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 06/29/2020

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

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite on 6/16/20 and additional phone interviews were conducted offsite on 6/29/20. All 4 of the complaint allegations were unsubstantiated. However the deficiencies of F607 and F695 were discovered during the investigation related to the named residents. See event ID HHS411 for further information.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and review of the facility ' s abuse policy the facility failed to implement their abuse policy in the area of reporting an allegation of staff to resident sexual abuse for 1 of 3 sampled residents reviewed for abuse (Resident #2). The findings included: Review of the policy titled, Elder Justice Act, with an effective date of 6/1/19, revealed any owner, operator, employee, manager, agent, or	F 607	1. The 24 hour and five-day allegation report was submitted for resident #2 on 7/9/20. • The report was not submitted for resident # 2 prior to this date due to the resident’s denial of the allegation upon interview. 2• The regional nurse consultant re-educated the administrator and Director of nursing (DON) on facility policy regarding reporting allegations and the	7/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/09/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 contractor of a long-term care facility must report to the State Survey Agency as the designate of the Secretary of the Department of Health and Human Services, and one or more law enforcement entities as appropriate, any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from the facility. Timing: Serious Bodily Injury-2 hour limit: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than two (2) hours after forming the suspicion. All others-Within 24 hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than twenty-four (24) hours after forming the suspicion. Review of Resident #2 ' s most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 6/8/20. The resident was coded as having not displayed any inappropriate behaviors or mood disturbances. Resident #2 ' s hospital History of Present Illness (HPI) dated 4/20/20 by the Physician ' s Assistant (PA) who attended to Resident #2 was reviewed. The HPI specified the resident lived at a nursing home and reported having been held by two personnel when he was not cooperating and one of them grabbed his private area to gain control. The PA further documented the resident reported trying to stay in the bathroom away from the person trying to get in. The PA documented the resident denied any injury to his genital area during the time of evaluation but reported when	F 607	time frame required on (6/16/20) •The Administrator re-educated current licensed and unlicensed nursing staff, housekeeping staff, dietary staff, rehabilitation staff, activity staff and leadership staff on facility policy regarding reporting allegations and the time frame required on 6/16/20. No current employee will be allowed to work until re-education and this education has been added to the new hire orientation. •A review by the facility administrator and regional nurse consultant on 7/14/20 of the previous 30 days of admissions to review hospital discharge information to ensure no allegations were noted in the information. No other allegation was noted. 3• A log will be maintained by the administrator that documents all notifications to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. Log will be placed in binder maintained by Administrator. •The Director of nursing will review discharge paperwork from the hospital on each admission to ensure no allegations of abuse have been verbalized. •The log maintained by the administrator will be reviewed by the regional nurse upon visits to ensure timely reporting. .The regional nurse consultant will audit all discharge summaries from the hospital weekly for 4 weeks and monthly for 2 months to ensure any allegation is addressed and reported.	

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F 607	Continued From page 2 the incident happened that his penis was swollen. During the time of examination, the resident denied sexual interaction. The genitourinary examination revealed no observed abnormalities or indications of injury. The PA documented Adult Protective Services (APS) would be called regarding the possible abuse of genitals. During an interview with the Administrator conducted on 6/16/20 at 1:44 PM the Administrator stated he was aware of an allegation regarding sexual abuse by Resident #2. However, the Administrator continued, he had not reported the resident ' s allegation of sexual abuse because it had been determined the allegation was unfounded. A second interview was conducted with the Administrator on 6/16/20 at 3:41 PM in conjunction with a record review. During the interview with the Administrator stated it had been reported to him, but he couldn ' t remember by who, Resident #2 had made the statement someone tried to touch his scrotum. The Administrator additionally stated he did not feel this allegation had to be reported because the resident refuted the allegation when he returned to the facility from the hospital on 04/21/20 and the resident had dementia with behaviors. During a phone interview conducted with the Administrator on 6/29/20 at 1:57 PM he stated he considered the information he received regarding Resident #2 ' s allegations of abuse to be hearsay. The Administrator stated the Director of Nursing (DON) interviewed the resident when he returned to the on 4/21/20 about the statements, he had made of being touched inappropriately. The Administrator stated they did not report the	F 607	4• Effective 7/10/20 The administrator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.	

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F 607	Continued From page 3 resident ' s abuse allegations to the State survey agency because they didn ' t know if it was an actual case. The Administrator explained when the resident returned to the facility, he denied any allegations of abuse and it was also explained to the resident he had a rash in the groin area. A phone interview was conducted on 6/29/20 at 2:09 PM with the facility Social Worker (SW). The SW stated the DON had found out from the hospital the information about the resident ' s abuse allegation. The SW stated she and the DON had interviewed Resident #2 when he returned to the facility from the hospital on 4/21/20 regarding the allegation of sexual abuse. The SW stated the resident denied any sexual abuse had occurred and the DON had explained to him he had a rash to his groin which was causing him discomfort and the resident responded he was unaware he had a rash. The SW stated she had a conversation with the Administrator about the interview with the resident and the resident had denied sexual abuse. The Social Worker stated she interviewed all alert and oriented residents on the same unit as Resident #2 regarding abuse on 4/21/20 and the interviews revealed no evidence of abuse.	F 607		
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,	F 695		7/14/20

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F 695	Continued From page 4 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to secure an oxygen cylinder that was in a resident ' s room (Resident #1) for 1 of 1 resident reviewed for respiratory care. The findings included: Resident #1 was admitted to the facility on 10/5/17. The resident ' s cumulative diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), fibromyalgia, dementia, chronic respiratory failure with hypoxia, history of falling, and shortness of breath. Resident #1 ' s most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 3/20/20. Review of the assessment revealed the resident was coded as having had severe cognitive impairment and was coded as having received oxygen therapy at the facility. Resident #1 ' s Medication Administration Record (MAR) for June 2020 was reviewed on 6/16/20. The review revealed the resident had an order to receive oxygen as needed at 2 liters per minute via nasal canula. The administration of the oxygen was signed off as having been administered each shift from 6/1/20 through 6/15/20. Observations conducted in the room of Resident #1, on 6/16/20 at 9:15 AM and on 6/16/20 at 10:11 AM revealed an unsecured oxygen tank (size E 4.3 inches in diameter, 25.5 inches in	F 695	1. Resident #1 oxygen cylinder was secured in a holder on 6/16/20 2. An visual audit of residents with oxygen cylinders was conducted by the Director Of Nursing to ensure each tank was secured in a holder and no other oxygen cylinders were noted to be out of the holder. 3. On 6/16/20 Licensed and unlicensed staff were re-educated by Director of nursing regarding how to secure an oxygen cylinder Visual Audits will be conducted by Director of Nursing/Nurse Managers to monitor residents with oxygen to ensure oxygen cylinder is always secured in a holder. This audit will be conducted on all residents with oxygen 5 x per week x 12 weeks 4. Effective 7/14/20 the director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance	

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F 695	Continued From page 5 height, and 7.9 pounds in weight empty and without regulator) standing vertically near the wall to the resident ' s right of the resident ' s head of bed. The gauge on the regulator indicated the tank was just under 3/4 of a full tank. The resident was observed to have a nasal canula on her which was connected to an oxygen concentrator while the resident was resting in bed. An observation of Resident # 1 ' s room on 6/16/20 at 1:42 PM to 1:46 PM revealed the facility Floor Technician (FT) was working in the resident ' s room and appeared to have been cleaning the room due to the presence of a housekeeping cart outside of the room. The FT was observed to have gone in the room and returned to the cart several times through the observation period. After the FT had left the room, revealed an unsecured oxygen tank remained near the wall to the resident ' s right of the resident ' s head of bed. The resident was observed to have a nasal canula on her which was connected to an oxygen concentrator while the resident was resting in bed. An interview was conducted on 6/16/20 at 1:50 PM of Resident #1 ' s room with Nurse #1. The observation revealed an unsecured oxygen tank remained near the wall to the resident ' s right of the resident ' s head of bed. The nurse stated the oxygen tank was in the resident ' s room for the resident ' s use and she was aware it was in the resident ' s room. An interview was conducted on 6/16/20 at 1:51 PM with Nursing Assistant (NA) #1. The NA stated the oxygen tank was in the resident ' s room for the resident ' s use, such as when she	F 695		

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F 695	Continued From page 6 went out of the facility for appointments. The NA further stated she was aware the oxygen tank was in the resident ' s room. An interview was conducted on 6/16/20 at 1:54 PM with the FT. The FT stated he was aware the oxygen tank was in the resident ' s room while he was cleaning the resident ' s room. The FT further stated he doesn ' t touch the oxygen cylinders. An interview with the Director of Nursing (DON) was conducted on 6/16/20 at 2:41 PM. During the interview the DON stated the oxygen tank had been removed from Resident #1 ' s room and placed in proper storage. The DON further stated it was not normal for oxygen tanks to be stored just standing in a resident ' s room without being secured in some way, such as a cart or rack on the back of a wheelchair. The DON explained she believed the oxygen tank may have been in the resident ' s room since the power went out, but she was unable to recall when the power had most recently gone out. The DON clarified it was her expectation for oxygen tanks to be in an oxygen cart, in a rack on the back of a wheelchair, or properly secured and stored in the oxygen storage room. During an interview with the Administrator on 6/16/20 at 3:41 PM he stated it was his expectation for oxygen cannisters to be properly stored and secured. The Administrator also stated it was his expectation for the facility staff to be aware of how oxygen tanks need to be stored so as to minimize the risk of them falling over.	F 695		