STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 01/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted 01/13/20 - 01/14/20. There were 50 allegations investigated and 4 were substantiated. Event ID# LKNR11.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, nurse practitioner (NP) interview, staff interviews, and record review, the facility failed to provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #8). Findings included: Resident #8 admitted to the facility on 8/6/2019. Diagnoses included chronic obstructive pulmonary disease (COPD) and chronic pulmonary embolism. Resident #8's quarterly Minimum Data Set (MDS) dated 11/22/2019 revealed she had moderate cognitive impairments. She was coded as receiving oxygen therapy. Resident #8 had a plan of care in place, with	F 695	The Plan of Correction is not to be construed as an admission of any wrong doing of liability. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves the rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any	2/11/20

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

Electronically Signed | 02/05/2020

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F 695	Continued From page 1 most recent revision dated 11/3/2019, related to alteration in respiratory status due to COPD. Interventions were inclusive of administering oxygen as needed per physician order. Resident #8's January 2020 physician's orders revealed the following: Oxygen at 2 liters continuous via nasal cannula An observation was completed on 1/13/2020 at 2:21 PM of Resident #8. Resident #8 was observed in the east day room without her oxygen in place. The portable oxygen tank was observed to the back of her wheelchair in a black sling. No tubing was applied via nasal cannula to her nares. Her portable oxygen tank was observed to be set at 3 liters. The portable oxygen tank was turned off. Resident #8 did not appear in any distress. An observation and interview was attempted with Nurse #1 on 1/13/2020 at 2:25 PM. She was not available at that time. An observation and interview was completed on 1/13/2020 at 2:32 PM with the Unit Manager (UM). The UM reviewed the electronic medication administration record (eMAR) which revealed Resident #8 had an order in place for oxygen 2 liters continuous via nasal cannula. Resident #8 was observed by the UM which revealed her oxygen was not applied to her nares via nasal cannula. Continued observation revealed the portable oxygen tank to be set at 3 liters and turned off. The UM verbalized the portable oxygen tank setting should have been on 2 liters, per the physician order, and turned on. The UM communicated Resident #8 would not be	F 695	administrative, civil or criminal claim, action or proceedings. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents. F695 Respiratory/ Tracheostomy Care 1. The corrective action will be accomplished for the resident found to have been affected by the deficient practice. Resident #8 on January 13, 2020 the oxygen was applied via nasal cannula at 2L/per minute as ordered. On January 14, 2020 resident #8 concentrator was set on 2L/per minute via nasal cannula as ordered. 2. All residents currently on oxygen therapy are at risk for the deficient practice. By February 5th, 2020 a 100% audit was performed by the Unit Manager and the Director of Nursing identifying residents currently on oxygen therapy per physician orders. Each resident identified the Kardex and care plan were updated by the Minimum Data Set Nurse. 3. The following measures were put in place on January 17th to ensure the Plan of Correction is effective and remains in compliance. All Licensed Nursing staff were re-educated by the Director of Nursing to ensure all residents who require oxygen therapy are provided the necessary services needed to maintain the correct ordered settings, frequent checks of settings of oxygen concentrators/ portable 02 tanks q shift to	

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F 695	Continued From page 2	F 695		

able to manipulate the portable oxygen tank settings, just the removal or placement of her nasal cannula. An oxygen saturation reading was obtained from Resident #8, by the UM, which revealed 80% on room air. Resident #8 did not appear in any distress. The UM took Resident #8 to the nurse's station and reapplied her portable oxygen via nasal cannula to her nares. The setting was observed at 2 liters continuous.

An interview was completed on 1/13/2020 at 2:35 PM with Nurse #1. Nurse #1 stated she last visualized Resident #8 in her wheelchair around 10:15 AM with her portable oxygen applied to her nares via nasal cannula. Resident #8 was on her way to the Beauty Shop. Nurse #1 explained she recalled Resident #8's portable oxygen tank being set at 2 liters continuously. She further verbalized Resident #8's oxygen saturation for the morning was 98% with in-room oxygen applied via nasal cannula. This was taken prior to Nurse #1 administering Resident #8's morning inhalations. Nurse #1 communicated if something were wrong with a resident while getting their hair done, the beautician would notify staff immediately. Nurse #1 expressed the beautician did not notify her of any concerns related to Resident #8. Nurse #1 was not certain when Resident #8 departed from the Beauty Shop or why Resident #8's portable tank was turned off.

An interview was completed on 1/13/2020 at 2:52 PM with the Nurse Practitioner (NP). The NP stated Resident #8's oxygen should not be turned off. Her oxygen should remain in place continuously as ordered. She further verbalized Resident #8 had a history of chronic lung disease.

ensure the correct setting is in place, and that only licensed Nursing staff are trained to make any changes to settings in accordance with the physician order. New hires will be educated upon hire.

4. Monitoring: Progress of daily audits are discussed in morning stand -up meeting with the interdisciplinary team. Beginning February 7, 2020, the Unit Manager and/or the Director of nursing will audit 10 residents daily requiring oxygen therapy. This audit will occur 5 times weekly for 4 weeks, then 2 times weekly for 2 months. The results of audits will be discussed monthly in our Quality Assurance and performance improvement Meeting by the Director of Nursing for 3 months. Review and any changes will be made as necessary.

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F 695	Continued From page 3	F 695		

A follow up observation of Resident #8 was completed on 1/13/2020 at 2:58 PM. She was observed sitting in her wheelchair with her portable oxygen set at 2 liters with the nasal cannula applied to her nares. She was not in distress. Her oxygen saturation was obtained by the UM and the reading was 94%.

An additional observation was completed on 1/14/2020 at 8:40 AM of Resident #8 in her room. The observation revealed Resident #8's in-room oxygen concentrator was set on 3 liters. Resident #8 did not appear in distress.

An interview and observation was completed on 1/14/2020 at 8:47 AM with Nurse #1. She stated Resident #8's in-room concentrator should be set on 2 liters. The observation revealed Resident #8's in-room oxygen concentrator set on 3 liters. Nurse #1 explained nurse aides were not responsible for manipulating in-room oxygen settings. She continued to explain hall nurses were responsible for monitoring and completing that task. Nurse #1 verbalized when she started her shift, she would spot check her residents and speak to them. Nurse #1 continued to explain when she administered medication, she would complete a more thorough assessment of the resident and any devices. Nurse #1 placed the in-room oxygen concentrator at the ordered setting of 2 liters.

An interview was completed with the Director of Nursing (DON) on 1/14/2020 at 8:55 AM. He stated staff should have assisted Resident #8 out of the Beauty Shop when she was done with her service. He further explained staff would have seen Resident #8's oxygen was not in place and could have reapplied her oxygen and checked

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F 695	Continued From page 4 her oxygen saturation level. The DON expressed in-room oxygen concentrators should be checked on rounds and during report by nursing staff. Anything over 2 liters should be questioned by nursing staff and orders verified to ensure the setting was correct. The DON verbalized Resident #8 should have had her oxygen in place per the physician's order and been properly saturated.	F 695		