STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 07/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 07/19/23 through 07/21/23. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# K09D11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation survey was conducted from 07/19/23 through 07/21/23. 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. Event ID# K09D11. The following intake was investigated NC00204655. 1 of the 2 complaint allegations resulted in a deficiency.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		8/16/23

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

Electronically Signed | 08/11/2023

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paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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F 623	Continued From page 2	F 623		

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff, and Responsible Party, the facility failed to inform the Responsible Party prior to discharging a resident to another skilled facility and failed to issue a 30-day discharge notice (Resident #1) for 1 of 3 residents reviewed for discharge. Findings included: Resident #1 was admitted to the facility on 05/12/23 with diagnoses that included mild cognitive impairment with memory loss. An admission Minimum Data Set (MDS) dated 05/18/23 indicated that Resident #1 was severely cognitively impaired. A nursing progress note dated 05/18/23 at 9:49 PM revealed Resident #1 attempted to stand without assistance of staff. Resident #1 became increasingly aggressive when staff tried to redirect him. The note revealed Resident #1 was exhibiting exit seeking behaviors. A nursing progress note dated 05/24/23 at 8:16 PM written by Nurse #2 revealed Resident #1 was observed outside of the facility. Staff went outside and assisted the resident back into the building. A nursing progress note dated 05/27/23 at 1:17 AM revealed Resident #1 was noted with increased behaviors and was extremely combative with staff. A nursing progress note dated 06/12/23 at 6:00 AM revealed Resident #1 was awake and exit	F 623	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident's Responsible Party has been informed of the discharge, and an explanation has been provided. This action was completed on Aug 11, 2023 by the Administrator. A review of the process has been conducted, and a corrective action plan has been implemented to ensure proper notification in the future.	

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F 623	Continued From page 4 seeking throughout the night. On 07/19/23 at 1:05 PM an interview was conducted with MDS Nurse #1. During the interview she stated Resident #1's elopement was discussed on 05/25/23 during morning meeting. The interview revealed management staff agreed Resident #1 needed placement in a locked memory care unit due to increased behaviors and exit seeking. She stated the Social Worker was responsible for discussing the options with the responsible party. On 07/19/23 at 9:00 AM a telephone interview was conducted with Resident #1's Responsible Party (RP). During the interview she stated she was contacted by the facility at the end of May regarding finding placement for Resident #1 due to the need for a memory care unit. She stated she and Family Member #1 studied the local facilities with memory care units and provided a list to the Social Worker. The interview revealed Family Member #1 went to the facility to take Resident #1's clothing to him and he had been discharged to another facility. She stated she was not notified Resident #1 had been discharged and the facility Resident #1 had been discharged to was not one of the facilities on the list provided to the Social Worker. The RP added, Family Member #1 was notified by a Nurse Aide (NA) that the resident had been sent to another facility earlier in the day. She stated she was upset and confused as to why the facility did not call and notify her. The interview revealed she had to look up the other facility via a search on the internet even to find it. On 07/19/23 at 12:45 PM an interview was conducted with the Social Worker. She stated	F 623	Date of compliance: Aug 11, 2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of recent discharges and transfers (other than to hospitals) over the past 180 days will be conducted to identify any failures in notification. This audit will be completed by the Administrator or designee by Aug 16, 2023. If issues are identified, they will be corrected, and measures put in place to prevent future occurrences. Date of compliance: Aug 16, 2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Re-education on current notice requirements policy will be conducted by the Administrator or designee for administrative staff, including but not limited to the social worker, business office staff, and nursing leadership. This will emphasize compliance with the regulatory requirements related to transfer/discharge notifications. Date of compliance: Aug 16, 2023	

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F 623	Continued From page 5 she had been in communication with Resident #1's Responsible Party (RP) and was given a list of facilities that the family wanted the resident to go to. She stated she faxed the resident's information to the different facilities, but they would not accept him. She stated the facility found out that a sister facility was accepting admissions and submitted Resident #1's information for approval. The interview revealed approval from the facility was received on 06/30/23 on the same day as it was sent, and they prepared Resident #1 for discharge that day. The Social Worker stated she did not call Resident #1's Responsible Party to let her know the resident was being discharged to another facility. She stated she also did not give the resident a 30-day discharge notice. She stated in the moment she was just thinking about finding the resident placement and the sister facility accepted him. On 07/19/23 at 12:53 PM an interview was conducted with the Admission Coordinator. During the interview she stated she had called the Admission Coordinator at the sister facility and determined Resident #1 would be appropriate for their locked memory care unit. She stated the information was going back and forth between an email from the Social Worker and the other facility Admissions Coordinator. She stated Resident #1's discharge happened very quickly, and she felt like the Social Worker oversaw sending the information and notifying the Responsible Party. She stated she had not contacted Resident #1's RP regarding discharge plans. On 07/19/23 at 1:45 PM an interview was conducted with the Business Office Assistant.	F 623	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of transfer/discharge notifications will be conducted by the Administrator or designee for 4 weeks, followed by monthly audits for 3 months. Results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) committee during monthly meetings, or immediately if any deficiency is identified. If results indicate that the desired outcome/goal is not being achieved or maintained, re-education will be provided by the Administrator or designee, and a root cause analysis will be performed to identify necessary changes. Date of compliance: Ongoing, with initial compliance by Aug 16, 2023	

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F 623	Continued From page 6 She stated the Business Office Manager was out of the facility on leave during the time frame of Resident #1's discharge. She stated 30-day discharge notices were usually issued by the business office but because the facility was trying to find placement so quickly for Resident #1, she didn't know if one was given or not. She stated she could not find a record of a discharge notice being issued for Resident #1. On 07/19/23 at 2:14 PM an interview was conducted with the Administrator. During the interview he stated he was unaware of any issues surrounding Resident #1's discharge. He stated he was responsible for signing 30-day discharge notices and had not seen one for Resident #1. The interview revealed it was the Social Worker's responsibility to ensure Resident #1's Responsible Party was notified when the Resident discharged and for the Resident to be issued a discharge notice.	F 623		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to prevent a cognitively impaired resident from exiting the facility without supervision for 1 of 3 resident reviewed for	F 689	Past noncompliance: no plan of correction required.	

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supervision to prevent accidents (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 05/12/23 with diagnoses that included mild cognitive impairment with memory loss and history of falls.

A wandering assessment was completed on 05/12/23 and indicated that Resident #1 was at low risk for wandering because he did not show any exit seeking behaviors.

An admission Minimum Data Set (MDS) dated 05/18/23 indicated that Resident #1 was severely cognitively impaired and required extensive assistance of one staff member with mobility on the unit. The MDS indicated that Resident #1 had shown no wandering behaviors during the assessment reference period. Devices listed for Resident #1 included the use of a wheelchair.

A nursing behavior note dated 05/18/23 at 9:49 PM written by Nurse #1 revealed Resident #1 was attempting to stand and ambulate with an unsteady gait. Resident #1 was noted to become increasingly aggressive when staff attempted to redirect him. Resident #1 was exhibiting exit seeking behaviors.

On 07/19/23 at 2:32 PM an interview was attempted with Nurse #1. The surveyor did not receive a return phone call.

A nursing progress note dated 05/24/23 at 8:16 PM written by Nurse #2 revealed Resident #1 was observed outside of the facility. Staff went outside and assisted the resident back into the

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building. Resident #1's vital signs were within normal range. Resident #1 was noted with no visible injuries and denied any pain. The Resident's responsible party was notified along with the Medical Director. The Administrator was noted to be onsite. Resident #1 was immediately placed with a one-on-one sitter.

Review of the National Weather Service information revealed on the date of 05/24/23 at 7:00 PM it was 74 degrees in the area of the facility.

On 07/19/23 at 12:26 PM an interview was conducted with Nurse #2. She stated on 05/24/23 the facility door system must have not been working properly and Resident #1 had exited the building through a side door. She stated she was working on the unit and knew he had family visiting with him prior to him exiting. The last time Nurse #2 saw Resident #1 was around 6:30 PM when he was sitting at the nurses station and a family member had left the facility. The interview revealed she had gotten up to go check other residents and that was the last time she saw Resident #1 until she was notified, he was outside. She stated the proximity where she last saw him to the door, he exited was just down a short hall with approximately 5 resident rooms. She stated Resident #1 did not seem agitated nor was looking for the doors to exit. The interview revealed Nurse #4 was coming on shift at 7:00 PM when she saw Resident #1 standing in front of the building holding onto a tree. She stated the nurse called facility staff and notified them that she was standing with the resident and needed assistance. Nurse #2 stated when she got outside, she saw Resident #1 leaning onto the tree at the edge of the parking lot, but he did not

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look like he was going to fall. She stated they got him into a wheelchair and took him inside of the facility through the front door. The interview revealed Resident #1 was talking with staff and did not show any signs of distress from her assessment. She stated the door system was checked and they found that the side door of the facility was unlocked. The interview revealed a one-on-one sitter was immediately placed with the resident to ensure he did not get back out of the facility. Nurse #2 stated she had observed the resident having exit seeking behaviors in the days prior by going to the doors and looking for ways out. The interview revealed she did not inform administrative staff of the exit seeking behaviors because she thought the door locking system was in place. She stated if the staff saw a resident with exit seeking behaviors, they were to ensure the doors were locked and when he showed behaviors prior the door system was working.

On 07/19/23 an interview was attempted with Nurse #4 who no longer worked in the facility. The surveyor left four voicemail's for the staff member with no return phone call. The facility Administrator was asked to help get in touch with Nurse #4 and attempted to without success.

Review of Nurse #4's timecard dated 05/24/23 revealed she clocked into the facility at 7:03 PM.

On 07/20/23 at 2:35 PM an interview was conducted with Nurse Aide (NA) #1. During the interview she stated the incident happened right at shift change. She stated she was responsible for Resident #1 and had received nothing in report about him having any exit seeking behaviors. She stated when she came on shift,

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she saw him sitting in his wheelchair at the nurses station. NA #1 stated she was down the hall providing patient care when staff members brought him back inside and stated he was found outside. The interview revealed she did not see him exit the facility. She stated he was talking with staff and did not look like he was in distress when she saw him.

On 07/19/23 at 10:50 AM an interview was conducted with Door Systems Company Owner. During the interview he stated the company was responsible for maintaining the facility door systems in working condition. He stated he was notified on 05/24/23 that the facility had an elopement and one of the side doors was not locked. The interview revealed he went to the facility around 8:30 PM that night to see what supplies were needed to fix the door system. He stated once he saw that it was a wiring issue, he called one of his trucks that works 24 hours a day and had them come to the facility. He stated they fixed the wiring system for the door and the lock system was in working order within a few hours of the incident occurring. The interview revealed with the wiring issue the alarm would not have sounded for the facility to know the door system was not working.

On 07/19/23 at 11:00 AM an interview was conducted with the Regional Maintenance Director. He stated he was notified of 05/24/23 of an elopement in the facility. He stated he was on his way to the facility and called the door systems company to ask them to come out and look at the door system. The interview revealed the wires on the door were pulled causing the locking system to be disabled. He stated they immediately rewired the door and the system was fixed

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immediately. The interview revealed the facility had a Maintenance Director at the time of the incident but he no longer worked in the facility. He stated the doors were checked weekly to ensure the doors were secure. The interview revealed the doors were supposed to be locked at all times with the front door containing a key code that the secretary could let someone out.

On 07/19/23 at 1:05 PM an interview was conducted with MDS Nurse #1. During the interview she stated the incident was discussed on 05/25/23 during morning meeting. She stated she then updated Resident #1's care plan and wandering assessment.

On 07/19/23 at 1:33 PM an interview was conducted with Director of Nursing (DON) #1. She stated she was working in the facility orienting under the former DON at the time of the incident. She stated she was not in the building when the incident occurred, but it was discussed first thing the next morning during the morning meeting she attended. The interview revealed the former Administrator had been in the building and the resident was immediately placed with a one-on-one sitter and the doors were repaired. She stated the administrative team went outside and did a reenactment of what route Resident #1 had exited the building on 05/25/23. The interview revealed she and the former DON started educating all staff members on the facility elopement policy starting on 05/25/23. She stated she expected all staff to report any exit seeking behaviors immediately.

On 07/19/23 at 1:40 PM DON #1 and the Administrator took the surveyor through the route that Resident #1 exited the building. The resident

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(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
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was last seen at the nurse's station located a short distance from the side exit door of the facility with approximately 5 rooms. Resident #1 exited the door and walked left through an unlatched side gate. The gate was unlatched during the walk through of the incident. DON #1 and the Administrator stated the gate was supposed to be latched and latched the gate back. The surveyor observed under a tree at the end of the sidewalk approximately 50 feet from the gate. DON #1 stated that was where Resident #1 was found at the edge of the parking lot. Cars were noted to be parked directly in front of the tree where Resident #1 was found standing.

On 07/19/23 at 3:54 PM an interview was conducted with Director of Nursing (DON)#2. During the interview she stated she was the active DON on 05/24/23 and was notified by the former Administrator that Resident #1 was found outside of the building. She stated the facility had no issues with the door system prior to that happening. The interview revealed the former Administrator handled the incident by having the Regional Maintenance Director come out and fix the door system and place the resident with a one-on-one sitter. She stated she started education to all staff the next day and completed wandering assessments for all residents in the building. The interview revealed Resident #1 was the only resident that was high risk of wandering in the facility. She stated she expected all of her staff to immediately report exit seeking behaviors.

On 07/19/23 at 4:23 PM an interview was attempted with the former Administrator. The surveyor did not receive a return phone call.

On 07/19/23 at 10:19 AM an interview was

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	345201	A. BUILDING _____ B. WING _____	C 07/21/2023

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conducted with Receptionist #1. She stated she had been working on 05/24/23 from 5:00 PM to 9:00 PM. She stated Resident #1 did not exit through the front door because she would have let him out using a keycode. She stated as a nurse was coming on shift, she saw him standing outside at a tree in front of the facility. She stated the resident was not sweating, he was happy and talking with the staff members around 7:00 PM. The interview revealed Receptionist #1 had seen Resident #1's family member leave the facility at 6:30 PM.

On 07/19/23 at 10:40 AM an interview was conducted with Nurse #3. During the interview she stated she had taken care of Resident #1 in the days prior to him getting outside of the facility. She stated she did notice him wandering around the facility and standing without assistance from staff. She stated she had not witnessed him pushing on the doors or trying to get out of the building. The interview revealed she had not updated any wandering assessments when she noticed him. She stated, "everyone saw him wandering". Nurse #3 stated after the incident Resident #1 always had a one-on-one sitter until he was discharged from the building.

The facility provided the following the following corrective action plan with completion date of 05/27/23:

The facility failed to supervise a cognitively impaired resident who exited the building through an unlocked and unalarmed side door (Resident #1). Resident #1 was new to the facility and had a risk for falling. A Nurse coming on shift at 7:00 PM observed Resident #1 standing in front of the building underneath a tree in close proximity to

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the parking area.
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

" Resident #1 was safely returned to the facility.
" A nursing assessment and skin assessment were completed by the Charge Nurse on 5/24/23 with no injuries noted.
" One on one supervision was initiated.
" The Administrator was present in the facility and was notified immediately by the Charge Nurse.
" On 5/24/23 a new wandering assessment was completed by Charge Nurse for Resident #1.
" One on One supervision continued for Resident #1 while he remained in the facility.
" On 5/24/23 the Maintenance Director came into the facility to assess the door. An outside vendor was available to visit the facility immediately. Door repair completed on 5/24/23.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
" On 5/24/23 the Administrator initiated an investigation into the elopement with root cause identified as a faulty locking mechanism on an exit door.
" On 5/24/23 the Nurse Manager on duty visually accounted for all residents currently admitted to the facility.
" On 5/25/23, Nurse Manager reviewed current wandering assessments which reflected no other residents at risk for elopement.
" On 5/26/23 the Director of Nursing and Nurse Managers completed a review of current residents assessed at risk for elopement to

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ensure the wandering assessments and care plans were complete and current photos posted in the electronic record.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
" On 5/24/23 the Maintenance Director secured repairs to the door locking mechanism from an outside vendor on all other doors in the facility were evaluated for functioning locking mechanisms and found to be in working order.
" On 5/26/23 the Director of Nursing and Nurse Managers completed education for all staff, including agency staff, on the facility policy for Elopement including monitoring and reporting wandering behaviors and providing increased supervision.
" The Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff and agency staff, without receiving this education.
" On 5/25/23 an elopement drill was conducted by the Maintenance Director and Nurse Managers.
" Wandering assessment and wandering care plans are updated weekly and as needed by the Director of Nursing and Nurse Managers with new admissions and readmissions beginning on 5/26/23.
" The Maintenance Director monitored exit doors daily for two weeks followed by 5 days a week to ensure locking mechanisms are in place and functioning.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
" On 5/26/23 the plan to correct was reviewed

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F 689	Continued From page 16 with the Interdisciplinary team by the Administrator and Director of Nursing during the morning meeting as part of the QAPI process. " The Maintenance Director and Director of Nursing will report the results of this monitoring during the monthly QAPI meeting and recommendations made by the committee as needed. Effective 5/27/23 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Plan of Correction Completion Date: 5/27/23 On 07/21/23, the facility's corrective action plan effective 05/27/23 was validated by the following: Staff interviews revealed they had received education on the elopement policy, including to not leave a resident who has exited the building unattended. All staff were educated on notifying Administration immediately by a phone call if they have a resident who is missing from the facility and if they see a resident to remain with them. Wandering assessments were reviewed for all residents in the facility. Observations were conducted of all of the facility doors. The doors were observed to be locked with alarm systems in place. The facilities audit tools were reviewed and no other incidents were documented of the door system malfunctioning. The facility's action plan was validated to be completed as of 05/27/23.	F 689		

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