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	345201	A. BUILDING _____ B. WING _____	C 11/16/2020

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PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 11/9/2020 and 11/10/20 with exit from the facility on 11/10/20. Additional information was obtained through 11/16/20. Therefore, the exit date was changed to 11/16/20. The facility was found to be in compliance with Emergency Preparedness at 42 CFR §483.73 related to E-0024 (b)(6). Event ID#Y3C411.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 11/9/2020 and 11/10/20 with exit from the facility on 11/10/20. Additional information was obtained through 11/16/20. Therefore, the exit date was changed to 11/16/20. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One of the three complaint allegations was substantiated and cited. Event ID#Y3C411.	F 000		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		12/12/20

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

Electronically Signed | 12/11/2020

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, nursing staff, nurse practitioner, wound doctor and medical director interviews, the facility failed to document skin assessments and provide services to treat two wounds on the sacrum of a resident at risk for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers in the facility (Resident #1). Findings included: Resident #1 was readmitted to the facility on 7/20/20 with medical diagnoses inclusive of nontraumatic intracerebral hemorrhage, obstructive hydrocephalus and a severe mental illness. Resident #1 was discharged to the hospital on 10/25/20 for rectal bleeding. Resident #1's annual Minimum Data Set (MDS) dated 7/27/20 revealed she was cognitively intact. The MDS identified she required extensive assistance with bed mobility and total dependence on bathing, suprapubic catheter, and incontinent of bowel. There was no refusal of care noted. Resident #1's quarterly Minimum Data Set (MDS) dated 10/25/20 revealed she had moderately impaired cognition. The MDS identified she had clear speech, adequate hearing and vision, ability to understand and make self-understood. She required one-person extensive assistance with bed mobility, turning and repositioning, always incontinent of bowel, suprapubic catheter at risk for pressure ulcer, one stage three and one stage	F 686	Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #1 was sent to the ER on 10/25/20 for evaluation of possible rectal bleeding. Prior to transfer treatment nurse observed wounds and notified on call MD and received orders for treatment to be applied to wounds and initiated these orders/treatment. Nurse involved in incident was terminated from employment at the facility. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken: All residents are at risk for alleged deficient practice therefore a 100% skin audit of every resident was completed on 10/26/20 to identify any undocumented wounds. All documentation is reflected in each resident□s chart. Measure/systemic changes put in place to ensure the deficient practice does not reoccur: Effective 12/14/20 all nursing staff have been provided with re-education by the Director of Nursing and/or the Assistant Director of Nursing for all Licensed Nurses and Certified Nursing Assistants on completion of weekly skin assessments, monitoring skin integrity during all care provided, documentation and communication of any	

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F 686	Continued From page 2 4 pressure ulcer. The MDS also included refusal of care with verbal behaviors demonstrated. Resident #1's care plan dated 7/28/20 included focus areas for activities of daily living self-care performance deficit and at risk for potential pressure ulcer development due to immobility and incontinent of bowels. The care plan was revised on 10/7/20 to include resistive to care with showers, hair combing, nail care and weights. A review of Resident #1's progress notes included documentation of refusal of care by nursing and assessments by the nurse practitioner on the following dates: - 9/10/20 Writer Social worker spoke to Resident #1 about her shower routine. She was upset about it and stated that she doesn't like to shower at all. She was educated about hygiene and ways we can accommodate her reasons not to shower, but she continued to refuse anything offered including bed bath. Family member was notified and stated that she would continue to encourage Resident #1. - 9/15/20 Nurse Practitioner progress note - Noncompliance - ongoing, patient educated about proper hygiene, risk for severe and worsening of (abdominal) infection. - 9/21/20 Nursing Progress Note - Resident #1 refused to be changed even though staff told her that she needed to be changed because her brief being full of BM (bowel movement). Resident #1 still said no. - 10/10/20 Nursing progress note - Resident #1 refused NA (Nurse Aide) care or to be repositioned. Writer explained the need to be repositioned and to provide peri (perineal) care to help avoid skin breakdown, Resident #1	F 686	changes to any residents skin and who to communicate those issues to. All weekly skin assessments and POC documentation will be reviewed daily in daily clipboard meeting to ensure completion and any issues documented. Included in this education was reinforcement of the STOP and WATCH forms that are integrated into the electronic medical record and allow staff to document change in condition with automatic notification to the Director of Nursing and hall Nurse. Monitoring of the corrected action to ensure the deficient practice will not reoccur; beginning on 12/07/2020, the Director of Nursing and/or the Assistant Director of Nursing will audit 5 weekly skin assessments 5 x per week x 4 weeks , then 3x per week for 2 months. The Director of Nursing will follow wound nurse and observe wounds weekly for changes and review the Wound Report in Clinical Risk Meetings weekly. The Director of Nursing will present results of this audit to the Quality Assurance Performance Improvement committee monthly for 3 months. The QAPI committee will make any changes necessary to ensure the facility remains in compliance. The administrator will oversee this process.	

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continues to refuse.
- 10/14/20 Social Worker note - A care plan was held today with (Power of Attorney) POA. Nursing reported that resident is refusing daily hygiene care and medication. Staff continue to educate and redirect. Resident is on psych (psychiatry) caseload but always declines to talk to Nurse Practitioner (NP). Family is open to Palliative services. NP will be notified.
- 10/20/20 Nursing Progress Note - Resident #1 refused check/change on last round during 3rd shift (11:00 pm - 7:00 am). Resident #1 approached three times by CNA and nurse.

A weekly skin assessment completed by Nurse #3 on 9/23/20 noted preexisting redness abdominal area.

During an interview with Nurse #3 on 11/9/20 at 2:22 PM, she acknowledged Resident #1 was cooperative with the head to toe, weekly skin assessment on 9/23/20. Nurse #3 stated at that time of the assessment, Resident #1 only had an abdominal wound. Nurse #3 also described how it was brought to her attention via text message by Nurse #2 that Resident #1 had two wounds on her sacrum on the day of her transfer to the hospital.

A weekly skin assessment completed by Nurse #4 on 10/2/20 no documentation of observation.

On 11/10/20 at 2:30 during an interview with Nurse #4, he acknowledged he had completed the weekly skin assessment for Resident #1 on 10/2/20. He reported Resident #1 refused an assessment of her full body, therefore, he only observed Resident #1's skin and abdominal wound while she was lying on her back. During

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the interview, he stated he was not aware or had been notified of any wounds on Resident #1's sacrum.

Weekly skin assessment completed by Nurse #1 on 10/9/20, 10/16/20 and 10/23/20 revealed no documentation of observations.

Nurse #1 was interviewed on 11/10/20 at 12:46 PM. Nurse #1 stated she worked at the facility on second shift. Nurse #1 estimated in mid-October, she observed two wounds on Resident #1's sacrum. She described the inside of the bed of the wound was bluish with pink edges, no crusting, discharge or odor and a fourth of a centimeter deep. Nurse #1 acknowledge she did not notify the provider nor did she check for treatment orders. Nurse #1 stated she believed the facility wound nurse was providing treatment for the wound. She also could not recall where or if she had documented her observations on the weekly skin assessments she initialed as completed in October 2020. Nurse #1 reported to prevent infection, she cleaned and placed a gauze over the wounds without an order two to three times before Resident #1 was transferred to the hospital on 10/25/20.

During an interview on 11/9/20 at 3:38 PM Nurse Aide (NA) #1 stated she primarily worked second shift, 3:00 PM - 11:00 PM, and Resident #1 often refused care but occasionally allowed incontinent care after a bowel movement. She reported approximately two weeks prior to Resident #1's transfer to the hospital, she observed a blackened area the size of a sausage patty above the split of Resident #1's buttocks; the area had no odor or drainage. NA #1 stated Nurse #1 was present during this observation and placed a

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bandage over the area and secured it with tape. NA #1 recalled approximately three to four days after the initial observation, she observed the same area on Resident #1 as the same size with some redness around the edges, no drainage or odor, and reported to Nurse #1. She observed Nurse #1 spray the area and placed a bandage over the area; she was not familiar with the contents of what had been sprayed on the wound. NA #1 reported when care was allowed by Resident #1 following the second observation, the area was already covered with a bandage with no initials or date.

A phone interview was conducted with NA #2 on 11/13/20 at 10:57 AM. She reported on her first day at the facility 10/25/20, she assisted NA #3 with incontinent care for Resident #1. NA #2 and NA #3 observed Resident #1 had a bandage covering her backside with no initials or date. NA #2 stated Nurse #2 was notified of the bandage. NA #2 reported Nurse #2 stated she was not aware of Resident #1 having a wound on her backside. NA #2 stated Resident #1 was treated by Nurse #2 and transferred to the hospital later that day.

During a phone interview on 11/13/20 at 11:03 AM, NA #3 reported while providing incontinent care after a bowel movement, she observed Resident #1 had a soiled, pink colored bandage on her backside with no initials or date. NA #3 and NA #2 informed Nurse #2 of the need for wound care. NA #3 stated Nurse #2 indicated she was not aware of wound care orders for Resident #1. NA #3 noted 10/25/20 was her first day at the facility and Resident #1 was transferred to the hospital on that day.

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Nursing progress notes dated 10/25/20 at 10:59 AM revealed documentation by Nurse #2 as follows: Nurse #2 was called to Resident #1's room for wound care. Upon observation, Resident #1 was found with open areas to left buttock- slough present with irregular shape and beefy red granulation to edges and coccyx area open with 100% slough. Both open areas had moderate amount of yellow drainage without odor. Resident #1 denied pain to either site, on call nurse practitioner was made aware and the nurse practitioner gave new orders for treatment and orders were carried out and new dressings were applied. Message was left for Resident #1's family member.

A phone interview with Nurse #2 was conducted on 11/10/2020 at 8:37 AM. Nurse #2 worked in the facility as an agency nurse and provided wound care for the residents on the weekends. Nurse #2 reported on 10/25/20, she informed NA #2 and NA #3 that she was going to the other side of the facility to start wound care for the residents and to notify her of when residents assigned to them were ready for wound care. Nurse #2 stated the aides indicated Resident #1 had a soiled bandage on her sacrum and was experiencing rectal bleeding. Nurse #2 stated she was only aware of an abdominal wound and had no orders for wound care for Resident #1's sacrum. Nurse #2 observed a taped gauze pad covering Resident #1's sacrum. Nurse #2 informed the facility's weekend supervisor, the facility's unit manager, the on- call nurse practitioner and the facility's Director of Nursing. Nurse #2 stated no one was aware of the wound. Nurse #2 reported she treated the wounds according to the orders received by the on-call nurse practitioner.

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A phone interview was conducted with NA #4 on 11/13/20 at 11:45 am. During the interview, NA #4 stated Resident #1 did not like to be touched and refused care by several nurse aides and nurses. NA #4 reported at times on second shift, she gave Resident #1 a bed bath, provided incontinent care after a bowel movement, and changed the bed linen.

Resident #1's physician orders did not include treatment orders for wounds on her sacrum prior to the day she was transferred to the hospital on 10/25/20.

Hospital transfer note dated 10/25/20 at 12:12 PM revealed Resident #1 was transferred to the hospital for rectal bleeding.

The hospital admission history and physical dated 10/25/20 revealed Resident #1 was admitted to hospital for progressive confusion and reported blood in her stools. Resident #1 presented to the hospital due to poor appetite for a week, dark stool and foul-smelling urine. Resident #1 was hypotensive (low blood pressure) and hyponatremic (lower than normal level of sodium in the bloodstream) in the Emergency Department and was admitted for further treatment. A stage three ulcer to her left buttocks and a stage four ulcer on her sacrum were noted, and wound care was consulted on 10/26/20. On the first night of admission, she developed hypotension and anemia related to lower gastrointestinal bleed. Resident #1 was seen by a wound care physician on 10/26/20 who noted a stage four sacral decubitus ulcer. The ulcer was debrided at bedside. Necrotic tissue at periphery; however, the ulcer appeared to be amenable to local wound care with a topical enzymatic

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debriding agent.

On 11/10/20 at 3:03 PM, a phone interview was conducted with the Nurse Practitioner (NP). The NP stated she was not aware of Resident #1's wounds on her sacrum. The NP reported the DON made her aware of the status of Resident #1's wounds at the time of transfer to the hospital. The NP reported due to Resident #1's noncompliance, poor nutrition, and lying on her back, skin breakdown would have been unavoidable due to Resident #1 refusal to allow nursing staff and providers to perform assessments and care.

A phone interview was conducted with the Director of Nursing (DON) on 11/9/20 at 11:15 AM. The DON stated an investigation began the day following Resident #1's transfer to the hospital. The DON reported the investigation revealed Nurse #1 was aware of the wounds on Resident #1's sacrum for a couple of weeks and had cleaned the wounds and applied a gauze pad to the area. The DON also reported Nurse #1 had not contacted Resident #1's family member, notified a provider or checked for treatment orders. The DON reported Nurse #1 stated she thought other nurses were aware of the wounds. The DON received statements from nurses indicating no knowledge of the wounds on Resident #1's sacrum. As a result of the investigation, the facility reeducated all nursing staff regarding the expectation to notify a provider of a change of condition, notify the resident's family member, and to initiate any orders received by the provider.

An interview conducted on 11/9/20 at 1:45 PM with the Administrator revealed the facility began

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a performance improvement plan and identified quality measures to ensure all residents received a full skin assessment, documentation of new and existing wounds, submission of shower sheets by the nurse aides to the nurses, notification of change in condition to a provider and resident ' s family. The Administrator reported nursing management began the process of daily monitoring of weekly skin assessments for completion on the day following Resident #1's transfer to the hospital.

A phone interview was conducted on 11/13/20 at 11:56 AM with the facility's consulting wound doctor. During the interview, the wound doctor reported Resident #1 chronically refused observation, assessments, and treatment of her abdominal wound. The wound doctor stated after reviewing the hospital record provided by the facility, her impression was the initial skin breakdown was most likely a result of Kennedy terminal ulcers. She also indicated once the wounds were identified, it would be difficult to determine length of time the wounds were present, especially since Resident #1 laid in bed on her back and refused care. The wound doctor stated Resident #1 may not have experienced any pain from the wounds.

During a phone interview with the Medical Director on 11/10/20 at 5:17 PM, he reported Resident #1 refused care and was experiencing a general decline in health due to multiple medical conditions. The MD stated he and the NP had several conversations regarding Resident #1, losing weight, refusing care, consults, and surgery for nonhealing abdominal wound. He was not aware of Resident #1 having wounds on her sacrum. MD stated ulcers were likely

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F 686	Continued From page 10 unavoidable and due to Resident #1's physical decline, refusal of care and all medications, the facility staff discussed palliative care with Resident #1 and her family.	F 686		