vaccine or the influenza vaccine and there was no signed consent to receive or refuse the immunizations.

The Director of Nursing (DON)/Infection Prevention Nurse was interviewed on 09/01/2022 at 1:05 PM regarding pneumococcal vaccine and influenza vaccine documentation and administration. The DON revealed she did not know that vaccine education had to be documented in EMRs and she believed that the consents had been scanned into each resident's EMR.

4.Resident #56 was admitted to the facility on 12/23/2017.

Review of a quarterly MDS dated 02/02/2022 revealed Resident #56 had severe cognitive impairment and had not received the influenza vaccine for the most recent influenza season and the pneumococcal vaccine was up to date.

The immunization history record for Resident #56 revealed she received the pneumococcal vaccine on 06/24/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 87	F 883		

A review of Resident #56's medical record revealed there was no documentation to indicate whether the resident or her representative received education regarding the pneumococcal vaccine and there was no signed consent to receive or refuse the immunization.

The Director of Nursing (DON)/Infection Prevention Nurse was interviewed on 09/01/2022 at 1:05 PM regarding pneumococcal vaccine and influenza vaccine documentation and administration. The DON revealed she did not know that vaccine education had to be documented in EMRs and she believed that the consents had been scanned into each resident's EMR. The DON/Infection Prevention Nurse did not know the if Resident #56 received the influenza vaccine or not during the previous influenza vaccine season.

5.Resident #57 was admitted to the facility on 07/11/2019.

The quarterly MDS dated 08/03/2022 revealed Resident #57 had severe cognitive impairment and indicated the influenza vaccine had been received for the recent influenza season and the pneumococcal vaccine was up to date.

The immunization history record for Resident #57 revealed she received the pneumococcal vaccine on 06/24/2021 and the influenza vaccine on 11/29/2021.

A review of Resident #57's medical record revealed there was no documentation to indicate whether the resident or her representative received education regarding the pneumococcal vaccine or the influenza vaccine and there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 883	Continued From page 88 signed consent to receive or refuse the immunizations. The Director of Nursing (DON)/Infection Prevention Nurse was interviewed on 09/01/2022 at 1:05 PM regarding pneumococcal vaccine and influenza vaccine documentation and administration. The DON revealed she did not know that vaccine education had to be documented in EMRs and she believed that the consents had been scanned into each resident's EMR.	F 883		