	-	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO.	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	.ETED
		345520	B. WING		C 03/0	;)5/2021
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 550 SS=D	from 03/01/21 throug conducted onsite on 0 through 03/05/21. Ex five complaint allegat resulting in deficienci Resident Rights/Exer	cise of Rights	F 550			3/30/21
	§483.10(a) Resident The resident has a rig self-determination, ar access to persons an	Rights. ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
	cally Signed				(03/26/2021

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.

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/15/2021 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345520	B. WING			-		C 05/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				10	28 BLAIR STREET			
PELICAN	HEALTH THOMASVILLE			Т	HOMASVILLE, NC 273	60		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 550	Continued From page §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, correprisal from the facilit rights and to be support exercise of his or her subpart. This REQUIREMENT by: Based on record revif family interview, the fac resident's dignity whe observed the resident wearing no clothing, b subsequently failed to request to cover and/of 45 minute time period respond to a family's of resident for a 1 hour t of 1 residents (Reside The findings included: Resident #1 was adm 12/23/20 and most re- with multiple diagnose (inflammation/infection	 1 illity must ensure that the his or her rights without , discrimination, or reprisal isident has the right to be bercion, discrimination, and ty in exercising his or her borted by the facility in the rights as required under this is not met as evidenced ew, staff interview, and acility failed to maintain a n a family member e during a window visit brief, or other covering and to respond to the family's brief could be the resident for a . The facility also failed to request to reposition a ime period. This was for 1 ent #1) reviewed for dignity. itted to the facility on cently readmitted on 1/8/21 es that included mastoiditis n of the mastoid bone r), spinal stenosis, and 		550	D	o longer a resident a h potential to be ed on 3/17/21 to sidents were noted to briefs, or other ndow visits or e visitation. No other ies or Responsible regarding appropria imeliness response ng assistance. vere in serviced on ctor of Nursing on th ring that all resident dressed in briefs an s positioning proper identified to be ss, not properly	at o er ite for s d ly.	
	Record (EMR) indicat	in the Electronic Medical ed family member #1 and re emergency contacts.			Staff will immediate of Nursing will moni dress, briefs, and co positioning for all re	ly assist. The Direct itor for appropriate overings, proper		

Facility ID: 20020005

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		IO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· · /	G	(´coi	MPLETED
		245520	B. WING			С
	ROVIDER OR SUPPLIER	345520	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2021
NAME OF P	ROVIDER OR SUPPLIER			1028 BLAIR STREET	-	
PELICAN	HEALTH THOMASVILLE			THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 550	The admission Minim	um Data Set (MDS)	F 5	50		
	 The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) and the mood interview were not completed. The behavior section (Section E) was also not completed. Resident #1 was assessed as requiring the limited assistance of 1 with bed mobility, transfers, dressing, toileting, and personal hygiene. Locomotion and walking had not occurred during the MDS review period. Resident #1 was occasionally incontinent of bladder. The EMR indicated that Resident #1 was discharged home at the resident and family 's request on 1/22/21. A review of Resident #1 's care plan from his initial admission on 12/23/20 through his 			4. This will be monitored 4 tim for 4 weeks. 3 times per week weeks, and 1 time per week for The results of this process will reviewed monthly in Quality A Performance Improvement Me Interdisciplinary team for 3 mo	for 4 or 4 weeks. be ssurance eeting by the	
	mention of his needs Living (ADL) care. The revealed no informati Resident #1. An interview was con	revealed there was no related to Activity of Daily le care plan additionally on related to behaviors for ducted with the Social 21 at 1:00 PM. She was				
	asked if she was fam revealed she had new spoken to him. She e diagnosed with COVI admitted to the facility with residents while the She reported that she of Resident #1 's fam visits when he was at indicated that there w	iliar with Resident #1. She ver met Resident #1 or explained that he was D-19 shortly after being y and she had not visited hey were COVID positive. was aware that members hily made frequent window				

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	MENT OF HEALTH AN						FORM): 04/15/2021 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345520	B. WING					C 05/2021
NAME OF F	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COL	DE		
				1	028 BLAIR STREET			
PELICAN	HEALTH THOMASVILLE			Т	HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 550	upset that Resident # wheelchair and she w She explained that far with Resident #1 from observed him by wind that one of the nurses mentioned this phone how she knew family stated that after this p transferred by nursing his bed within a few n A phone interview wa #1 's family member Family member #1 sp history prior to being a indicated that Resider humble, and conserva when he was at home dressed and neatly gr during the time Resid either he or family me Resident #1 by windo every time he visited wearing a hospital go never seen Resident clothes. Family mem there was one instance #2 told him that she a Resident #1 laying in window. He reported very embarrassing for member #1 indicated passed away and was experience. He was a the facility about this of	1 was sleeping in his ranted him put him in bed. mily member #2 was visiting o outside of the facility and low visit. The SW reported s, unable to recall who, had c call to her and that this was member #2 was upset. She shone call Resident #1 was g staff from his wheelchair to ninutes. s conducted with Resident #1 on 3/2/21 at 12:19 PM. woke about Resident #1 's admitted to the facility. He nt #1 was a very proud, ative man. He stated that e he was always well roomed. He indicated that ent #1 was at the facility that ember #2 visited with w daily. He revealed that by window, Resident #1 was wn. He stated that he had #1 dressed in actual ber #1 further revealed that ce in which family member rrived at the facility and saw bed fully nude through the that this would have been r Resident #1. Family that Resident #1 has since s unable to speak about this asked if he had spoken to concern. He revealed that ecifically about this issue.	F	550				

Facility ID: 20020005

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CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345520 B. WING _		C 03/05/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET	
PELICAN HEALTH THOMASVILLE	THOMASVILLE, NC 27360	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D 475
 F 550 Continued From page 4 complaining to the facility would cause Resident #1 to be treated in a negative manner. He further explained that there were some other concerns family member #2 had observed during her window visits so rather than bringing these concerns to the facility 's attention he and family member #2 decided to remove Resident #1 from the facility. Family member #1 suggested that family member #2 be interviewed for additional information. He was asked if he was made aware of any behaviors for Resident #1 and he stated that he had not been made aware of any behaviors. A phone interview was conducted with Resident #1 's family member #2 on 3/2/21 at 1:13 PM. She stated that there was a 4 day period from 1/15/21 through 1/18/21 that she visited Resident #1 by window daily. She reported that on Friday 1/15/21 when she arrived at the facility for the window visit she had to call the facility to request for them to open the window blinds. She indicated that on Saturday 1/16/21 when she arrived at the facility for here window visit, Resident #1 's blinds were open and she saw him through the window laying on his bed nude. She indicated he had nothing covering him, not even a brief. Family member #2 revealed that she phoned the facility and asked the person who answered, unable to recall who this was, to either have someone dress or cover Resident #1 as she could see from outside of his window that he was completely nude. She reported that it took 45 minutes from her first call for a staff member to enter Resident #1 's room and cover him. She explained that she had to call 2 additional times before a staff member tatended to Resident #1 's needs. She stated that it was daylight outside, 	550	

Facility ID: 20020005

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A BOILDING			С
		345520	B. WING		0;	3/05/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	but she was unsure of incident and she was staff member was that as she had never me because she was not due to their visitation #2 was asked if Resid from outside of the but there were parking sp but she had not belief been visible from the was a grassy area be and the facility buildir although others may bed, Resident #1 wor embarrassed for her condition as he was a conservative man. Fa that on Monday 1/18/ facility for a window v	of the exact time of this unable to state who the at attended to Resident #1 t any of the staff members permitted inside the facility restrictions. Family member dent #1 was visible to others uilding. She stated that baces outside of his room, ved Resident #1 would have parking spaces as there etween the parking spaces ng. She reported that not have seen him nude in uld have been very to witness him in that	F 55	50		
	and he was "slumped down towards his che knocking on the wind Resident #1 was not She indicated she ph for someone to transf was afraid he was go wheelchair. Family n additional calls during a staff member entern Resident #1. She ad phone call she was a calls being ignored an with whoever she spo stated that after this 3 member finally came	d over" with his head bent est. She stated that she tried ow to get his attention, but responsive to her knocks. oned the facility and asked fer him to his bed as she ing to fall out of the nember #2 revealed it took 2 g a 1 hour timeframe before ed the room to assist ded that during her 3rd ngry due to her previous 2 nd she had used profanity oke with on the phone. She				

Facility ID: 20020005

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/15/2021 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345520	B. WING		_	(03/	。 05/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 273	360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	unsure of the exact tin was unable to state w that attended to Reside met any of the staff m Based on the schedul working on Resident a during the 7:00 AM to included Nurse #2, M Nursing Assistants (N A phone interview wat on 3/2/21 at 4:15 PM reached. A phone interview wat 3/3/21 at 8:50 AM. N with Resident #1 regu facility and she thoug Resident #1 on Sature that he needed assist Daily Living (ADLs). S included dressing. Sf #1 had a behavior of t throwing them on the he was sometimes dr because he normally himself. The 1/16/21 #1 was observed by f window visit to be lyin brief, and no covering 45 minutes for staff to reviewed with NA #1.	daylight outside, but she was me of this incident and she tho the staff member was dent #1 as she had never embers. We with assignments, staff #1 ' s unit on Friday 1/16/21 7:00 PM timeframe edication Aide (MA) #2, A) #1, #3, #4, and #5. Is attempted with Nurse #2 but she was unable to be s conducted with NA #1 on IA #1 stated that she worked ularly when he was at the ht she was assigned to day 1/16/21. She stated ance with most Activities of	F 550		DEFICIENCY)		
	1/16/21, but stated the NAs were working "sh	at there were times that the nort". She explained that ing "short" she was still able					

Facility ID: 20020005

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 04/15/2021 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345520	B. WING			-		C 05/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
PELICAN	HEALTH THOMASVILLE				028 BLAIR STREET HOMASVILLE, NC 2730	60		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 550	but it took longer to de call bells and/or call b requested tasks had t A phone interview was 3/3/21 at 1:35 PM but reached. A phone interview was 3/3/21 at 2:05 PM. M unable to recall anyth and she was also una A phone interview was 3/3/21 at 4:19 PM. N agency NA and she o 2 days. She confirme days she worked. Th Resident #1 was obse during a window visit clothes, no brief, and subsequently taking 4 to Resident #1 was re revealed that she cou specific incident from had not surprised her Resident #1 to receive explained that it was although she was able assigned tasks, it was would have liked to ar complete non-emerge A phone interview was 3/3/21 at 5:40 PM. NA	essential assigned tasks, o things such as answering ells were answered and the o be prioritized. a attempted with NA #3 on she was unable to be a conducted with MA #2 on A #2 reported that she was ing specific about 1/16/21 ble to recall Resident #1. a conducted with NA #4 on A #4 revealed she was an nly worked at the facility for d 1/16/21 was one of the e 1/16/21 incident in which erved by family member #2 to be lying in bed with no no covering and it 5 minutes for staff to attend eviewed with NA #4. NA #4 Id not remember this 1/16/21, but stated that it that it took 45 minutes for e assistance. She very busy that day and that e to complete her essential a taking longer than she nswer call bells and	F	550				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/15/2021 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345520	B. WING		_	(03/	C 05/2021
NAME OF PF	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	_	
PELICAN	HEALTH THOMASVILLE			028 BLAIR STREET	360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	working on Resident a 1/18/21 during the 7:0 included Nurse #3, M During a phone interv 8:50 AM she stated th assigned to Resident incident in which Resi family member #2 dur over" in his wheelchai 1 hour for staff to atter reviewed with NA #1. could not recall anyth 1/18/21 incident. She #1 was in his wheelch staff assistance to tran A phone interview was Aide (MA) #1 on 3/2/2 incident in which Resi family member #2 dur over" in his wheelchai 1 hour for staff to atter reviewed with MA #1. aware Resident #1 's window visits, but she specific incident from A phone interview was on 3/3/21 at 11:30 AM reached. A phone interview was 3/3/21 at 9:30 AM. N unable to recall anyth and she was also una	le with assignments, staff #1 's unit on Monday 00 AM to 7:00 PM timeframe A #1, NAs #1, #6, and #8. riew with NA #1 on 3/3/21 at hat she thought she was #1 on 1/18/21. The 1/18/21 ident #1 was observed by ring a window visit "slumped ir and it subsequently taking nd to Resident #1 was NA #1 revealed that she ing specific about this e indicated that if Resident hair he would have required nsfer to his bed. s conducted with Medication 21 at 3:45 PM. The 1/18/21 ident #1 was observed by ring a window visit "slumped ir and it subsequently taking nd to Resident #1 was MA #1 stated that she was a family made frequent e was unable to recall this 1/18/21 for Resident #1. s attempted with Nurse #3 I but she was unable to be s conducted with NA #6 on A #6 reported that she was ing specific about 1/18/21 able to recall Resident #1.	F 550				
	A phone interview was	s conducted with NA #8 on					

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345520	B. WING			С
	ROVIDER OR SUPPLIER	0.0020		TREET ADDRESS, CITY, STATE, ZIP CODE		3/05/2021
				028 BLAIR STREET		
PELICAN	HEALTH THOMASVILLE			HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 550 F 563 SS=D	Resident #1 was obs during a window visit wheelchair and it sub staff to attend to Resi NA #8. NA #8 reporter recall this specific inco Resident #1. She inco that the NAs were wo although she was abl assigned essential ta would ' ve liked to any bells were answered to be prioritized. During a phone interv on 3/4/20 at 3:40 PM incidents for Residen Administrator. The A although he was unal times reported by fan incident dates (1/16/2 and 1/18/21: 1 hour m have expected staff to needs as identified by 10 to 20 minutes dep were going on at the indicated that he expl be treated with dignity Right to Receive/Dem CFR(s): 483.10(f)(4) The resi visitors of his or her of her choosing, subject	he 1/18/21 incident in which erved by family member #2 "slumped over" in his sequently taking 1 hour for dent #1 was reviewed with ed that she was unable to ident from 1/18/21 for dicated that there were days orking "short" and that e to complete all of her sks it took longer than she swer call bells and/or call and the requested tasks had view with the Administrator the 1/16/21 and 1/18/21 t #1 were reviewed with the dministrator stated that ble to validate the response hilly member #2 for both 21: 45 minute response time esponse time) that he would to respond to the resident ' s y family member #2 within ending on what other events facility during that time. He ected the facility residents to y and respect at all times. by Visitors iii)-(v) ident has a right to receive choosing at the time of his or to the resident's right to applicable, and in a manner	F 550			3/30/21

Facility ID: 20020005

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/15/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345520	B. WING		C 03/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				1028 BLAIR STREET	
PELICAN	HEALTH THOMASVILLE			THOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 563	Continued From nor	- 10	F F0		
F 303	Continued From page		F 56	3	
		provide immediate access to			
	-	ate family and other relatives			
		ct to the resident's right to			
	deny or withdraw cor	•			
		provide immediate access to			
		who are visiting with the			
		nt, subject to reasonable strictions and the resident's			
		raw consent at any time;			
		provide reasonable access			
		entity or individual that			
		al, legal, or other services to			
	-	to the resident's right to deny			
	or withdraw consent	• •			
		nave written policies and			
		the visitation rights of			
	residents, including th	hose setting forth any			
	clinically necessary o	or reasonable restriction or			
	limitation or safety re	striction or limitation, when			
	such limitations may	apply consistent with the			
	requirements of this s	subpart, that the facility may			
	need to place on suc	h rights and the reasons for			
		restriction or limitation.			
		Γ is not met as evidenced			
	by:				
		iew, staff interview, and		1. Resident #1 is no longer a resi	dent at
		acility failed to honor a		the facility.	
		mpassionate care visitation			
	In accordance with gi Medicare and Medica	uidance from the Centers for		2. All Residents with potential to b affected were audited. No other re	
				were affected. All Residents and f	
		the facility's COVID-19 of 1 residents reviewed for		were affected. All Residents and f were notified Via Phone about	annings
	-	visitation (Resident #1).		compassionate care visitations in	
	Compassionale Gale			accordance with guidance from th	<u>م</u>
	The findings included	ł		Centers for Medicare and Medica	
		•-		Services (QSO-20-39-NH) and the	
	A Contone for Modice			, , ,	<u> </u>
	A Centers for Menica	re and Medicaid Services		facilities current visitation noticy	
		re and Medicaid Services 20-39-NH) dated 9/17/20		facilities current visitation policy.	

Facility ID: 20020005

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/15/202 ⁷ FORM APPROVEE MB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		345520	B. WING _			C 03/05/2021
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET		
				THOMASVILLE, NC 2736	0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 563	the heading of "Comp While end-of-life situal examples of compassionate exclusively refer to er Examples of other typ situations include, bu - A resident, who was before recently being is struggling with the lack of physical family - A resident who is gr member recently pass - A resident who need encouragement with provided by family an experiencing weight I - A resident, who use others, is experiencing seldom speaking, or of (when the resident has Allowing a visit in the consistent with the im care situations" Fu not an exhaustive list compassionate care situation A review of the facility Visitation Policy" last 9/29/20 under the head Care Visits" replicated	following information under passionate Care Visits": ations have been used as sionate care situations, the care situations" does not nd-of-life situations. Des of compassionate care t are not limited to: a living with their family admitted to a nursing home, change in environment and y support. ieving after a friend or family sed away. ds cueing and eating or drinking, previously d/or caregiver(s), is oss or dehydration. d to talk and interact with g emotional distress, crying more frequently ad rarely cried in the past). se situations would be tent of, "compassionate rthermore, the above list is as there may be other situations not included. / ' s policy titled "COVID 19 reviewed and reviewed on ading of "Compassionate d the above information from d 9/17/20 (QSO-20-39-NH).	F 5		care visitation during ill updates. The viced The n which includes Social Services hager, Activity Office Manager, or, Medical Records bing Director, and Jurse on guidelines on 3/5/21 ent/Unit manager and completed in-servicin n compassionate n guidelines. All e party will be notifie ne Compassionate ss. This will also be our/Care Plan es Director will ompassionate ss. This will be er week for 4 weeks. '4 weeks, and 1 time s. The results of this wed monthly in terformance ng by the	d g ed
	12/23/20 and most re with multiple diagnos	cently readmitted on 1/8/21 es that included mastoiditis n of the mastoid bone		Continue 20020005		

Facility ID: 20020005

If continuation sheet Page 12 of 28

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/15/2021 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345520	B. WING				。 05/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27	360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 563	diabetes mellitus type Resident #1 ' s care p focus are of the risk for well-being related to r to COVID-19. This ar and included the follor initiated on 12/24/20: new admission; encor communication with v psychosocial changes changes in mental sta stressors; and provide expression of feelings stressors. The 5 day Minimum E dated 12/27/20 indica speech, was understo understands others. Mental Status (BIMS) not completed. The b was also not complete The admission Minim assessment dated 1/1 had clear speech, was understands others. interview were not cor section (Section E) was A review of the facility revealed Resident #1 COVID-19 on 1/13/21	r), spinal stenosis, and 2. Jan included, in part, the pralteration in psychosocial estriction on visitation due rea was initiated on 12/24/20 wing interventions, also all contact isolation related to urage alternative isitors; monitor for s; observe and report any atus caused by situational e opportunities for a related to situational Data Set (MDS) assessment ted Resident #1 had clear bod by others and The Brief Interview for and mood interview were behavior section (Section E) ed. um Data Set (MDS) 12/21 indicated Resident #1 s understood by others and The BIMS and the mood mpleted. The behavior as also not completed. r's COVID-19 testing log tested positive for	F 56				
) note dated 1/18/21 ntacted by Resident #1 ' s o reported he wished to					

Facility ID: 20020005

If continuation sheet Page 13 of 28

-					FORM): 04/15/2021 MAPPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345520	B. WING		_	C 03/05/2021	
ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	00,	
		1	028 BLAIR STREET			
HEALTH THOMASVILLE		т	HOMASVILLE, NC 273	360		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
Continued From page	13	F 563				
	•					
meeting was conduct family member #1 atte	ed for Resident #1 and ended by phone and					
with Resident #1 's fa	mily member and he					
#1 was discharged ho The nurse wrote that	me with family member #1. Resident #1 was happy and					
3/1/21 at 1:00 PM. S facility 's protocol wa visits. She stated that permitting indoor visit at the very end of life/ revealed there were r to have compassiona asked if she was awa was for compassiona indicated that she wa information. The SW familiar with the facilit compassionate care v was not certain what reiterated that the fac compassionate care v at the very end of life.	he was asked what the s for compassionate care the facility was only ation for residents who were actively dying. She to other residents permitted te care visits. The SW was re what the CMS guidance te care visits and she s not familiar with this was asked if she was y ' s policy for visits and she revealed she this policy said. She lifty was only permitting visits for residents who were She added that families					
	ROVIDER OR SUPPLIER HEALTH THOMASVILLE SUMMARY STA (EACH DEFICIENCIES REGULATORY OR L Continued From page discharge the residen meeting was schedule discharge planning. A SW note dated 1/19 meeting was conducte family member #1 atte discharge planning was A SW note dated 1/21 with Resident #1 's fa wished to have Resid home on 1/22/21. A nursing note dated #1 was discharge dated #1 was discharge dated met ing was conducted family member #1 atte discharge planning was A SW note dated 1/21 with Resident #1 's fa wished to have Resid home on 1/22/21. A nursing note dated #1 was discharged ho The nurse wrote that excited to be returning An interview was cond 3/1/21 at 1:00 PM. SI facility 's protocol was visits. She stated that permitting indoor visits at the very end of life/ revealed there were m to have compassional asked if she was awa was for compassional indicated that she was information. The SW familiar with the facilit compassionate care w at the very end of life. who voiced an interest	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345520 ROVIDER OR SUPPLIER HEALTH THOMASVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 discharge the resident to his home. A care plan meeting was scheduled for 1/19/21 to discuss discharge planning. A SW note dated 1/19/21 indicated a care plan meeting was conducted for Resident #1 and family member #1 attended by phone and discharge planning was discussed. A SW note dated 1/21/21 indicated she spoke with Resident #1 's family member and he wished to have Resident #1 discharged to his	RESPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345520 B. WING	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIENCIES CONTRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: 345520 B. WING ROVIDER OR SUPPLIER HEALTH THOMASVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 discharge the resident to his home. A care plan meeting was scheduled for 1/19/21 to discuss discharge planning. A SW note dated 1/19/21 indicated a care plan meeting was conducted for Resident #1 and family member #1 attended by phone and discharge planning was discussed. A SW note dated 1/21/21 indicated she spoke with Resident #1 's family member and he wished to have Resident #1 discharged to his home on 1/22/21. A nursing note dated 1/22/21 indicated Resident #1 was discharged home with family member #1. The nurse wrote that Resident #1 was happy and excited to be returning home. An interview was conducted with the SW on 3/1/21 at 1:00 PM. She was asked what the facility 's protocol was for compassionate care visits. She stated that the facility was only permitting indoor visitation for residents who were at the very end of life/actively dying. She revealed there were no other residents who were at the very end of life/actively dying. She revealed that she was not familiar with this information. The SW was asked she was familiar with the facility was only permitting compassionate care visits and she revealed she was not certain what this policy said. She reiterated that the facility was only	SPOR MEDICARE & MEDICAID SERVICES OF DEFINICIENCIES (x1) PROVIDERVALPPLIERCULA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING INTELETADRESS, CITY, STATE, JP CODE 345520 Intelline REALTH THOMASVILLE ISTREET ADDRESS, CITY, STATE, JP CODE IEACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC DEMINIFYING INFORMATION) PRECENTIFIC ADDRESS, CITY, STATE, JP CODE IEACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC DEMINIFYING INFORMATION) PRECENTIFIC ADDRESS, CITY, STATE, JP CODE Continued From page 13 ID PRECENTIFIC ADDRESS PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BY CONTINUE ADDRESS PLAN OF CORRECTIVE ACTION SHOLD BY CONTINUE ADDRESS PLAN OF CORRECTIVE ACTIONATION) F 563 Continued From page 13 F 563 discharge planning. A SW note dated 1/19/21 indicated a care plan meeting was scheduled for 1/19/21 to discuss discharge planning was discussed. F 563 A SW note dated 1/12/21 indicated hes spoke with Resident #1 is family member and he wished to have Resident #1 discharged to his home on 1/22/21. F An unsing note dated 1/22/21 indicated Resident #1 was discharged home with family wember #1. F The nurse wrole that Resident #1 was happy and excited to be returning home. She stated that the facility was only permitting indoor visitation for residents who were at the vary end of lifeatively dying. She revaeled there was aware what the facility 's protocy for	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICAD SERVICES OMB NC or DEFICIENCIES OMB NC additional services of the service

Facility ID: 20020005

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	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	E SURVEY IPLETED	
			A. DOILDING			С	
		345520	B. WING		03/05/2021		
NAME OF P	ROVIDER OR SUPPLIER		- i	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 563	acknowledged that ou winter could be challe weather and cold term This interview with the asked if she was fami revealed she had new spoken to him. She ed diagnosed with COVI admitted to the facility with residents while th The SW revealed tha BIMS nor had she cor for Resident #1 so sh cognitive abilities or ha acknowledged that si spoken to Resident # determine how he wa She reported that she was very involved wit they made frequent w the facility. The SW w family had ever reque compassionate care w stated that they had r question, but that even not have been permit dying. The SW was a family had chosen to the completion of reha- she was not certain o A phone interview wa #1 's family member He reported that Resi going to the facility for	attoor visitation during the enging due to inclement operatures. e SW continued. She was iliar with Resident #1. She ver met Resident #1 or explained that he was D-19 shortly after being y and she had not visited hey were COVID positive. t she had not completed a mpleted a mood interview we was unable to speak to his his mood state. The SW nce she had never seen or 1 she was unable to us adjusting to the facility. e was aware that his family h his care decisions and that vindow visits while he was at was asked if Resident #1 ' s ested an indoor visit with the resident. She not specifically asked this en if they had asked, it would ted as he was not actively asked why Resident #1 ' s discharge him home prior to abilitation and she indicated	F 56				

If continuation sheet Page 15 of 28

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		IO. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /	G		IPLETED	
						с	
		345520	B. WING		0:	3/05/2021	
NAME OF P	ROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP COI		0/00/2021	
				1028 BLAIR STREET			
PELICAN	HEALTH THOMASVILLE			THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETIO DATE	
F 500		45					
F 563			F 56	53			
		culty adjusting to the facility					
		be at home. Family member					
		V told him that outdoor					
		on, but he had not wanted to					
		me outside during the winter					
		He indicated that he had not					
	-	ance allowed for indoor					
		visits so he had never asked					
	anyone at the facility						
		Family #1 reported that while					
		nt #1 had a decline in					
		that he appeared "sad"					
		. He explained that this was					
	-	and family member #2					
		discharge Resident #1					
	home prior to the con	npletion of rehabilitation.					
	A phone interview wa	as conducted with Resident					
		#2 on 3/2/21 at 1:13 PM.					
	She reported that Re	sident #1 was not in favor of					
	going to the facility fo	or rehabilitation, but he had					
	been talked into it by	the family. She indicated					
		nily member #1 visited with					
		ow daily. She reported that					
		culty adjusting to the facility					
		be at home. She stated that					
		riod from 1/15/21 through					
		ed daily and had observed a					
	-	servation and that Resident					
		ly a butter packet and a					
		out the entirety of these 4					
		She reported that she was					
		the window encouraging					
		n to eat, but she was unsure					
		even hear her. Family					
		ported that on one of these					
		served Resident #1 seated in					
	his wheelchair "sobbi	ing" and again she was trying					
		rds to him through the					

Facility ID: 20020005

If continuation sheet Page 16 of 28

CENTERS FOR MEDICARE & MEDICAID SERVICES OM	FORM APPROVED MB NO. 0938-0391	
	(X3) DATE SURVEY COMPLETED	
345520 B. WING	C 03/05/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN HEALTH THOMASVILLE 1028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 563 Continued From page 16 F 563 window. Family member #2 stated that family member #1 had been in touch with the SW and was told that outdoor visitation was an option, but they (the family) had not thought it was a good idea to make Resident #1 come outside during the winter weather conditions. She indicated that she had not known the CMS guidance allowed for indoor compassionate care visits so she had never asked anyone at the facility if she could visit with Resident #1 inside. During an interview with the Administrator on 31/121 at 12:14 PM he was asked what the facility 's policy was regarding compassionate care visits. He indicated that the needed to review the policy prior to speaking about it. A second interview was conducted with the Administrator on 31/121 at 12:14 21:04 PM. The Administrator stated that the facility was permitting indoor compassionate care visits for residents who were actively dying. He revealed that they had permitted no other compassionate care sisting aper with that they had permitted no other compassionate care sisting and that compassionate care visits for residents who were actively dying. He revealed that they had permitted no other compassionate care sisting and other compassionate care visits for residents who were actively dying. He revealed that they had permitted no other compassionate care visits of a necessary for reasons other than end of life situations had not exclusively referred to end of life situations what not exclusively referred to the administrator. The Administrator reported that he was aware the guidance related to visitation allowed for compassionate care visit. The Administrator was asked who determined to require a compassionate care visit and no residents who were determined to require a compassionate care visit and no residents who were determined to require a compassionate care visit. The		

Facility ID: 20020005

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				E CONSTRUCTION		10.0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	· · · ·	E SURVEY IPLETED	
			A. DOILDING			с	
		345520	B. WING		03/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
			1028 BLAIR STREET				
PELICAN	HEALTH THOMASVILLE			THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 563	Continued From page	a 17	F 563				
1 303		uested to speak about	F 303	5			
		visits again on 3/1/21 at 2:45					
		t after speaking with staff he					
	learned that care plar	n meetings were the time					
		d if a compassionate care					
	visit was determined						
	plan meetings. The i	/ was in charge of the care					
		at 1:00 PM in which she					
		protocol was to permit					
		visits only for residents who					
	were at the end of life	e was reviewed with the					
		knowledged that up through					
	this date, 3/1/21, ther						
	compassionate care	visits conducted for any					
	reason other than en	d of life.					
	A phone interview wa	is conducted with Medication					
	Aide (MA) #1 on 3/2/2	21 at 3:45 PM. She reported					
		with Resident #1. She					
		at the facility for short term					
		t he was alert and oriented confusion. MA #1 stated					
		frequently by window visit					
		acility. She revealed that the					
		tting any indoor visitation for					
	any residents unless	they were actively dying.					
	During a follow up int	erview with the Administrator					
		t 3:40 PM he stated that he					
	expected the CMS gu						
	compassionate care						
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) ł)(i)-(iv)(15)	F 580			3/30/21	
	§483.10(g)(14) Notific						
		ediately inform the resident;					
	consult with the resid						

Facility ID: 20020005

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HUMAN SERVICES				FORM	: 04/15/2021 APPROVED
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE S COMPL	SURVEY .ETED
345520	B. WING		_		;)5/2021
	· [STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		1028 BLAIR STREET THOMASVILLE, NC 273	360		
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE) CROSS-REFEREI	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
18 er authority, the resident there is- ing the resident which is the potential for requiring is in the resident's physical, I status (that is, a mental, or psychosocial atening conditions or itment significantly (that is, in existing form of se consequences, or to of treatment); or er or discharge the y as specified in ration under paragraph (g) is facility must ensure that is specified in §483.15(c)(2) ed upon request to the so promptly notify the int representative, if any, it roommate assignment (e)(6); or it rights under Federal or is as specified in paragraph cord and periodically alling and email) and esident	F 5	580			
	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 8 8 er authority, the resident there is- g the resident which the potential for requiring e in the resident's physical, status (that is, a mental, or psychosocial atening conditions or ment significantly (that is, n existing form of se consequences, or to of treatment); or er or discharge the v as specified in ation under paragraph (g) e facility must ensure that specified in §483.15(c)(2) d upon request to the o promptly notify the nt representative, if any, r roommate assignment (e)(6); or t rights under Federal or as specified in paragraph cord and periodically align and email) and sident	EDICAID SERVICES (X2) MULT IDENTIFICATION NUMBER: (X2) MULT 345520 B. WING_ EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL ID PREFID CIDENTIFYING INFORMATION) 8 F 5 er authority, the resident there is- g the resident which the potential for requiring ID PREFID TAG a in the resident 's physical, the potential for requiring ID PREFID TAG e in the resident which the resident which the potential for requiring ID PREFID TAG e in the resident which the resident which the potential for requiring ID PREFID TAG e in the resident which the resident which the potential for requiring ID PREFID TAG e in the resident which the resident 's physical, the status (that is, a mental, or psychosocial atening conditions or ID PREFID TAG e in the resident 's physical, tation under paragraph (g) e facility must ensure that specified in §483.15(c)(2) d upon request to the o promptly notify the nt representative, if any, r roommate assignment (e)(6); or t rights under Federal or a specified in paragraph cord and periodically alling and email) and sident ite distinct part. A facility	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345520 B. WING B. WING	HUMAN SERVICES EDICAID SERVICES I) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER: 345520 B. WING STREET ADDRESS.CITY, STATE, ZIP CODE 1028 BLAR STREET THOMASVILLE, NC 27360 INST BE PRECEDED BY FULL 2:DENTIFYING INFORMATION) B. WING END OF DEFICIENCIES NUTS BE PRECEDED BY FULL 2:DENTIFYING INFORMATION) B. WING END OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCE TO THE APPROPRIA DEFICIENCY) B. B. er authority, the resident there is- g the resident which there is, g the resident's physical, istatus (that is, a mental, or psyclosocial atening conditions or ment significantly (that is, n existing form of se consequences, or to of treatment); or er or discharge the /as specified in ation under paragraph (g) e facility must ensure that specified in §483.15(c)(2) d upon request to the o promptly notify the rt representative, if any, rroommate assignment (e)(6); or t rights under Federal or .as specified in paragraph cord and periodically ulling and email) and sident ite distinct part. A facility	HUMAN SERVICES FORM EDICAID SERVICES OMB NO DENTFICATION NUMBER: 345520 B. WING 345520 B. WING 345520 B. WING 345520 B. WING C 345520 B. WING C 345520 B. WING C 345520 B. WING C 1028 BLAIR STREET THOMASVILLE, NC 27360 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES OF POLL IDENTFIVING INFORMATION) TAG C B C C C C C C C C C C C C C

Facility ID: 20020005

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				TID! -			D. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· /	E SURVEY PLETED	
			/		с			
		345520	B. WING			03/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN	HEALTH THOMASVILLE	1			028 BLAIR STREET 'HOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOT TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETIO DATE	
F 580	Continued From page	e 19	F	580				
		e in its admission agreement		000				
		tion, including the various						
	locations that compris	se the composite distinct						
		y the policies that apply to						
	-	en its different locations						
	under §483.15(c)(9).							
	by:	is not met as evidenced						
	-	iew and interviews with			1. Resident #1 is no longer a resident	at		
		n, and Registered Dietician,			the facility.			
	the facility failed to no	-						
	-	representative of a change in condition that			2. All Residents with the potential to be			
	included an altered m			affected were audited on 3/20/21 By Th				
	hospitalization and al			Minimum Data set Nurse to verify if the				
		cant decline in nutritional neal refusals for 1 of 1			was any significant change. No resider were found to have experienced a	us		
		(1) reviewed for notification			significant change.			
	of changes.							
	5				3. 100% of staff were in-serviced on			
	The findings included	1:			3/24/21 by Director of Nursing about			
					notifying families and responsible partie			
		dmitted to the facility on			when change in condition is current. Al			
		ecently readmitted on 1/8/21			residents who have a significant chang	е		
		es that included mastoiditis on of the mastoid bone			of conditions Responsible Party and Medical Director will be notified by the	unit		
		ar), spinal stenosis, and			nurse. The Director of Nursing will mon			
	diabetes mellitus type				the process of responsible parties bein			
					notified of significant changes. This	-		
	-	ofile in the Electronic			monitoring will be reviewed in daily			
		R) indicated he was his own			morning clinical meetings and as neede	ed.		
		RP). Family member #1 was			4. This will be menitored 4 times per un	ook		
	listed as emergency of member #2 was listed	d as emergency contact #2.			4. This will be monitored 4 times per we for 4 weeks. 3 times per week for 4	CCK		
		a as emergency contact #2.			weeks, and 1 time per week for 4 week	s.		
	The 5 day Minimum [Data Set (MDS) assessment			The results of this process will be			
	-	ated Resident #1 had clear			reviewed monthly in Quality Assurance			
	speech, was understo	-			Performance Improvement Meeting by			
		The Brief Interview for			Interdisciplinary team for 3 months.			
	Mental Status (BIMS)) was not completed.					1	

Facility ID: 20020005

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/15/2021 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345520	B. WING		_		_ 05/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
PELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET	360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	20	F 580				
	Nurse #1 indicated Re during the day which was noted with a decr call physician was not received to send Resi Department (ED) for e Medical Services (EM transported Resident A hospital transfer sur at 11:16 PM complete Resident #1 was bein altered mental status. titled "Key Contacts" a the key contact and in notified of the transfer no other family memb were notified of the ho A phone interview was Worker on 3/1/21 at 1 she had never met Re could not speak to his that he had 2 family m and family member #2 his care decisions and with family member #2 notifications such as 0 A phone interview was 12:19 PM with Reside He stated that he was Resident #1 and that	mmary form dated 12/27/20 ed by Nurse #1 indicated g sent to the hospital for This form had a section and listed Resident #1 as indicated he, himself, was to the hospital. There were bers noted on the form who ospital transfer. s conducted with the Social :00 PM. She revealed that esident #1 in person and a cognition. She indicated nembers, family member #1 2, who were involved with d that she kept in contact					
	Resident #1 ' s transfe	that he was not notified of er to the hospital on d that on the following day,					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/15/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345520	B. WING		_	C 03/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DELICAN	HEALTH THOMASVILLE			1028 BLAIR STREET			
PELICAN				THOMASVILLE, NC 273	60		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	the facility in the late a speak with Resident # wasn ' t there because hospital. Family mer he or family member a contacted as Residen where he, himself, co A phone interview waa 1:13 PM with Resider She confirmed family that they had not been transfer to the hospita additionally confirmed she was with family m the facility to speak w told he had been sent member #2 stated that member #1 should hat Resident #1 was not in himself, could have not A phone interview waa on 3/2/21 at 1:50 PM. no recollection of Res 12/27/20 were review that although she cout that normally if there was involved with the reside emergency contact, the member regardless of the time of the transfer if she had notified Res of the transfer to the hosp She was unable to ex notified Resident #1 '	ember #2 and they phoned afternoon/early evening to 41 and they were told he e he was sent to the nber #1 stated that he felt #2 should have been t #1 was not in a condition uld have notified his family. s conducted on 3/2/21 at at #1 's family member #2. member #1 's statement in notified of Resident #1 's al on 12/27/20. She t that on the following day, member #1 and they called ith Resident #1 and were to the hospital. Family at she felt she or family to been contacted as in a condition where he, potified his family. s conducted with Nurse #1 Nurse #1 stated she had ident #1. Her notes from ed with her. She reported Id not recall this resident,	F 58				
	She was unable to ex	plain why she had not					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	E SURVEY PLETED	
		345520	B. WING			C 03/05/2021		
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN	HEALTH THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG				G PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 580	A phone interview wa Administrator on 3/4/2 asked what the facility notification of family v cognitively intact was change in mental stat confusion and decrea Administrator indicate for a designated fami significant changes in status, such as hospi resident may not be a personally. He furthe should have notified f	s conducted with the 21 at 3:40 PM. He was y 's protocol was for when a resident who was sent to the hospital for a tus that included increased used responsiveness. The ed the facility 's protocol was ly member to be notified of the resident 's health tal transfers, because the able to notify them or indicated that Nurse #1	F	580	D			
	 1b. The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated Resident #1 had clear speech, was understood by others and understands others. The Brief Interview for Mental Status (BIMS) was not completed. The behavior section (Section E) was also not completed. Resident #1 was assessed as independent with set up assistance only for eating. He was 182 pounds with no significant weight loss noted. The Care Area Assessment (CAA) related to nutrition for the 1/12/21 MDS indicated Resident #1 was on a therapeutic diet which could affect his meal intake, he had a high Body Mass Index (BMI) and was currently eating less than 75 percent (%) most of the time. He was to be care planned for nutrition due to low meal intake and the risk for unplanned weight loss. Resident #1 was also to be referred to the Registered 							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345520	B. WING			C 03/05/2021		
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PELICAN	HEALTH THOMASVILLE				1028 BLAIR STREET THOMASVILLE, NC 27360			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE	
F 580	of a nutritional problem less than 75% and the area was initiated and The interventions, init monitoring/document signs or symptoms of pocketing, choking, co food in mouth, several refusing to eat, or app concerned during me as ordered and monit record every meal. A Registered Dietician indicated Resident #1 no added salt diet wit consuming approxima ate independently and chewing/swallowing of An Occupational The 1/15/21 indicated Resident to eat. A nursing note dated #2 indicated Resident he drank fluids. A review of Resident from 1/8/21 through 1 a regular, no added s no nutritional supplen	low meal intake. I an included the focus area m related to meal intake e risk for weight loss. This d last revised on 1/13/21. iated on 1/13/21, included: ing/reporting as needed any dysphagia such as oughing, drooling, holding al attempts at swallowing, bearance of being als; and provide/serve diet or nutritional intake and n (RD) note dated 1/11/21 was on a regular-textured h thin liquids and he was ately 26-100% of meals. He d had no lifficulties noted. rapy (OT) note dated sident #1 ' s lunch meal was he stated he had no appetite 1/16/21 completed by Nurse t had no appetite to eat, but #1 ' s physician ' s orders /22/21 indicated he was on alt diet, and he was ordered	F	580				
	from 1/8/21 through 1	/22/21 was reviewed and nutritional intake resulting in						

Facility ID: 20020005

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/15/2021 APPROVED). 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
345520			B. WING	B. WING				C 03/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE			
PELICAN	HEALTH THOMASVILLE				028 BLAIR STREET HOMASVILLE, NC 2736	60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 580	through the dinner me Assistant (NA) nutritic revealed the following - 1/15/21 resident - 1/16/21 resident and there was no doc - 1/17/21 there wa breakfast or lunch inta 25% of dinner - 1/18/21 he consu	with no nutritional the dinner meal on 1/15/21 eal on 1/18/21. The Nursing onal intake documentation j:	F 5	80					
	 #1 's family member She stated that she co from 1/15/21 through meal during each obs Resident #1 consume each meal she observ meal she saw him ear a separate meal he di food. A phone interview wa on 3/2/21 at 4:15 PM reached. Based on the schedul information provided 1 3/4/21 at 1:31 PM NA Resident #1 on 1/15/2 	by the Administrator on							

Facility ID: 20020005

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STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 345520 B. WING C 03/05/2021 NAME OF PROVIDER OR SUPPLIER 345520 STREET ADDRESS, CITY, STATE, ZIP CODE C PELICAN HEALTH THOMASVILLE STREET ADDRESS, CITY, STATE, ZIP CODE C 03/05/2021 ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE C ICACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX PROVIDERS PLAN OF CORRECTION (EACH ODERCETIVE ACTION SHOULD BE ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX PROVIDERS PLAN OF CORRECTION (CS) Y Continued From page 25 F 580 F 580 F 580 F 580 F 580 F bate dual to Aide (MA) was to be notified. NA #1 indicated a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake doccumentation from 1/15/21, 1/16/21, and 1/16								FORM	D: 04/15/2021	
345520 B. WING 03/05/2021 NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH THOMASVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAR STREET THOMASVILLE, NC 27360 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) F 580 Continued From page 25 A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for 1/16/21 and the was unable to explain why there was no documentation of dinner intake With Was was not documentation of discumentation of dinner intake								· · ·		
PELICAN HEALTH THOMASVILLE 1028 BLAR STREET THOMASVILLE, NC 27360 (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x) F 580 Continued From page 25 A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for Resident #1 vere reviewed with NA #1. NA #1 indicated she had no recollection of documenting meal refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake	345520			B. WING	B. WING					
PELICAN HEALTH THOMASVILLE THOMASVILLE, NC 27360 (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 SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY F 580 Continued From page 25 A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for Resident #1 were reviewed with NA #1. NA #1 indicated she had no recollection of documenting meal refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake	NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE			
THOMASVILLE, NC 27360 (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 OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE F 580 Continued From page 25 A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that he recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional 1/18/21 for Resident #1 were reviewed with NA #1. NA #1 indicated she had no recollection of documenting meal refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake					1	1028 BLAIR STREET				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 580 Continued From page 25 A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for Resident #1 were reviewed with NA #1. NA #1 indicated she nad on recollection of documentation grad refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake	PELICAN	HEALTH THOMASVILLE			1	THOMASVILLE, NC 273	360			
A phone interview was conducted with NA #1 on 3/3/21 at 8:50 AM. She reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #1 indicated she recalled Resident #1 and she worked with him several times while he was at the facility. She was unable remember any instance that Resident #1 completely refused a meal. She stated that she recalled that there were days that he had very poor intake and she tried to encourage him to eat, but this was not always successful. The nutritional intake documentation from 1/15/21, 1/16/21, and 1/18/21 for Resident #1 were reviewed with NA #1. NA #1 indicated she had no recollection of documenting meal refusals for Resident #1 on 1/15/21 or 1/16/21 and she was unable to explain why there was no documentation of dinner intake	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		COMPLETION	
 on 1/16/21 or lunch and dinner on 1/18/21. NA #1 was asked if she informed the nurse and/or MA on the unit of Resident #1 's poor nutritional intake and she reported that she thought she had mentioned this to the nurse or MA, but she was unable to recall with certainty. A phone interview was conducted with NA #2 on 3/3/21 at 5:34 PM. He reported that nutritional intake was supposed to be documented for every meal and if a resident refused a meal the Nurse or Medication Aide (MA) was to be notified. NA #2 stated that he was unable to recall Resident #1. He added that assignments frequently changed and he may have only worked with this resident once or twice as he was agency staff. The nutritional intake documentation from 1/17/21 for Resident #1 were reviewed with NA #2. He indicated that there were times that he was very busy with his tasks on the floor and he was 	F 580	A phone interview wa 3/3/21 at 8:50 AM. Si intake was supposed meal and if a resident or Medication Aide (M #1 indicated she reca worked with him seve the facility. She was instance that Residen meal. She stated tha were days that he had tried to encourage hir always successful. T documentation from 1 1/18/21 for Resident # #1. NA #1 indicated si documenting meal ref 1/15/21 or 1/16/21 an why there was no doc on 1/16/21 or lunch af was asked if she infor on the unit of Resider intake and she report mentioned this to the unable to recall with of A phone interview wa 3/3/21 at 5:34 PM. He intake was supposed meal and if a resident or Medication Aide (M #2 stated that he was #1. He added that as changed and he may resident once or twice The nutritional intake for Resident #1 were indicated that there w	is conducted with NA #1 on he reported that nutritional to be documented for every t refused a meal the Nurse MA) was to be notified. NA illed Resident #1 and she eral times while he was at unable remember any at #1 completely refused a t she recalled that there d very poor intake and she in to eat, but this was not the nutritional intake M/15/21, 1/16/21, and #1 were reviewed with NA she had no recollection of fusals for Resident #1 on ad she was unable to explain cumentation of dinner intake ind dinner on 1/18/21. NA #1 rmed the nurse and/or MA at #1 's poor nutritional ed that she thought she had nurse or MA, but she was certainty. is conducted with NA #2 on e reported that nutritional to be documented for every t refused a meal the Nurse MA) was to be notified. NA is unable to recall Resident ssignments frequently have only worked with this e as he was agency staff. documentation from 1/17/21 reviewed with NA #2. He vere times that he was very	F	580					

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		ID HUMAN SERVICES				FORM	: 04/15/2021 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
345520			B. WING			C 03/05/2021		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
PELICAN	HEALTH THOMASVILLE			028 BLAIR STREET HOMASVILLE, NC 273	60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	unable to recall if he r nutritional intake on 1 on the unit. Based on the Medica (MAR) the following N (MAs) worked with Re through 1/18/21: - 1/15/21: MA #1 - 1/16/21: Nurse # - 1/18/21: Nurse # - 1/18/21: MA #1 A phone interview wa 3/2/21 at 3:45 PM. M with Resident #1 and his assigned NA repo food during a meal. S made aware of this in relayed the informatic were working. She ad agency nurses workin time period and she w spoke with. A phone interview wa on 3/3/21 at 11:30 AM reached. A phone interview wa on 3/3/21 at 9:13 AM reached. A phone interview wa Manager (DM) on 3/2 asked if she had beer #1 's minimal oral interview and the set of the set o	s documentation. He was reported Resident #1 ' s poor /17/21 to the nurse or MA tion Administration Record Jurses/Medication Aides esident #1 from 1/15/21	F 580					

Facility ID: 20020005

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						FORM	04/15/2021 APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
345520			B. WING		_	C 03/05/2021				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE					
PELICAN HEALTH THOMASVILLE			1028 BLAIR STREET THOMASVILLE, NC 27360							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 580	DM indicated that dur out sick so she was u A phone interview wa 3/2/21 at 2:35 PM. Sh been made aware of 1 intake from the dinner the dinner meal on 1/ she had not been may The RD reported that aware of this informat reassessed the reside added a nutritional su Resident #1 ' s calorio A phone interview wa #1 ' s physician on 3/2 asked if she had beer #1 ' s minimal oral inta 1/15/21 through the d physician stated that so of this information. SI expected to be notifie that normally the staff information with her s resident and determin necessary with his pla A phone interview wa Administrator on 3/4/2 interview the NA docu intake for Resident #1 1/18/21 was reviewed indicated that he wou physician and/or the F	ing this timeframe she was naware of this information. Is conducted with the RD on the was asked if she had Resident #1 's minimal oral remeal on 1/15/21 through 18/21. She indicated that de aware of this information. if she had been made ion she could have ent and possibly would 've pplement to increase to intake. Is conducted with Resident 2/21 at 3:23 PM. She was in made aware of Resident ake from the dinner meal on inner meal on 1/18/21. The she had not been informed the reported that she d of this information and would share this type of to she could reassess the re if any changes were an of care. Is conducted with the 21 at 3:40 PM. During this imentation of nutritional from 1/15/21 through with the Administrator. He d have expected the RD to be made aware of as well as minimal oral	F 580							

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