

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 An unannounced complaint investigation survey was conducted from 9/12/22 through 9/16/22. The credible allegation of compliance was validated on 9/20/22. Therefore the exit date was changed to 9/20/22. 16 of the 48 complaint allegations were substantiated resulting in deficiencies. Intakes NC00189897, NC00190896, NC00190915, NC00191039, NC00191248, NC00192430, NC00192440, NC00192545, NC00192705, NC00192790, NC00193077, and NC00193139 were investigated. Intake NC00192790 resulted in immediate jeopardy, past-noncompliance. Event ID# SN7G11. Past-noncompliance was identified at: CFR 483.25 at tag F 698 at a scope and severity K. The tag F 698 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000			
F 584 SS=B	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	F 584		10/14/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/15/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	<p>Continued From page 1</p> <p>receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to repair a clogged sink in room 203 for 1 of 2 resident rooms reviewed for repairs.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on 8/11/20.</p>	F 584	<p>F584</p> <p>1. Facility failed to provide a safe homelike environment to Resident #5. Corrective action for the alleged deficient practice was completed on 09/13/22 by the Maintenance Director by unclogging the sink in Room 203.</p> <p>2. All residents have the potential to be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	<p>Continued From page 2</p> <p>Review of the facility list of maintenance repairs for July - September 2022 revealed no documentation of repairs to room 203.</p> <p>An observation of the sink in room 203 occurred on 9/12/22 after 3:00 PM. The sink was filled with water that drained slowly. Resident #5, identified with intact cognition on a quarterly Minimum Data Set assessment dated 6/18/22, stated that the water in the sink in her room drained slowly. She stated she told the Maintenance Director about it about 3-4 months ago, but that it was not fixed yet. Resident #5 stated that she saw "gnats" over the sink every day because of the water. Resident #5 further stated that when staff ran water in her sink to help her wash up, the sink backed up with water and the water took "forever to drain out".</p> <p>A second observation of the sink in room 203 occurred on 9/13/22 at 1:15 PM. Nurse #3 was observed to run water in the sink to wash her hands. The water remained in the sink and did not drain. Resident #5 stated that about a month ago, it took longer for the water to get hot, so staff had to let the water run a while. She stated that by the time the water got hot, the sink was so full of water it would overflow. She stated she told the Maintenance Director about this again about 2 months ago, but that it was still not fixed. Resident #5 stated that the Maintenance Director came to her room a week or two ago, he said he would try to fix it, but that the problem was still not fixed.</p> <p>An interview occurred on 9/14/22 at 11:00 AM with Med Aide (MA) #1 who stated that for the past month when she turned on the water at the sink in room 203 the water drained slowly. MA #1 stated "if you don't watch it, the water will</p>	F 584	<p>affected by the alleged deficient practice. An audit was completed of all sinks in all residents' rooms to ensure that no other sinks were clogged.</p> <p>3. The Maintenance Director re-educated all staff regarding the facility process using the TELS system to report any repairs that are needed for sinks in the facility. The Maintenance Director will audit 5 rooms per week for 12 weeks to ensure all sinks are draining properly.</p> <p>4. To monitor the effectiveness of the above action plan, the QAPI committee will evaluate the process monthly x3 months beginning October 20, 2022. Pelican Health Charlotte LNHA will be responsible for the completion of this plan of correction</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	<p>Continued From page 3</p> <p>overflow". The MA #1 also stated that Resident #5 told the Maintenance Director about it and someone in that department poured something down the drain, but that the water still drained slowly.</p> <p>An observation of the sink in room 203 occurred on 9/13/22 at 6:34 PM with the Maintenance Director. The water in the sink was observed draining slowly. The Maintenance Director stated he was made aware a few months ago that the sink in this room backed up with water and he tried to fix it and thought he had it repaired. He said then about 1 - 2 weeks ago, he was told again that the sink was backing up, so he removed piping to the sink and cleaned out the debris that caused the sink to back up. He stated this helped, but that the sink still drained slowly. He stated that the water eventually goes down, with a bubbling noise.</p> <p>A follow up interview with the Maintenance Director occurred on 9/14/22 at 12:15 PM and revealed that sometime in August 2022 he was made aware that the sink in room 203 was clogged, he removed the drainpipe, found that the pipe was clogged, cleaned out the pipe and the sink worked fine. He stated then about 1 - 2 weeks ago, he was told that the sink now drained slowly. He said he had not had a chance to address it, but that he looked at the sink yesterday (9/13/22) and saw that it backed up with water, so he would try to remove the drainpipe again and clean it out to see if that would work, but that he had just not had a chance to address it in the last couple weeks.</p> <p>The Administrator stated in an interview on 9/14/22 at 1:00 PM that she was aware that the</p>	F 584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 4	F 584			
F 698 SS=K	<p>Dialysis CFR(s): 483.25(l)</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, Nephrologist, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to schedule and continue dialysis services for Resident #6. As a result, he missed 3 consecutive dialysis appointments (8/18/22, 8/20/22, 8/23/22) and was scheduled for a non-emergent dialysis treatment on 8/25/22 and died 8/24/22. This occurred for 1 of 4 sampled residents reviewed for dialysis (Resident #6).</p> <p>Findings included:</p> <p>Resident #6 was admitted to the facility on 8/17/22 after a hospitalization for abdominal ascites. His diagnoses included stage 5 chronic kidney disease (CKD) and end-stage renal disease (ESRD) (on dialysis).</p> <p>A hospital discharge summary dated 8/17/22 indicated Resident #6 to continue with dialysis. The discharge summary did not specify which days to continue with dialysis and when he last received dialysis.</p>	F 698	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	Continued From page 5 An Admission Skin Assessment dated 8/17/22 was conducted by Nurse #1 and revealed Resident #6's left arm had a bruised dialysis shunt. A physician order for dialysis was not identified at time of the admission skin assessment. A 5-day Minimum Data Set (MDS) dated 8/24/22 indicated Resident#6 had mild cognitive impairment. He required extensive assistance with bed mobility and personal hygiene; he was totally dependent on staff for bathing, toileting, and dressing. The MDS did not identify dialysis. A Care Plan dated 8/24/22 did not indicate dialysis for Resident #6. A Nurse Practitioner (NP) progress note dated 8/22/22 indicated she examined Resident #6 as a new admission into the facility after hospitalization and he was alert and oriented at baseline. She further indicated he had a skin tear to his left forearm, fistula to his left upper arm, and denied pain or acute distress. The Resident was to continue dialysis 3 days per week for CKD Stage 5. A Physician progress note dated 8/23/22 revealed he examined Resident #6 as a new admission to the facility after a hospitalization. He further revealed the Resident was alert, oriented with confusion and denied pain or distress. Resident's lungs were non-labored and mild ascites was noted. Resident #6 was to continue dialysis on a schedule of 3 days a week. All medications and records were reviewed. A Registered Dietician progress note dated	F 698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 6</p> <p>8/24/22 indicated Resident #6 received routine hemodialysis 3 days per week and some weight changes were expected.</p> <p>A Nursing Progress Note dated 8/24/22 revealed Nurse #2 spoke with the NP regarding Resident #6 dialysis status. Resident #6 had no signs or symptoms of any respiratory distress. Respirations were even and non-labored. Skin was warm and dry to touch, dialysis catheter patent no signs or symptoms of any bleeding noted and there was no edema noted. A new order was given to send Resident #6 to the emergency room the following morning for non-emergent dialysis. Nurse #2 called the emergency room to inform them that Resident #6 would be sent over for dialysis in the morning. The dialysis schedule was to be set up once dialysis was completed in the am. The Director of Nursing (DON) was made aware of the new order.</p> <p>A Social Services Assessment dated 8/24/22 indicated Resident #6 was dependent on renal dialysis.</p> <p>A death certificate for Resident #6 revealed he died on 8/24/22 and cause of death was ESRD.</p> <p>A phone interview with the hospital discharge Social Worker (SW) on 9/14/22 at 1:40 PM revealed she first contacted the facility on 8/8/22 and spoke with the Assistant Business Office Manager (ABOM) who accepted Resident #6 for rehabilitation. She provided the ABOM with the name, location of the dialysis center and days. The initial referral packet was sent via Care Port (referral portal) for the facility to review. On 8/12/22 she updated the ABOM that the</p>	F 698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 7</p> <p>Resident's discharge changed due to not being medically eligible for discharge. On 8/15/22 the SW communicated through Care Port that Resident #6 was ready to be discharged to the facility and the acceptance was contingent on the facility's ability to provide transportation to dialysis. The Resident was discharged to the facility on 8/17/22.</p> <p>An interview with the ABOM on 9/15/22 at 12:58 PM indicated she utilized Care Port to review hospital discharges for possible admissions to the facility. She printed out Resident #6's history & physical, medication list, clinical notes, and progress notes, then gave it to the DON, who reviewed and approved the admission. The approval meant the facility could provide transportation to dialysis. A post-it note regarding the Resident's dialysis days and location was placed on the discharge paperwork and was given to the DON. On 8/8/22 the ABOM communicated with the hospital discharge SW through Care Port about the name and location of the dialysis center, then accepted the Resident. After the Resident arrived, the nurses should have communicated the information to the receptionist who provides transportation. She further indicated she uploaded the updated hospital DC Summary into the electronic medical record (EMR) and provided a copy to the DON. The ABOM stated she made announcements during the interdisciplinary morning meetings about possible admissions or new admissions that had arrived. She further stated, since the incident related to Resident #6 missing dialysis days after he was admitted to the facility, the Admissions Coordinator entered more specific information on the admission form (such as dialysis or oxygen status) before providing the</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 8 DON with the form.</p> <p>A phone interview with Nurse #1 on 9/14/22 at 3:45 PM, who no longer worked at facility, revealed she admitted Resident #6 on 8/17/22. She could not recall conducting a skin assessment, although she entered the assessment into the EMR. She stated she last worked at the facility one week prior and she could only recall working the night Resident #6 died. She further stated she barely remembered admitting him.</p> <p>An interview with the Rehabilitation Director on 9/13/22 at 3:45 PM indicated the Speech Therapist informed her on 8/22/22 that Resident #6 needed dialysis. She then mentioned it in the morning meeting the same day (8/22/22) and the DON and Unit Manager #1 stated they would take care of it. She further indicated the DON usually set up the dialysis and the receptionist provided transportation to dialysis appointments.</p> <p>An interview with the NP on 9/12/22 at 2:49 PM revealed she examined Resident #6 on 8/22/22 who presented with no symptoms and said he felt ok. She was unaware at the time of her assessment that he was not getting dialysis as ordered. The NP further revealed nursing staff contacted her on 8/24/22 and reported Resident #6 had not been dialyzed since his admission to the facility. She expected nursing staff to set up the dialysis schedule when he was admitted from the hospital. She gave an order to go to ER the following day 8/25/22 to be dialyzed, since he presented with no symptoms such as fluid overflow or shortness of breath. The Unit Manager usually set up the dialysis schedule and it had not been done. He missed at least 3</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 9</p> <p>dialysis days since his admission to the facility.</p> <p>An interview with the Medical Director (MD) on 9/13/22 at 9:42 PM indicated he examined Resident #6 on 8/23/22 and he was alert and oriented. He did not understand how Resident #6 could have missed dialysis. He further indicated he and his NP were made aware of it and agreed that the Resident was okay when they examined him. However, they were troubled that at least 20 people encountered the Resident before his death but did not detect he missed dialysis. The MD stated he reviewed the Resident's discharge summary before he examined him. He stated that he mainly focused on his medications. The MD was unsure whether the Resident would have survived even if he had dialysis during those days missed. In the MD's opinion, the Resident probably had a failed arrhythmia (sudden heart episode). The MD expected nursing staff would have transposed the dialysis information from the hospital discharge summary. He stated the Resident had several medical issues that could have caused his death. He further stated he placed the initial diagnosis, which was "end-stage renal disease" on the Resident's death certificate.</p> <p>During an interview on 9/13/22 at 11:00 AM Nurse #2 stated she worked 7am- 11pm on the west unit and was assigned to Resident #6 on 8/23/22 and 8/24/22. She further indicated while administering medications, she noticed he was bleeding on his right arm. She informed the treatment nurse, who performed a skin assessment and noticed there was a dialysis catheter. Nurse #2 went to the east unit of the facility where the Resident had transferred from the previous day and inquired with nursing staff about the Resident's dialysis catheter and dialysis status. Nursing staff on the</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 10</p> <p>east unit were unaware of the Resident's dialysis status. She then stated she went to the DON's office and inquired about the Resident's dialysis status. She further stated the DON was unaware that Resident #6 should have been receiving dialysis since he was admitted to the facility on 8/17/22. Nurse #2 then asked Resident #6 if he was on dialysis. He stated he usually went to dialysis on Mondays, Wednesdays, and Fridays. It was determined that Resident #6 missed at least three dialysis visits between 8/17/22 and 8/24/22. The NP was contacted and informed of the Resident's need for dialysis. The NP informed Nurse #2 that if the Resident was not showing any symptoms, he could go to the emergency room in the morning 8/25/22 for non-emergent dialysis treatment. The nearest hospital was contacted, and the plan was for the Resident to be transported the following morning for dialysis, since the assigned dialysis center could not service the Resident on short notice.</p> <p>Interviews with the DON on 9/12/22 at 6:11 PM and 9/14/22 at 10:55 AM revealed she was unaware Resident #6 was supposed to have dialysis. On 8/24/22 Nurse #2 informed her that the Resident was supposed to go to dialysis 3 days per week and had not gone since he was admitted to the facility 8 days prior (8/17/22). The dialysis center was also contacted, and they were unable to accept the Resident that day. Instead, they recommended an emergent dialysis at the emergency room. The DON further revealed she and Nurse #2 contacted the NP, who stated since the Resident was asymptomatic and the emergency room would not dialyze him until the morning, the Resident could be sent to the emergency room the following morning 8/25/22. The DON stated that usually, the discharging</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 11</p> <p>hospital would contact the admitting facility to provide report. The Admissions Coordinator would print the discharge summary and provide her with a copy. The DON further stated she would usually review the discharge summary and set up dialysis. She then stated she failed to set up dialysis and it was a big miss on the facility's part. Since then, it was determined that an admission audit of the Resident needs was not completed. She in-serviced the charge nurses who admitted residents and created an admission audit tool.</p> <p>A phone interview with the Nephrologist on 9/14/22 at 10:34 AM indicated Resident #6 had been his patient since 2010. The Resident started with dialysis in January 2015 and had been a dialysis patient since that time. He went from his home to the hospital, and he had a primary care team. The Nephrologist further indicated the Resident was still a patient with the dialysis center at the time he was discharged from hospital to the facility on 8/17/22. Per hospital records he was last dialyzed on Tues 8/16/22. His nephrology group saw him throughout his hospital stay.</p> <p>The Administrator, the DON, the Regional Nurse Consultant, and the Regional Director of Operations were informed of Immediate Jeopardy on 9/14/22 at 8:37 PM. The facility provided the following corrective action plan:</p> <ul style="list-style-type: none"> Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. <p>Resident #6 was admitted 8/17/22 after a hospitalization for abdominal ascites from 8/3/22-8/17/22. Diagnoses included: CKD Stage</p>	F 698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 12</p> <p>5, a fib, CHF, idiopathic hypotension, primary hypertension anemia, and ESRD on dialysis.</p> <p>The facility failed to schedule and continue dialysis services for, Resident #6, admitted on 8/17/22 with diagnoses including end stage renal disease (Stage 5). As a result, he missed 3 consecutive dialysis appointments.</p> <p>All residents who have a physician's order for dialysis could be affected.</p> <p>On 8/25/22, the Director of Nursing (DON)/ Regional Director of Clinical Services (RDCS) completed an audit of all new admissions and readmissions from the previous 60 days to ensure that no further residents missed dialysis orders/treatments. No further missed dialysis orders/treatments were identified.</p> <p>·Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete</p> <p>On 8/25/22, the Regional Director of Clinical Services (RDCS) educated the Director of Nursing (DON), Nurse Manager, and the Administrator regarding the clinical morning meeting process for the DON to run and review the Order Listing report and compare it to the discharge summary of any new admission/readmissions to ensure dialysis orders have been entered for new admissions and readmissions for dialysis services and dialysis treatments are scheduled. On 8/25/22, the DON and Nurse Manager were educated regarding this process and the use of the New Admission Audit tool.</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 13</p> <p>On 08/25/22, the Administrator notified the Admission Coordinator of the new process using the New Referral Admission Sheet and provide to the DON for review. Information for new referrals requiring dialysis orders/treatments will be reviewed by the DON prior to admission.</p> <p>On 8/25/22, the Director of Nursing re-educated the Licensed Nurses and Nurse Manager including agency staff, to review hospital discharge orders for new admissions and readmissions to identify dialysis treatment orders, to notify Nurse Practitioner/Physician of admission of dialysis resident, and to place the discharge summary in the Physician/Nurse Practitioner book. The Licensed Nurses were educated to enter these orders in the electronic record and notify the DON at time order entry; if the DON isn't in the building, the nurse will call her at the number provided for after hours. The Physician will be notified of new admissions or readmissions requiring dialysis treatments by the Licensed Nurse and/or the DON. The Nurse Manager will coordinate scheduling of dialysis with the Director of Nursing.</p> <p>The Director of Nursing will ensure no new licensed nursing staff will work without receiving this education. Any new hires, including nursing agency staff will receive education prior to the start of their shift.</p> <p>·Measures will be put in place/systemic changes made to ensure that the deficient practice will not recur</p> <p>On 08/25/22, the Administrator began reviewing all admissions/readmissions data provided by the</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 14</p> <p>DON/Nurse Manager in the morning meeting using the New Admission Audit tool that indicates the need for dialysis treatment/orders. DON/Nurse Manager will conduct an audit of all admissions/readmissions daily to validate that dialysis treatment/orders have been entered into the electronic medical record and dialysis treatments have been scheduled. On 08/25/22, the Administrator notified the DON/Nurse Manager on this responsibility.</p> <p>·How facility plans to monitor its performance to ensure that solutions are sustained</p> <p>All admissions/readmissions will be reviewed to ensure dialysis orders/treatments received at weekly QAPI meeting x 3 months. Administrator will monitor the review of new admissions at weekly QAPI meeting x 3 months to ensure that dialysis orders/treatments were followed. The DON will provide all audits for the QAPI committee to review and make recommendations.</p> <p>Effective 8/25/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.</p> <p>The facility's alleged correction date of 08/26/22 was verified by the following:</p> <p>On 09/20/22, the facility's corrective action plan with correction date of 08/26/22 was validated on-site by observations, interviews with residents and staff and record review.</p> <p>Six residents were admitted/readmitted to the facility after 08/26/22 who required dialysis</p>	F 698			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 698	<p>Continued From page 15</p> <p>services. These residents received coordination of dialysis services on admission/readmission to the facility based on observations of transportation to/from dialysis, record review of hospital discharge summaries, admission assessments, physician orders, and care plans. Interviews with facility nursing staff and staff contracted to provide dialysis and transportation services were also conducted. No concerns related to the coordination of dialysis services were identified.</p> <p>Interviews with nursing staff from all shifts revealed they had been re-educated per the documentation of in-services provided related to coordinating dialysis services on admission/readmission to the facility.</p> <p>Interviews with alert and oriented residents revealed nursing staff coordinated dialysis services upon admission/readmission to the facility.</p> <p>Review of in-service records revealed on 08/25/22, the Administrator and Director of Nursing completed re-education via phone and in-person in-services on providing dialysis services on admission/readmission to the facility. Review of a sample of nursing staff who worked after 08/26/22 revealed re-education prior to the start of their shift.</p> <p>Review of monitoring tools revealed the management staff had completed audits and monitoring per the audit tools and monitoring documentation provided.</p> <p>Alleged Date of IJ Removal: 8/26/2022</p>	F 698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 16	F 812			
F 812 SS=D	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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 facility failed to serve lunch on dinnerware in good condition for 1 of 1 lunch meal observation.</p> <p>The findings included: On 9/12/22 at 1:00 PM an in-room observation revealed 2 residents in room 114 were eating lunch meal off chipped plates. The resident in B bed had 3 chipped areas around the lip of the plate and A bed had 1 chipped area on the lip of the plate. The chipped edges where jagged with 2 chipped areas sharp to touch. The resident in B bed reported she often received plates that were chipped or damaged with meals. Further</p>	F 812 F 812	<p>F812</p> <ol style="list-style-type: none"> 1. Corrective action was accomplished for the alleged deficient practice by the Dietary Manager(DM) inspecting and removing all broken, chipped and/or stained dishes from service on 9/12/22. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Dietary Manager educated all dietary staff on the facility process for inspecting and recognizing dishes that are in dis- 	10/14/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 812	Continued From page 17 observation of the meal cart in the hallway found an additional 3 plates with chipped edges. The Dietary Manager (DM) stated in an interview on 9/13/22 at 8:30 AM she was aware that the plates would chip easily and ordered new plates regularly to replace them. The DM said kitchen staff (cooks, aides) are not supposed to send food out on damaged plates. The cook should be checking the plates before plating the food and then the dietary aide before placing the plate on the meal cart. The Administrator verbalized on 9/13/22 at 10:32AM residents should not be served meals on chipped or damaged plates and that DM usually removed the damaged plates before they reach the residents.	F 812	repair and the ordering process on 9/12/22. The DM will audit 50 dishes per week and discard any dishes that are damaged. 4. To monitor the effectiveness of the above action plan, the DM will review findings with QAPI committee monthly x3 months beginning October 20, 2022. Pelican Health Charlotte LNHA will be responsible for the completion of this plan of correction.		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and 3 residents (Resident #1, #5 and #9) and record review, the facility failed to maintain 1 of 3 hot water heaters operating which resulted in no running hot water for 35 days from 7/25/22 to 8/29/22 to residents on the West Unit. This failure had the potential to impact 31 residents, causing them to bathe with carafes of hot water. The findings included: Review of the facility document, Work History	F 908	F908 1. Corrective action was accomplished for the alleged deficient practice of not maintaining equipment in a safe operating condition on 8/29/22 by installing a new water heater. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Administrator re-educated the Maintenance	10/14/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 908	<p>Continued From page 18</p> <p>Report, for the months of March - July 2022, revealed "No action recorded" for weekly hot water temperatures and "Done late" on 5/28/22, 6/23/22, 6/27/22 and 7/7/22.</p> <p>Review of the facility document, Water Temps Monitoring, recorded water temperatures for 6/6/22 - 6/10/22 and 6/15/22 - 6/19/22. There were no water temperatures documented for May 2022 or July 2022.</p> <p>Review of the facility document, Work History Report, May - July 2022 revealed, "Boilers: Flush to remove impurities, test pressure relief valve", completed 5/31/22, 6/17/22 and 7/12/22.</p> <p>An observation on 9/12/22 from 10:45 AM to 11:45 AM of the shower room and rooms 200 - 230 on the West Unit, revealed hot water was available.</p> <p>During an interview on 9/12/22 at 11:00 AM, Resident #1, a Resident assessed with intact cognition on a quarterly (Q) Minimum Data Set (MDS) assessment dated 8/12/22, she stated that she resided on the West Unit and for about 4 weeks in August 2022, she was without hot water in her room. She stated the facility provided carafes of hot water for residents to wash up with and if she wanted to take a shower, she had to go to the shower room on the East Unit.</p> <p>During an interview on 9/12/22 at 11:10 AM, Resident #9, a Resident assessed with intact cognition on a quarterly MDS assessment dated 8/7/22, stated the hot water was out for about a month in August 2022 on the West Unit. She stated during this time, staff provided hot water in carafes for residents to bathe and when she</p>	F 908	<p>Director on taking water temperatures daily on 9/13/22.</p> <p>The Administrator will review water temp logs completed by the Maintenance Director weekly x3 months.</p> <p>4. To monitor the effectiveness of the above action plan, the Administrator will review findings with QAPI committee monthly x3 months beginning October 20, 2022.</p> <p>Pelican Health Charlotte LNHA will be responsible for the completion of this plan of correction.</p> <p>F925</p> <p>1. Corrective action was accomplished for the alleged deficient practice of maintaining an effective pest control program by cleaning, sanitizing, and providing pest management services to Rooms #1, #5, #8, and #11 on 9/12/22.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice. An audit was completed of all resident rooms to inspect for pests. Opportunities identified and corrected as needed. The Administrator/Maintenance Director will audit 10 rooms weekly x 12 weeks for any signs of pest control issues.</p> <p>3. The Administrator re-educated the Maintenance Director and the Maintenance Assistant on the process of pest control management. The DON and Maintenance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 908	<p>Continued From page 19</p> <p>showered, she had to use the shower room on the East unit.</p> <p>During an interview on 9/12/22 at 4:08 PM, with Resident #5, a Resident assessed with intact cognition on a quarterly MDS assessment dated 6/18/22, she stated that she resided on the West Unit and for 5 weeks, July - August 2022, she was without hot water in her room. She stated the facility provided carafes of hot water for residents to wash up with but there were days when the carafes only had cold water. She stated she did not like being without hot water in her room and she did not like bathing with cold water.</p> <p>An interview with the Director of Nursing (DON) occurred on 9/12/22 at 4:50 PM which revealed that the last week of July 2022, the hot water heater went out on the West Unit. She stated that hot water was provided in carafes to residents on the West Unit to make sure hot water was available for resident use. Residents on the West Unit who wanted a shower, were encouraged to use the shower room on the East Unit until the hot water heater could be replaced. The DON stated it took several weeks to replace the broken hot water heater because the piping system to the hot water heaters was old and the facility had to locate a hot water heater that was compatible to the facility's current piping system.</p> <p>An interview with Maintenance Director #1 occurred on 9/13/22 at 2:25 PM. He stated that he started in March 2022 at the facility. He stated that he rounded the facility upon hire to identify repair needs and prioritized what he would repair first. He stated for the first few months, he checked water temps, but that he did not check or document every week. He stated he did not get</p>	F 908	<p>Director educated staff regarding the facility processes of managing pests and to complete pest control request work orders for the Maintenance Director.</p> <p>4. To monitor the effectiveness of the above action plan, the QAPI committee will review findings monthly x3 months beginning October 20, 2022. Pelican Health Charlotte LNHA will be responsible for the Completion of this plan of correction.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 908	<p>Continued From page 20</p> <p>to drain the facilities water heaters until June/July 2022. He was not aware of the times the water heaters were drained prior to that. He stated that when he drained the water heater for the West Unit in June 2022, he noticed rust and sediment in the water, but he did not think it was enough to indicate there was a problem and then the water heater went out in July 2022. He stated that draining the water heaters and monitoring water temperatures was preventive maintenance that would let him know if there was a problem. He stated when he came to work on 7/25/22, staff told him there was no hot water on the West Unit. When he assessed the hot water heater for that unit, he identified a leak in the bottom of the heater because of a hole where it had rotted out. He stated that in June/July 2022 he inspected the hot water heaters weekly, looked at the bottom periodically, but that the hole was not found under the bottom until he inspected the hot water heater on 7/25/22. He said there was no prior indication of a leak or hole observed during his prior inspections and that the rust/sediment he saw in the water when he drained the heaters in June 2022 was not enough to indicate a problem. He said he notified the Administrator on 7/25/22 that the water heater on the West Unit was out. Bids were obtained, and the heater was replaced on 8/29/22. He said it took so long because the piping system was so old, and the facility had to find a water heater that was compatible with the current piping system. He said three bids were requested, two vendors declined to bid on 8/11/22, and the final bid was accepted on 8/18/22. The hot water heater was ordered on 8/18/22 and delivered/installed on 8/29/22.</p> <p>An interview with the Administrator occurred on 9/13/22 at 2:48 PM. She stated she was notified</p>	F 908			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 908	Continued From page 21 on 7/25/22 the hot water heater on the West Unit had a hole in it and was leaking water. The Administrator stated she met with the department managers to discuss a plan for repair and based on the Maintenance Director, it could not be repaired, but had to be replaced. They obtained bids and accepted a bid mid-August 2022, the water heater arrived on 8/29/22 and was replaced the same day. During this period, we notified the Residents in Resident Council and the Social Worker contacted families. The team discussed a plan for showers, baths, and access to hot water. A phone interview occurred on 9/15/22 at 2:32 PM with Maintenance Director #2. He stated that he was the Maintenance Director at the facility for about 3 weeks between the end of February 2022 to March 2022. He stated on his first day as the Maintenance Director at the facility he received a list of items in need of repair and so he started working on these repairs. He stated that while he was the Maintenance Director at the facility, he did not get an opportunity to check the hot water heaters, but that he did check water temps and they were in range. Maintenance Director #2 stated that routine maintenance for hot water heaters should include temperature monitoring at least weekly of all areas where water is used and draining the hot water tank to check for rust/sediment which could be an indication that the tank is having problems. He stated that if rust/sediment was found in the water when the tank was drained that he would tell the Administrator so that a plan could be developed to replace the tank before it goes out.	F 908			
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		10/14/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 22</p> <p>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews, resident interviews and record review, the facility failed to maintain an effective pest control program for 4 of 4 sampled residents (Residents #1, #5, #8 and #11) reviewed for pest control. The Resident census was 83.</p> <p>Findings included:</p> <p>1a. Resident #8 was admitted to the facility 4/20/22. A quarterly Minimum Data Set (MDS) assessment dated 8/30/22 indicated Resident #8 was cognitively intact.</p> <p>During an interview on 9/12/22 at 4:20 PM with Resident #8 she revealed she first saw a mouse a few weeks ago. There was a hole in the wall in her room and the Maintenance Director eventually covered the hole. She further revealed she continued to see mice and other residents also saw mice and roaches, especially at night. She never saw the exterminator treat her room for pests. She stated her family member brought her a sticky trap for roaches. A few days later roaches and a mouse were caught on the sticky trap. She further stated she gave the sticky trap to a maintenance person that day. She pointed to the location of the patched hole and no holes were observed.</p> <p>A small unidentified black bug was observed in Resident #8's bed during the interview with the Resident, on 9/12/22 at 4:25 PM. The Resident killed the bug and reported she observed the</p>	F 925	<p>F925</p> <ol style="list-style-type: none"> Corrective action was accomplished for the alleged deficient practice of maintaining an effective pest control program by cleaning, sanitizing, and providing pest management services to Rooms #1, #5, #8, and #11 on 9/12/22. All residents have the potential to be affected by the alleged deficient practice. An audit was completed of all resident rooms to inspect for pests. Opportunities identified and corrected as needed. The Administrator/Maintenance Director will audit 10 rooms weekly x 12 weeks for any signs of pest control issues. The Administrator re-educated the Maintenance Director and the Maintenance Assistant on the process of pest control management. The DON and Maintenance Director educated staff regarding the facility processes of managing pests and to complete pest control request work orders for the Maintenance Director. To monitor the effectiveness of the above action plan, the QAPI committee will review findings monthly x3 months beginning October 20, 2022. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 23</p> <p>same or similar looking bug the Maintenance Director was informed and arrived to remove the bug from the bed.</p> <p>An interview on 9/12/22 at 4:35 PM with the Maintenance Director revealed the Pest Control Company arrived on 9/12/22 and treated several rooms. He further revealed the Pest Control Company visits were increased from monthly to 2 times per month to weekly, due to continued pest sighting reports in September. The Maintenance Director stated he patched holes and filled cracks according to the Pest Control recommendations made over the past few months.</p> <p>1b. Resident #1 was admitted to the facility on 1/15/22. A quarterly MDS assessment dated 8/12/22 indicated Resident #1 was cognitively intact.</p> <p>An interview with Resident #1 on 9/13/22 at 4:05 PM revealed a family member found rodent droppings in her dresser drawer about 2 weeks ago and a Nurse Aide saw a mouse in her room. The Resident could not recall the name of the Nurse Aide. She further revealed there was a hole in the wall that maintenance patched up twice because a mouse ate through it on two occasions.</p> <p>During the interview patched holes were observed in the wall.</p> <p>An interview with the Maintenance Director on 9/13/22 at 5:50 PM revealed he was informed of mouse droppings in Resident #1's dresser drawer and a Nurse Aide saw a mouse in her room a few weeks ago. He further revealed he patched up the hole in her room and filled in the holes on the</p>	F 925	<p>Pelican Health Charlotte LNHA will be responsible for the Completion of this plan of correction.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 24</p> <p>outside of the air conditioning unit a few weeks ago. He stated the Pest Control company made a service visit after the mouse was observed. Pest Control visits took place on 8/8/22, 8/20/22, 9/3/22 and 9/12/22 and traps were set inside and outside the building.</p> <p>1c. Resident #11 was re-admitted on 6/7/22. A quarterly MDS assessment dated 8/20/22 revealed he was cognitively intact.</p> <p>An interview with Resident #11 on 9/12/22 at 12:15 PM revealed he had observed roaches running across the nurse's station on more than one occasion and roaches in his roommate's bed over the weekend of 9/10/22. He further revealed he saw mice in the lunchroom that was being renovated and not in use. He stated he did not report his observations to staff because the facility was already aware of the problem. After the interview with the Resident, an observation of the dining room further revealed it was closed and under renovations.</p> <p>1d. Resident #5 was admitted to the facility on 10/6/2017. A quarterly MDS assessment dated 6/18/22 indicated she was cognitively intact.</p> <p>During an interview with Resident #5 on 9/12/22 at 2:10 PM, she stated there had always been mice in the facility, but this time was worst she had ever seen. She last saw a mouse about 2 weeks prior ago, gnats around her sink a few days ago and roaches all the time. She stated maintenance put down sticky traps about one month ago. During the interview with the resident no holes were observed in the wall.</p> <p>A review of the Pest Control invoices between</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 25</p> <p>April 2022 through September 2022 indicated target areas in resident rooms, the break room, kitchen and laundry were treated for pests and rodents. The recommendations to the facility included patching holes in the walls to prevent pests from entry and harboring. Pest Control visits were increased from 3 times per month to weekly and as needed in September. Further review of Pest Control invoices revealed recommendations were duplicated and carried over to each visit invoice.</p> <p>The following recommendations made in April 2022- September 2022:</p> <p>April 18, 2022 invoice- The kitchen interior/exterior was inspected and treated selected areas. Entrance and exit doors and common areas. A hole/gap was noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area. Kitchen area interior with excess water noted, leaking from dishwashing sink pipes. Action Needed/ taken: Keep area dry. Dining Room was closed. Interior resident rooms services with hole/gap and floor tiles or baseboards loose or missing, noted in various rooms around the air conditioning unit. Action needed: Seal to prevent entry or harborage; Rooms serviced: 100 wing rooms and 217. Performed exterior rodent service. Checked accessible rodent stations and cleaned/reset traps as needed. No pest activity noted.</p> <p>May 16, 2022 invoice- Inspected and treated selected areas, Entrance and exit doors and common areas. Rooms serviced: 100 wing rooms; Performed exterior rodent service.</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 26</p> <p>Checked accessible bait stations and replaced bait as needed. Checked accessible rodent stations and cleaned/ reset traps as needed. Performed interior rodent service, checked and reset all traps. No rodent activity was noted during the inspection and/or service. The kitchen interior/ exterior was inspected and treated selected areas. Entrance and exit doors and common areas. A hole/gap was noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area. Interior resident rooms services with hole/gap and floor tiles or baseboards loose or missing, noted in various rooms around the air conditioning unit. Action needed: Seal to prevent entry or harborage; interior had hole/gap noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area. No pest activity noted.</p> <p>August 8, 2022 invoice- Inspected and treated selected areas, Entrance and exit doors and common areas. Rooms serviced: 200 wing rooms, nurses station and rehab; performed exterior rodent service. Checked accessible bait stations and replaced bait as needed. Checked accessible rodent stations and cleaned/reset traps as needed. Performed interior rodent service, checked and reset all traps. No rodent or cockroach activity was noted during the inspection and/or service. The kitchen interior/exterior was inspected and treated selected areas. Entrance and exit doors and common areas. A hole/gap was noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 27</p> <p>measures will reduce the number of pests entering the area. Interior resident rooms services with hole/gap and floor tiles or baseboards loose or missing, noted in various rooms around the air conditioning unit. Action needed: Seal to prevent entry or harborage; interior had hole/gap noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area.</p> <p>August 20, 2022 invoice- Inspected selected areas and 100 hall and 200 hall resident rooms. No pest activity found; No sanitation issues found.</p> <p>September 12, 2022 invoice- The kitchen interior/exterior was inspected and treated selected areas. Entrance and exit doors and common areas. A hole/gap was noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area. Interior resident rooms services with hole/ gap and floor tiles or baseboards loose or missing, noted in various rooms around the air conditioning unit. Action needed: Seal to prevent entry or harborage; interior had hole/gap noted behind dish machine and prep sink. Action needed: Seal to prevent entry or harborage. Exclusion measures will reduce the number of pests entering the area. Rooms serviced East wing rooms 230-227.</p> <p>During an interview with the Maintenance Director on 9/13/22 at 6:34 PM, he stated when he was made aware there was a mouse and roaches in Resident #5's room, he called the Pest Control Company, and they came out to treat her room.</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 28</p> <p>Her room was also deep cleaned. He further stated he had observed pests and rodent droppings in the facility, although the Pest Control Company was treating the facility. He indicated he completed all recommendations made by the Pest Control Company and was unaware of the reason why the repeated recommendations flowed to each invoice.</p> <p>An interview with Nurse #2 on 9/13/22 at 11:20 AM revealed about two weeks ago, while she was administering medication to Resident #11 in room 203, two mice ran across her feet. She informed the unit manager and Administrator, who stated she could call someone. Nurse #2 was unaware if anyone (Pest Control) came out to exterminate. She further revealed a Nurse Aide (unavailable for an interview) was about to provide personal care to Resident #11 and observed a mouse crawl from under her roommate's mattress and run to the other side of the room. Nurse #2 stated she observed pests and rodents in the facility as recently as the beginning of September 2022.</p> <p>An interview with Unit Manager #2 on 9/15/22 at 2:26 PM revealed she no longer worked at the facility as of 8/21/22. She further revealed she observed mice and roaches in the facility during the entire 6 years she worked at the facility. She stated the pest problem worsened in the past few months. Initially, the facility would not bring mouse traps in the building. She last observed a mouse in room 130. The resident in that room reported to another nurse that a mouse had been in her bed, and she refused to get back in her bed.</p> <p>An interview with Med Aide #1 on 9/15/22 at 3:16 PM indicated she observed roaches in the facility</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 29 as recent as one week ago.</p> <p>During an interview with the Housekeeping Manager on 9/14/22 at 9:35 AM, he stated he started working at the facility one week ago and was working on a plan to have 4 rooms deep clean each day. He also planned to deep clean the common areas and wheelchairs on the weekends. An evening housekeeping technician had not been hired yet.</p> <p>During an interview with the Training Environmental Services (EVS) Manager on 9/14/22 at 2:50 PM, he stated that the Housekeeping Manager was hired one week ago. They were without a manger in this department for a month and during this time he visited the facility twice weekly and some weekends. He and the Administrator managed the EVS services in the facility until they hired a Housekeeping Manager a week ago. When the Housekeeping Manager was hired, he set him up on a 30-day plan to deep clean each resident room and ancillary areas. The plan included the deep cleaning of 4 resident rooms per day until all rooms and ancillary areas were cleaned. The facility is a 120-bed facility with a current census of 83 residents.</p> <p>The EVS Manager provided a copy of the Action Plan that was initiated in August 2022, entitled 'Pest Sighting Daily Check List' which included:</p> <ul style="list-style-type: none"> -Declutter resident's rooms within the next 30 days -Called family members to retrieve refrigerators and excess property stored in resident rooms -Encouraged residents to store open food in plastic containers and zip lock bags -Maintenance is inspecting the 200 hall for pests 	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2022
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 925	<p>Continued From page 30 and droppings</p> <ul style="list-style-type: none"> -Increased Ecolab services from biweekly to weekly -Continuing to keep the exterior of the property cleaned and clear of debris -Talked to the residents in Resident Council about keeping open food containers closed and the general hygiene of their rooms between housekeeping <p>An interview with the Administrator on 9/13/22 at 6:09 PM indicated she was aware there were rodents and pests in the facility and the Pest Control Company and facility maintenance were patching holes and sealing cracks to resolve the problem. She further indicated families were recently contacted and encouraged to remove some of the resident's belongings, to declutter their rooms. The Administrator confirmed that the dining room was closed and under renovations.</p>	F 925			