DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		(X3) DATE SURVEY COMPLETED
		345134	B. WING		C 04/24/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PELICAN	HEALTH RANDOLPH LL	с		801 RANDOLPH ROAD CHARLOTTE, NC 28211	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	from 3/10/2024 to 3/1 The following intakes NC00214272 and NC complaint allegations	c00214282. 2 of the 8 resulted in deficiency.			
	Immediate Jeopardy 483.25 at tag F689	was identified at CFR			
	483.25 at tag F684 at	was identified at CFR fter the case was transferred are and Medicaid Services			
	Past-noncompliance	was identified at:			
		684 at a scope and severity J 689 at a scope and severity J			
	Tags F684 and F689 Quality of Care.	constituted Substandard			
	A partial extended su	rvey was conducted.			
F 554 SS=D	due to notification of t Resident Self-Admin	was changed to 4/24/2024 the facility of the F684 IJ. Meds-Clinically Approp	F 554		4/25/24
	defined by §483.21(b this practice is clinica This REQUIREMENT by:	erdisciplinary team, as)(2)(ii), has determined that Ily appropriate. is not met as evidenced			
		view, observations, resident he facility failed to assess		Corrective Action A. Address how corrective action will	be
LABORATORY	 DIRECTOR'S OR PROVIDER/\$	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE	(X6) DATE
Electroni	cally Signed				04/03/2024

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.

			()(0)		CONSTRUCTION		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	E SURVEY PLETED
						С	
		345134	B. WING			04	/24/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH RANDOLPH LL	c		48	801 RANDOLPH ROAD		
ELICAN		6		С			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 554	Continued From page	e 1	F 5	554			
		inistration of medications			accomplished for those residents found	d to	
		iate for 1 of 1 resident			have been affected by the deficient		
		as observed to have a			practice.		
	medication at bedside	9.			On 3/10/2024 Resident #1 was observ	red	
					having medication at bedside.		
	The findings included	:			Nurse #1 went back into the room,		
					Resident #1 had taken medications.		
	Resident #1 was adm	-			Nurse #1 ensured Resident #1 took		
	9/19/2023 with diagnormagic ane				medications, Resident #1 is alert and oriented x 3.		
		ipheral vascular disease,			onemed x 5.		
		ent #1 was readmitted to the			B. Address how the facility will identi	fv	
	facility on 12/19/2023			other residents having the potential to	-		
	The admission Minim				affected by the same deficient practice		
	assessment dated 12	/19/2023 assessed			All residents on Nurse #1 assignment		
	Resident #1 to be cog behaviors.	gnitively intact without			(rooms 144-161) have the potential to affected.		
					On 3/10/2024 a whole house audit was	S	
		Resident #1 revealed the			conducted to check if there are any		
	-	d to be administered in the			medications at bedside, including roon		
	morning:				144-161, this resulted with no findings	of	
	AM	lligrams (mg) daily at 8:00			medications at bedside. No other residents were affected by th	io	
		ng daily at 8:00 AM aily at 8:00 AM			deficient practice.	15	
	" Juluca 50/25 mg	•			C. Address what measures will be pu	ut	
		mg daily at 8:00 AM			into place or systemic changes made t		
	" Aspirin 81 mg da	• •			ensure that the deficient practice will n		
	" Carvedilol 6.25 m	ng daily at 8:00 AM			recur.		
		mg daily at 8:00 AM					
		ng twice daily at 8:00 AM and			On 3/10/24 Director of Nursing (DON)		
	8:00 PM				interviewed Nurse #1, Licensed Practic	cal	
		onate 800 mg daily with			Nurse (LPN) who left medications at		
	meals at 8:00 AM, 12	:00 PM, and 5:00 PM			bedside, Nurse #1 stated Resident #1		
	A review of Resident	#1's medical record			requested medications to be left at bedside as they were eating and Nurse	o #1	
	revealed there was no				complied. DON educated Nurse #1 th		
		dminister his medications.			all medications must be observed for		
					consumption to ensure they were		1

Event ID: ZK7111

Facility ID: 922959

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				LE CONSTRUCTION		NO. 0938-039
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · ·	ATE SURVEY
						С
		345134	B. WING		()4/24/2024
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		
		_		4801 RANDOLPH ROAD		
PELICAN	HEALTH RANDOLPH LL	.C		CHARLOTTE, NC 28211		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 554	Continued From page	a 2	F 55	4		
1 004		an in place for Resident #1	F 33		ha raaidant	
	to self-administer me			swallowed for the safety of the DON also educated Nurse #		
				request to have medications		
	Resident #1 was obs	erved in bed on 3/10/2024 at		must take medications back		
	9:07 AM. Resident #7	1 was eating breakfast. A		and waste those medication	s after	
		10 medications was noted to		educating resident on import		
	-	-the-bed table beside his		taking medications in a time	y manner.	
		1 explained he didn't want to				
		when the nurse brought ner to leave the medication		On 3/11/2024 all in house nu were educated that all media	-	
		he would take them later.		be observed for consumption		
				they were swallowed for the		
	Resident #1 was obs	erved again at 9:28 AM and		resident.	baloty of the	
		as gone from his table.				
	Resident #1 reported			On 3/11/2024 All agency nu	rses who were	
	medications.			working at Randolph Garder		
				educated that all medication		
		ewed on 3/10/2024 at 9:30		observed for consumption to		
		ed she was assigned to		were swallowed for the safe	ty of the	
	Resident #1 and had			resident.		
	that Resident #1 insis	ning. Nurse #1 explained		Any agency nurses not work	ing on	
		able, and he would take them		3/11/2024 will be educated p		
		t. Nurse #1 reported she had		start of their shift that all me		
		#1's room "a few minutes		be observed for consumption		
		en the medications. Nurse #1		they were swallowed for the		
		nt leaving the medications at		resident.		
		fine because Resident #1				
	was alert and oriente	d.		All new RN s, LPN s, CMA	-	
	Nurse #2	awad an 2/11/2024 -+ 10.50		employment at Randolph Ga		
		ewed on 3/11/2024 at 10:56		educated at the time of emp all medications must be obse	•	
	AM. Nurse #2 reported he was the charge nurse on day shift (7:00 AM to 3:00 PM) and he assisted the floor nurses. Nurse #2 explained he			consumption to ensure they		
				swallowed for the safety of the		
		tions left at the bedside of				
				D. Indicate how the facility	plans to	
	An interview was con	ducted with the Unit		monitor its performance to m	•	
	Manager on 3/11/202	24 at 11:07 AM. The Unit		solutions are sustained.		

Facility ID: 922959

		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
		345134	B. WING			C 4/24/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LL	с		4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 554	Manager reported she for leaving medication not observed any inst residents to self-admi The Director of Nursin interviewed on 3/11/2 reported medications bedside and she was left the medications for self-administer. DON Nurse #1 on 3/10/202 Resident #1 insisted and Nurse #1 on 3/10/202 Resident #1 insisted and completed for a resid medications and Res assessed. DON #2 re- residents to have the bedside if they were re- safely self-administer During an interview w (NP), she reported sh staff that Resident #1 medications at times. missing one dose of re- harmed Resident #1. The Administrator wa at 4:10 PM. The Administer observed medications	e monitored the nursing staff ins at the bedside and had tances of medications left for inister. ng (DON) #2 was 2024 at 11:23 AM. DON #2 should not be left at the not certain why Nurse #1 or Resident #1 to #2reported she talked to 24 and Nurse #1 reported she leave the medications want to upset Resident #1. In assessment would be ent to self-administer ident #1 had not been eported she expected no ir medications left at the not assessed to be able to the had been told by nursing would refuse his The NP explained that medications would not have s interviewed on 3/11/2024 inistrator reported she #1 daily and had not s left at the bedside. The d she expected residents to	F 55		dications y / sure bedside. ast one heeting y and Plan be ng at the ths and rther /24 lividual	
F 684 SS=J	self-administer medic	tions and if they were not tions to be left at the beside.	F 68	4		

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			0.00			<u>10. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345134	B. WING			С
		545154	B. WING			4/24/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PELICAN	HEALTH RANDOLPH LL	.C		4801 RANDOLPH ROAD		
				CHARLOTTE, NC 28211		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	e 4	F 68	14		
	CFR(s): 483.25					
	§ 483.25 Quality of care Quality of care is a fundamental principle that					
		nt and care provided to ed on the comprehensive				
		dent, the facility must ensure				
		e treatment and care in				
		essional standards of				
		nensive person-centered				
	care plan, and the re	-				
		Γ is not met as evidenced				
	by:					
	Based on record rev	iew, observations, and		Past noncompliance: no	plan of	
		erviews, Transporter #1		correction required.		
		ncy medical services (EMS)				
	or have a resident as	•				
		noving Resident #1 after his				
		er and he fell to the floor of a				
		On 1/19/24 Transporter #1				
	·	vsis center parking lot and chair tipped backwards, and				
	he hit the left occipita					
		the transportation van over				
		fulled the resident back up				
		and transported Resident #1				
		facility. The transporter was				
		le a competent physical				
		nine if there was an adverse				
	outcome for this resid	dent who was on Plavix				
		ion that can have a side				
		Once back at the nursing				
		as assessed to have a				
	-	hind his left ear and he				
		nd nausea. Resident #1				
		ital for an evaluation and the				
		completed at the hospital resident returned to the				
	was negative and the		1			1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345134	B. WING _				C / 24/2024
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
	HEALTH RANDOLPH LL	c		801 RANDOLPH ROAD			
FLEIGAN		0		С	HARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	10		F	584			
	residents reviewed fo	r accidents.					
	The findings included	:					
	procedure dated 10/2 policy read, in part, " any transport that see because of securing r will be reported to the any appropriate author Resident #1 was adm 9/19/2023 with diagno posthemorrhagic ane	methodsany incident Administrator as well as prities or agencies." nitted to the facility on poses including acute					
		ed 12/15/2023 ordered o be administered once per					
	behaviors. The MDS had limited range of r upper body and both MDS documented Re wheelchair for mobilit The medical record d a below the knee amp An incident report dat the former Director of a phone call from Tra Resident #1's wheelc was driving the van. T						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/31/2024 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING			_		C 24/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				4	801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL	С		c	HARLOTTE, NC 28211	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	and secured the strap notified the facility of t report documented Re were driving, and my hit my head." The act documented in the ind assessed Resident #7 facility; Resident #1 n size knot to the right s Upon palpitation, the little bit." Emergency I notified for transporta for evaluation. Vital s 100/81, pulse 76, res 97.8, oxygen saturation noted from the bump report noted the famil provider were notified The emergency room 6:06 PM documented in the emergency room "(Resident #1) was or transport van after dia wheelchair he was res back and hit the back thinner). EMS noted r (Resident #1) repoi earlier, but denies any Vital signs for Residen 120/63, pulse 67, res 98.1, and oxygen saturation assessed to be without atraumatic (no trauma noted to be alert and computed tomograph imaging) of his head r	back into his wheelchair os. Transporter #1 then the incident. The incident esident #1's statement "we chair fell backwards, and I tions taken were cident report: immediately 1 upon his arrival back to the toted to have a small quarter side of the back of his head. resident stated, "It hurts a Medical Services (EMS) tion to the emergency room signs were blood pressure pirations 18, temperature on 94% and no bleeding was on his head. The incident y member, and the medical	F	684				

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CENTER STATEMENT C	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION		FORM OMB NO (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345134	B. WING		_	(04/:	C 24/2024
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	0-11	
DELICAN		6	4	801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL		(CHARLOTTE, NC 28211	l		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page to the facility without r Resident #1 was inter 11:17 AM. Resident # remember the inciden reported he was not of he had completed his #1 stated he rememb they had just left the p reported he did not no the way Transporter # straps. Resident #1 e the right and his whee straight back to the flo his head behind the e certain what he hit his reported he yelled for back and saw he was into a parking lot. Res Transporter #1 rushed wheelchair back into a #1 explained he told h floor of the van. Resid Transporter #1 called to call EMS, but she w to the facility. Resider when he got back to t	e 7 new medications. viewed on 3/10/2024 at #1 reported he was able to at on the van. Resident #1 ertain of the time of day, but dialysis treatment. Resident ered he was in the van, and parking lot. Resident #1 otice anything unusual about #1 secured his wheelchair explained the van turned to elchair tipped over and went for and he hit the left side of ar. Resident #1 was not a head on. Resident #1 the driver, and she looked on the floor, so she pulled sident #1 described how d to his side and pulled his a sitting position. Resident her to get him up from the lent #1 explained the facility and they told her vas already on her way back at #1 stated EMS came he facility, and he was spital emergency room. d he was not in the	F 684]			
	the facility without any Transporter #1 was in 1:47 PM. Transporter at the facility as a tran months and she had b facilities for the past 5 reported she was train	terviewed on 3/10/2024 at #1 reported she had been					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 05/31/2024 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_	(04//	; 24/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
			4	801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL	С	c	CHARLOTTE, NC 28211	I		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	years she had been a Transporter #1 explai Resident #1 up from o she had strapped his certain the wheels we were secure before sl Transporter #1 explai dialysis parking lot an heard Resident #1 sa Transporter #1 looked she couldn't see Resi described pulling over the van and going to b me up! Sit me up!" Th was so upset by the in supposed to call for E for injuries before she Transporter #1 report back to a sitting positi doing ok, he told her l explained she was tal the phone as she got position. Transporter driving back to the fac reported she should h pulled the van over an Resident #1 was sat B The Unit Manager wa at 11:07 AM. The Unit received a phone call reported Resident #1 The Unit Manager exp the Administrator to te the Administrator said have called EMS. Un had not been present	ansporting residents in the 5 in transportation aide. and she had picked dialysis on 1/19/2024 and wheelchair in and made are locked and the straps the started the van. and she pulled out of the d onto the road when she y her name, and when d into the rearview mirror, dent #1. Transporter #1 r into a parking lot, stopping Resident #1, who said, "Sit ransporter #1 explained she incident, she forgot she was MS to assess Resident #1 e moved the resident. ed she had Resident #1 ion and she asked if he was he was fine. Transporter #1 king to Unit Manager #1 on Resident #1 into a sitting #1 reported she started	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/31/2024 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING			_		C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
		_		48	801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL	C		С	HARLOTTE, NC 28211			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	 #1 should have called assessed before movily van. A phone interview was on 3/10/2024 at 2:25 was employed by the she was in the buildin called the Unit Manage the van. DON #1 explicitly the assessment and I paperwork related to a reported she did not a incident, and he was a emergency room for each of the complex of the assessment and I had experienced a fail and the Unit Manager Transporter #1 arrived completed an assess The ADON reported F bump behind his right Resident #1 told the A to the hospital, but the go to be evaluated. The Medical Director phone on 3/11/2024 at 2:31 PM #1 asked her to go out the hospital arrived completed an assess The ADON reported F bump behind his right Resident #1 told the A to the hospital, but the go to be evaluated. 	ager reported Transporter I EMS for Resident #1 to be ing him off the floor of the s conducted with DON #1 PM. DON #1 reported she facility on 1/19/2024 and g when Transporter #1 yer to report an incident on ained the ADON performed DON #1 completed the the incident. DON #1 assess Resident #1 after the sent to the hospital evaluation. ducted with the ADON on . The ADON explained DON itside to assess Resident #1 he transporter van after he I. The ADON reported she met the van when d with Resident #1 and ment of him immediately. Resident #1 had a small ear, but he denied pain. ADON he did not want to go e ADON convinced him to (MD) was interviewed by at 1:25 PM. He further 1 could have sustained a a fall on the van due to his	F	684				

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		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	TE SURVEY MPLETED	
			A. BUILDING	<u> </u>			
		345134	B. WING		C		
		545154	B. WING			4/24/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE		
PELICAN	HEALTH RANDOLPH LL	.C		4801 RANDOLPH ROAD			
				CHARLOTTE, NC 28211			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From page	> 10	F 68				
			FUC				
	was taking a blood th	a resident had a fall and inner.					
	An interview was con	ducted with the					
		/2024 at 5:40 PM and she					
		on of $1/19/2024$ when the					
	Unit Manager receive						
		Administrator explained the					
	· ·	nto her office and told her					
		n the phone and reported					
	Resident #1 had tippe	ed over in his wheelchair in					
	the transport van. Th	e Administrator asked the					
		dent #1 was hurt and asked					
	where Transporter #1	was located. The Unit					
		nsporter #1 was enroute					
		d the Administrator had					
		should have called EMS					
		o assess Resident #1 before					
		e floor. The Administrator					
	· ·	ne DON and the ADON to					
		Maintenance Director for					
		Resident #1 to arrive. The					
	Administrator reporte						
		ON and transferred to the					
	-	n by EMS. The Administrator					
		ident, the facility conducted					
		surance Performance					
		meeting to discuss the					
		a plan of correction. The ed Transporter #1 returned					
		3/2024 and completed					
	· ·	bserved for 2 transport trips					
	÷	Director. The Administrator					
		ansporter #1 received					
		ansporter #Treceived					
		e facility was under different					
		time. The Administrator					
	reported the facility h						
		ad their monthly (JAPI					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	HEALTH RANDOLPH LL	6		4801 RANDOLPH ROAD			
FELICAN		5		CHARLOTTE, NC 28211	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page audits, and the plan o		F 684	ł			
	The Administrator was jeopardy on 4/24/2024	s notified of immediate 4 at 1:10 PM.					
		he following corrective appletion date of 01/24/24.					
	Address how corrective accomplished for those been affected by the o	e residents found to have					
	by Transporter #1 and utilizing the secureme	ed up from dialysis 1/19/24 d secured into the van ent straps. The Transporter ay, Resident #1's chair					
	tipped backwards cau backward and resulte right side of his head	sing Resident #1 to fall d in Resident #1 hitting the on the floor of the van. The all emergency services at					
	they were okay and R	over, asked Resident #1 if esident #1 stated he was					
	facility. Transporter # back into seated posit						
		straps and began to drive to n to the facility the Director Director of Nursing					
	alert, oriented and abl	ed Resident #1, He was le to answer all questions. that he hit his head and					
	pointed to a spot on th	ne back right side of his sessed a raised area at that					
	orders to send Reside	an was notified and received ent #1 to the Emergency tion and 911 was contacted.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345134	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PELICAN	HEALTH RANDOLPH LL	c			1801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Resident #1's family w was alert and oriented Medical Services (EM to the ER. The ER ev laceration, no head the the fall. Resident #1 r 10:14 PM after evalual Address how the facili residents having the p the same deficient pra All residents being tra Transporter have the On 1/19/2024 all resid facility Transporter we and ADON to ensure occurred during facilit notification of emerge No other residents we practice. Address what measure systemic changes ma deficient practice will The facility currer contracted transportat is not to be moved un	vas notified. Resident #1 d at the time Emergency IS) arrived and transported valuation revealed no auma or other injury from eturned from the ER at ation from fall. ity will identify other botential to be affected by actice. unsported by the Facility potential to be affected. dents transported by the ere interviewed by the DON no unreported incidents y transportation requiring incy services. ere affected by this deficient res will be put into place or ide to ensure that the not recur. intly does not utilize any tion services. ing Home Administrator education to transporter ey of the following: In the ion related incident, resident til a licensed professional s and to contact emergency	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 MAPPROVED). 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING				C 24/2024
NAME OF PRO	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
PELICAN H	EALTH RANDOLPH LL	c	4	801 RANDOLPH ROAD			
		-	C	HARLOTTE, NC 28211			
(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
	through 1/23/24. A fu completed, and a plar On 1/22/2024 the Vice (VPM) educated the F on the following: 1. Current Policy an Transportation Vehicle emphasizing. "Calling 911 with any resident, emphasizing any transport that see because of securing r conditions of a reside conditions. Driver will Administrator/DON/Uf hours prior to resumir conditions that halted reasons the driver fee necessary, a second p assist the driver/trans On 1/23/24 Transport the following by the M 1. Current Policy an Transportation Vehicle Calling 911 with any in resident, emphasizing any transport that see because of securing r conditions of a reside conditions of a reside conditions of a reside conditions. Driver will Administrator, DON/U	d the in-house n and outsourced all cted vendor from 1/19/24 Il Investigation was n of correction was initiated. e President of Maintenance Facility Maintenance Director d Procedure of Facility e dated 10/2018, incidents in the van with a g "Drivers are trained to halt ems unsafe whether nethods, behavior or health nt, severe weather, or traffic contact the facility hit Manager, even if after ng transport to advise of the transport and the els safe beginning again. If person will be dispatched to porter." er #1 was re-educated on laintenance Director: d Procedure of Facility e dated 10/2018. ncidents in the van with a g "Drivers are trained to halt ens unsafe whether nethods, behavior or health nt, severe weather, or traffic	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345134	B. WING				/24/2024
NAME OF P	ROVIDER OR SUPPLIER	L		:	STREET ADDRESS, CITY, STATE, ZIP CODE		-
PELICAN	HEALTH RANDOLPH LL	c			4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	conditions that halted reasons the driver fee necessary, a second assist the driver/trans On 1/22/24 education managers by the NHA event that the transport them to contact emer move resident until a assess them. Effective 1/23/24 Res verbally made aware DON/Designee prior to incident shall occur, e contacted for assess professional. The facility has 2 train Maintenance Director Systematic Changes New Transporters will Maintenance Director all transporters will be on the following: 1. Current Policy an Transportation Vehick Calling 911 with any i resident, emphasizing any transport that see because of securing to the following that see	the transport and the els safe beginning again. If person will be dispatched to porter. A was provided to all nurse A on the following: In the ort driver notifies the facility ation related incident, inform gency services and not licensed professional can didents being transported are by transporter/LNHA, to transportation that if an emergency services will be ment by licensed hed transporters: The and Transporter#1 l be trained by the prior to any transports and trained on an annual basis of Procedure of Facility e dated 10/2018. Incidents in the van with a g "Drivers are trained to halt emethods, behavior or health nt, severe weather, or traffic contact the facility	F	684			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345134	B. WING			04	C / 24/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LL	с			4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	resuming transport to halted the transport a feels safe beginning a second person will be driver/transporter. The Maintenance Dire tracking and completi Indicate how the facili performance to make sustained. On 1/22/2024 an Ad H Performance Improve held to review the inc Utilizing the transport will randomly choose weekly for twelve wee occurred during trans procedure related to a by a licensed profess the resident was follo reported by the Admin meeting for 3 months committee to ensure a IJ removal date on 1/2 The Administrator is t compliance with this a On 3/11/2024 the faci for immediate jeopard the following: The facility provided of	advise of conditions that ind the reasons the driver again. If necessary, a dispatched to assist the ector is responsible for ing annual training. ity plans to monitor its sure that solutions are noc Quality Assurance ement (QAPI) meeting was ident and Plan of Correction. ation logs NHA / Designee one resident to interview exist to ensure if an incident portation the policy / a resident being assessed ional prior to repositioning wed. These reviews will be nistrator at the monthly QAPI and reviewed by the compliance is maintained. 24/24. he individual responsible for action plan.	F	684	4		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345134	B. WING _			C 04/24/2024		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-		
PELICAN	HEALTH RANDOLPH LL	c			01 RANDOLPH ROAD HARLOTTE, NC 28211			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Transporter #1. The p completed prior to any by Transporter #1. The audited these inspect 1/23/2024 to 3/11/202 Maintenance Director able to state the corre accident involving the resident(s). Interviews #2, the ADON, the Ur who reported if they re transporter reporting a transporter to call EM resident until EMS wa resident. QAPI meetir Administrator and me The facility's date of 1 action plan was valida Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on record revi and staff interviews, t safe transported for	by transportation in the van the Maintenance Director ions 3 times per week from 24. Transporter #1 and the twere interviewed and were existence for any incident or transportation van and a swere conducted with DON nit Manager, and Nurse # 2 eceived a phone call from a an accident with the ey would instruct the S and not to move the as able to assess the ngs were discussed with the eting notes were reviewed. 1/24/2024 for the corrective ated on 3/11/2024. ards/Supervision/Devices (2)		584	Past noncompliance: no plan of correction required.			

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	-	D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		345134	B. WING			C 04/24/2024		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
PELICAN	HEALTH RANDOLPH LL	c			4801 RANDOLPH ROAD CHARLOTTE, NC 28211			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 689	parking lot of the dialy #1's wheelchair tipper side of his head. Tran transportation van over Resident #1 insisted u him back upright, and resident back up into position. Transporter Resident #1 8.4 miles he was assessed by th Nursing (ADON) to have behind his left ear and nausea after the fall. I ADON Resident #1 net for evaluation. There serious adverse outco hitting his head when in the transportation v prescribed and receiv medication). The CT st hospital was negative for 1 of 3 residents re The findings included The Vehicle Anchorag Wheelchair Secureme 2020 was reviewed. T provided directions fo transport in the transp floor of the van (L-transp floor of the van (L-transp floor of the van (L-transp floor of the van the transp floor of the van	vsis center and Resident d over, and he hit the left isporter #1 pulled the er to a parking lot, where upon Transporter #1 sitting 1 Transporter #1 pulled the a sitting and upright #1 then transported b back to the facility where the Assistant Director of ave a bump on his head d he reported head pain and it was determined by the eeded to go to the hospital was a high likelihood of a ome for Resident #1 due to his wheelchair tipped over ran. Resident #1 was ed Plavix (a blood thinning scan completed at the for head injury. This was viewed for accidents. : ges for the 4-point ent Systems manual dated The illustrated manual r securing wheelchairs for portation van. Tracks on the ck) where the pin actors locked in place and ne wheelchair by a J-hook (a affixed to the fabric straps the connector pins). The	F	689	9			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
		-		4801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL			CHARLOTTE, NC 28211	l		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page of each side of the wh directed to follow the illustration and attach wheelchair frame in th Resident #1 was adm 9/19/2023 with diagno posthemorrhagic aner disease, dialysis, peri and diabetes. The admission Minim assessment dated 12 Resident #1 to be cog behaviors. The MDS of had limited range of n upper body and both MDS documented Re wheelchair for mobility The medical record da a below the knee amp An incident report dat documented the form (DON) #1 received a Transporter #1 that R tipped over while she Transporter #1 then n incident. The incident Resident #1's stateme chair fell backwards, a actions taken were do	e 18 neelchair. The instructions tie down angles in the ed the J-hooks on the ne proper locations. itted to the facility on oses including acute mia, end stage renal pheral vascular disease, um Data Set (MDS) (19/2023 assessed phitively intact without documented Resident #1 notion of one side of his sides of his lower body. The sident #1 used a manual y and was non-ambulatory. boumented Resident #1 had boutation of the right leg. ed 1/19/2024 at 3:33 PM er Director of Nursing phone call from the esident #1's wheelchair was driving the van. ed that she had pulled over d and assisted Resident #1 air and secured the straps. otified the facility of the report documented ent "we were driving, and my and I hit my head." The boumented in the incident	F 689				
	his arrival back to the to have a small quarter	ssessed Resident #1 upon facility; Resident #1 noted er size knot to the right side d. Upon palpitation, the					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
		-		4801 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL			CHARLOTTE, NC 28211	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Medical Services (EM to the emergency roo bleeding was noted fr The incident report no the medical provider was Resident #1 was inter 11:17 AM. Resident # remember the incident reported he was not of day, but he had comp Resident #1 stated he van, and they had jus Resident #1 stated he van, and they had jus Resident #1 reported anything unusual abo secured his wheelchat explained the van turr wheelchair tipped ove and he hit the left side Resident #1 was not of on. Resident #1 report and she looked back a floor, so she pulled in described how Transp and pulled his wheelch position. Resident #1 called the facility and but she was already of facility. Resident #1 eported (out of 10; 0 no pain, came when Resident with Transporter #1, a hospital emergency root	rts a little bit." Emergency (S) notified for transportation m for evaluation. No om the bump on his head. Meed the family member, and were notified of the incident. viewed on 3/10/2024 at 41 reported he was able to t on the van. Resident #1 ertain of the date or time of leted his dialysis treatment. eremembered he was in the t left the parking lot. that he did not notice ut the way Transporter #1 ir straps. Resident #1 ned to the right and his er and went down to the floor e of his head behind the ear. certain what he hit his head ted he yelled for the driver, and saw he was on the to a parking lot. Resident #1 oorter #1 rushed to his side hair back into a sitting explained Transporter #1 they told her to call EMS, on her way back to the explained he had pain in his d he felt queasy after he hit he ride back to the facility. the pain in his head was "8" 10 most intense pain). EMS #1 returned to the facility und he was taken to the poon. Resident #1 explained	F 689				
	came when Resident with Transporter #1, a hospital emergency ro he was not in the eme	#1 returned to the facility and he was taken to the					

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-		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF PROVIDER OR S	UPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		-		4801 RANDOLPH ROAD			
PELICAN HEALTH RAN	NDOLPH LL			CHARLOTTE, NC 28211	1		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
mostly pair facility after described Transporte 1:47 PM. T at the facility months an facilities fo reported sl the facility facility since had an ince in the 5 tot aide. Trans the dialysis afternoon of securement made certa securement started the parking lot out of the of when she I when Tran mirror, she #1 describe stopping th said, "Sit n explained si forgot that before she kept dema Resident # #1 asked if that he was was talking	is. Resident in free by the r free by the r the evalu- his head as r #1 was in r ransporter ity as a trand d she had be r the past 5 ne was train and explain the was train the was train the whe the straps we van and p the tartaps we the tartaps we van and p the tartaps we the tartaps we van and p the tartaps we the tartaps we van and p the tartaps we tartaps we van and p the tartaps we tartaps we tar	e 20 t #1 explained he was e time he returned to the ation at the hospital and b feeling "tender". Atterviewed on 3/10/2024 at #1 reported she had been asporter for almost 16 been a transporter at other by ears. Transporter #1 ned when she was hired at ned she had been at the er 2022, and she had never cident transporting residents e had been a transportation explained she had arrived at Resident #1 on the 4 and she had used the secure his wheelchair and els were locked and the ere secure before she repared to leave the dialysis er #1 explained she pulled king lot and onto the road dent #1 say her name, and looked into the rearview ee Resident #1. Transporter over into a parking lot, going to Resident #1, who he up!" Transporter #1 upset by the incident, she upposed to call for EMS e resident, but the resident him up, she repositioned a sitting position. Transporter #1 was doing ok, he told her nsporter #1 explained she anager #1 on the phone as nto a sitting position.	F 68				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/31/2024 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345134	B. WING				C 24/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
				4	801 RANDOLPH ROAD		
PELICAN	HEALTH RANDOLPH LL	C		С	CHARLOTTE, NC 28211		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Transporter #1 report to the facility. An observation of the conducted on 3/10/20 Transporter #1, the M the Administrator. Tra how she had secured on 1/19/2024 using th Transporter #1 locked wheelchair and secur using the pin connect J-hooks connected to the shoulder harness wiggled the wheelchai demonstrate it was se Director then explaine strap was too far to th wheelchair was move securement strap was wheelchair was able to was in the wheelchair then moved the wheel the wheelchair was all with the securement se frame. An interview was con 3/10/2024 at 2:31 PM and the Unit Manager Transporter #1 arriver completed an assess The ADON reported F bump behind his right Resident #1 told the A to the hospital, but the go be evaluated. The Maintenance Director	transportation van was 24 at 2:05 PM with laintenance Director, and nsporter #1 demonstrated Resident #1's wheelchair resecurement system. If the wheels on the ed the 4 securement straps ors in the L-track and the the wheelchair as well as and lap belt and then ir back and forth to ecured. The Maintenance ed the right front securement reside and when the d side to side, the s not secure, and the to tip over when Resident #1 c. The Maintenance Director lochair from side-to-side and ble to move, and the J-hook strap slid on the wheelchair ducted with the ADON on for the Van when d with Resident #1 and ment of him immediately. Resident #1 had a small c ear, but he denied pain. ADON he did not want to go e ADON convinced him to	F	589			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
		345134	B. WING			C 04/24/202		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PELICAN	HEALTH RANDOLPH LL	с			4801 RANDOLPH ROAD CHARLOTTE, NC 28211			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	able to identify the co positioned correctly for wheelchair. During an interview w on 3/10/2024 at 2:13 Transporter #1 return Resident #1 on 1/19/2 inspected the position the J-hooks and disco connector was position the J-hook securement wheelchair frame, wh movement of the wheel Director reported he p Transporter #1 on 1/2 about the pin connect straps and their use. reported since the ind van daily at different to the pin connectors and The Medical Director phone on 3/11/2024 at explained there would any time a resident w blood thinner. He furth could have sustained on the van due to his history. An interview was con Administrator on 3/11 described the afterno Unit Manager came in Transporter #1. The J Unit Manager came in Transporter #1 was o	nnector pins were not or one side of the with the Maintenance Director PM, he explained when ed to the facility with 2024, he immediately n of the pin connectors and overed the front right pin oned at an angle that allowed nt strap to move on the ich allowed the side to side belchair. The Maintenance orovided re-education to 23/2024 as well as videos tors, J-hooks, L-track, and The Maintenance Director cident he was checking the imes to monitor the use of ad straps. (MD) was interviewed by at 1:25 PM. The MD d be a concern about injury ould fall and was taking a her explained Resident #1 a serious injury during a fall medications and medical ducted with the /2024 at 5:40 PM and she on of 1/19/2024 when the	F	68	9			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/31/2024 APPROVED D: 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345134	B. WING				C 04/24/2024		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	TE, ZIP CODE			
DELIGAN		2			4801 RANDOLPH ROAD				
PELICAN	HEALTH RANDOLPH LL	C			CHARLOTTE, NC 28211				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 689	Unit Manager if Resid where Transporter #1 Manager relayed that back to the facility and stated that Transporte EMS. The Administra DON and the ADON to Maintenance Director Resident #1 to arrive. Resident #1 was asset transferred to the hosp The Administrator exp was sent to the hospi Maintenance Director Transporter #1 was si investigation. The Ad issue was identified a placed in the wrong L wheelchair to tip over after the incident, the Quality Assurance Pe (QAPI) meeting to dis develop a plan of corr explained Transporter on 1/23/2024 and cor observed for 2 transp Director. The Adminis Transporter #1 receiv certain about the anni was under different m The Administrator rep monthly QAPI meetin incident, the audits, a	e Administrator asked the lent #1 was hurt and asked was located. The Unit Transporter #1 was enroute d the Administrator had er #1 should have called ator reported she asked the o wait outside with the for Transporter #1 and The Administrator reported essed by the ADON and pital for evaluation by EMS. blained after Resident #1 tal, she and the discussed the issue and uspended during the facility lministrator explained the s the pin connector was -track which allowed the . The Administrator reported facility conducted an ad hoc rformance Improvement cuss the incident and rection. The Administrator r #1 returned to her position npleted re-training and was ort trips by the Maintenance strator reported she knew ed training on hire was not ual training, as the facility anagement at that time. orted the facility had their g in February to discuss the nd the plan of correction.	F	689					
	The Administrator was jeopardy on 3/10/2024	s notified of immediate							

Facility ID: 922959

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/31/2024 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING			_		C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		-
				480	01 RANDOLPH ROAD			
PELICAN	HEALTH RANDOLPH LL	C		Сн	HARLOTTE, NC 28211			
(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 TIVE ACTION SHOULD B ICED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
TAG F 689	Continued From page action plan with a con Address how corrective accomplished for those been affected by the of Resident #1 was picke by Transporter #1 and utilizing the secureme proceeded to pull awa tipped backwards cau backward and resulter right side of his head Transporter #1 pulled they were okay and R fine and insisted the T facility. Transporter # back into seated positive replaced the security the facility. Transporter # back into seated positive phone. The UM aske and Transporter # 1 st The UM reported the Nursing Home Adminion on the phone with Transporter was already driving bac assisting resident bac the wheelchair and set the security straps. T # 1 to return to the fac with the resident until	 24 Appletion date of 01/24/24. Are action will be the residents found to have deficient practice. and up from dialysis 1/19/24 discured into the van the straps. The Transporter ay, Resident #1's chain sign Resident #1 to fall d in Resident #1 hitting the on the floor of the van. over, asked Resident #1 if the sesident #1 stated he was transporter return him to the flassisted Resident #1 to fall the wheelchair, straps and began to drive to er #1 notified the Unit ent #1 fell in the van via cell d if the resident was injured, ated he was not injured. incident to the Director of nonediately walked into the strator's (NHA) office while nsporter #1. UM informed evan, NHA asked if resident sporter #1 stated he was d NHA that the transporter ack to the facility after k into the seated position in the UM directed Transporter ility and remain in the van the DON arrived to assess. 	F 6	89			ATE	
	Transporter #1 pulled DON/Assistant Directo	up to the facility, the						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY PLETED
	345134						C / 24/2024
NAME OF P	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PELICAN	HEALTH RANDOLPH LL	c			4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	(ADON)/Maintenance outside to assess Res assessed Resident # able to answer all que reported that he hit hi on the back right side ADON/DON assessed location with no other Resident #1 was bein Maintenance Director securement straps we manufacturer's recorn #1 incorrectly connec to the wheelchair's sid allowing the secureme remain taut. Resident #1's physicia orders to send Reside Room (ER) for evalua Resident #1's family w was alert and oriented Medical Services (EW to the ER. The ER ev laceration, no head the the fall. Resident #1 r 10:14 PM after evalua Address how the facil residents having the p the same deficient pra All residents being tra Transporter have the On 1/19/2024 all resid transporter were inte	 Director were waiting sident #1. The DON/ADON 1, He was alert, oriented and estions. Resident #1 s head and pointed to a spot of his head. The d a raised area at that injuries noted. While g assessed by Nursing, the observed the front ere not secured per the mendations. Transporter ted the securement straps de frame bar, therefore ent straps to slide and not an was notified and received ent #1 to the Emergency ation and 911 was contacted. was notified. Resident #1 d at the time Emergency IS) arrived and transported valuation revealed no auma or other injury from eturned from the ER at ation from fall. ity will identify other botential to be affected by actice. insported by the Facility potential to be affected. 	F	689	9		

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	-					FORM	APPROVED 0. 0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		345134	B. WING			C 04/24/2024		
NAME OF PF	ROVIDER OR SUPPLIER		1					
PELICAN	HEALTH RANDOLPH LL	HEALTH AND HUMAN SERVICES FC DICARE & MEDICAID SERVICES OMB ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) D JUPPLIER 345134 B WING C NDOLPH LLC STREET ADDRESS, CITY, STATE, ZIP CODE 4801 RANDOLPH ROAD CHARLOTTE, NC 28211 C SUMMARY STATEMENT OF DEFICIENCIES HDEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) From page 26 F 689 esidents were affected by this deficient F 689 that measures will be put into place or changes made to ensure that the ractice will not recur. F 689 4 the NHA interviewed the Maintenance do completed a review of the trer securement straps and wheelchair A root cause analysis of the event leted, and it was determined to be a te placement of the front wheel straps. ps were not placed further to the front urity track on the floor of the van. Per						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
F 689	Continued From page	26	F	689				
	No other residents we practice.	ere affected by this deficient						
	systemic changes ma deficient practice will On 1/19/24 the NHA i Director and complete manufacturer securer placement of securen placement. A root ca was completed, and ir result of the placemen These straps were no of the security track o the manufacturer's set the securement strap; the front track as post tight as allowed.	ade to ensure that the not recur. Interviewed the Maintenance ed a review of the ment manual including the ment straps and wheelchair use analysis of the event t was determined to be a int of the front wheel straps. of placed further to the front						
	securing a resident set van per the manufact moving the van. The in-house transportation all transports to a com 01/19/24 through 01/2	eated in a wheelchair in the urer's instructions prior to facility suspended the on program and outsourced						
		e President of Maintenance Facility Maintenance Director						
	1. Van safety includ and the placement of	les the use of the lift, use securement straps.						
	2. Current Policy ar	nd Procedure of Facility						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345134		_		C	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LL	345134 B. WING C 345134 B. WING 04/24/2024 STREET ADDRESS, CITY, STATE, ZIP CODE 4801 RANDOLPH ROAD 4801 RANDOLPH ROAD CHARLOTTE, NC 28211					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 689	seems unsafe whether methods, behavior or resident, severe weat Driver will contact the his/her designee prior advise of conditions to the reasons the driver of necessary, a secon to assist the driver/tra 3. Transportation D comprehensive check demonstration to valid prior to transport. 4. Transportation Sa review of securing the lift, with loading and u 5. Daily Pre-Trip Ins review of key function securing the wheelch facility. The following videos of 1. Manufacturer's Cor Operators Video Part 2. How to Operate a V 3. Manufacturer Rest Program. On 1/22/2024 Mainteel to manage the Facility and to provide training	e dated 10/2018, o halt any transport that er because of securing health conditions of a ther or traffic conditions. facility Administrator or r to resuming transport to hat halted the transport and r feels safe beginning again. d person will be dispatched insporter." river Skills Assessment- a klist used with return date Transportation Drivers afety Observation Report - a e wheelchair and using the inloading for transport. spection - a step by step as of the van and review of air prior to leaving the mmercial Wheelchair Lift 1 & 2, Wheelchair Lift	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345134	B. WING				C / 24/2024
NAME OF PI	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LL	с			4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	28	F	689			
	On 1/23/24 Transport the following by the M	er #1 was re-educated on laintenance Director:					
	•	ling the use of the lift, use surement straps including a					
	Transportation Vehicl Calling 911 with any i resident, emphasizing any transport that see because of securing r conditions of a reside conditions. Driver wil Administrator or his/h resuming transport to	ncidents in the van with a g "Drivers are trained to halt ems unsafe whether methods, behavior or health nt, severe weather or traffic I contact the facility					
	feels safe beginning a second person will be driver/transporter.	again. If necessary, a e dispatched to assist the					
	comprehensive check	river Skills Assessment- a klist used with return date Transportation Drivers					
	review of securing the	afety Observation Report - a e wheelchair and using the inloading for transport.					
	review of key function	spection - a step by step as of the van and review of air prior to leaving the					
		were viewed: A Commercial ators Video Part 1 & 2, How					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
PELICAN	HEALTH RANDOLPH LL	C		4801 RANDOLPH ROAD CHARLOTTE, NC 2821	1		
(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 689	place in the facility an return demonstration Director. The facility has 2 train Maintenance Director Systematic Changes New Transporters will Maintenance Director on an annual basis or on the Facility Van Ma securement straps, cu of Facility transportati daily pre-trip inspectic with any incidents in t Transportation Driver completed, Transport Report completed, Sa completed. The follow The Commercial Whe Part 1 & 2, How to Op the manufacturers Re Program. The Maintenance Director Indicate how the facil performance to make sustained. Effective 1/23/2024 th completed daily by the	hair Lift and a aint System Training of these videos takes d is confirmed by skills with the Maintenance hed transporters: The and Transporter#1 be trained by the prior to any transports and in the following: re-education anual and placement of the urrent Policy and Procedure on Vehicle dated 10/2018, on completion, calling 911 he van with a resident. A Skills Assessment will be ation Safety Observation offety observation report wing videos will be viewed: belchair Lift Operators Video berate a Wheelchair Lift and ostraint System Training ector is responsible for ng annual training. https://www.ins.ins.ins.ins.ins.ins.ins.ins.ins.ins	F 68	9			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED		
		345134	B. WING	B. WING			C //24/2024		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
PELICAN	HEALTH RANDOLPH LL	c		4801 RANDOLPH ROAD CHARLOTTE, NC 28211					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 689	weeks the Maintenan random resident with to ensure the straps a appropriate placemer instructions. On 1/22/2024 an Ad H to review the incident These audits will be r	times per week for 12 ce Director will inspect a their placement in the van are securely placed with the the per the manufacturer's noc QAPI meeting was held and Plan of Correction. eported by the Maintenance	F	68	9				
	Director at the monthl months and reviewed recommendations as The date of Completion	by the committee for further needed.							
	The Administrator is t compliance with this a	he individual responsible for action plan.							
	for immediate jeopard the following: The facility provided of their corrective action provided to the Mainte Transporter #1. The p completed prior to an by Transporter #1. The audited these inspect 1/23/2024 to 3/11/202 conducted of Transport Maintenance Director correct method to res resident into the trans securement straps, the and J-hooks. QAPI m	ore-trip inspections were y transportation in the van ne Maintenance Director ions 3 times per week from 24. An observation was							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_	(04//	_ 24/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LLO	c		4801 RANDOLPH ROAD CHARLOTTE, NC 28211			
(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 BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page reviewed.	9 31	F 68	9			
F 867 SS=D	action plan was valida	ent Activities	F 86	7			4/25/24
	monitoring. A facility must establis policies and procedure collections systems, a adverse event monito	and monitoring, including					
	systems to obtain and from direct care staff, resident representativ information will be use	maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and ovement.					
	systems to identify, co information from all de not limited to the facili §483.70(e) and includ	maintenance of effective ollect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance					
	and evaluation of perf	blogy and frequency for such					
	§483.75(c)(4) Facility	adverse event monitoring,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345134	B. WING				C / 24/2024
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PELICAN	HEALTH RANDOLPH LL	c			4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 867	systematically identify analyze and use data adverse events in the facility will use the data prevent adverse events §483.75(d) Program s systemic action. §483.75(d)(1) The face aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will devent will be designed to effi- level to prevent qualit safety problems; and (iii) How the facility with of its performance improve \$483.75(e)(1) The face performance improve high-risk, high-volume consider the incidence of problems in those a	s by which the facility will y, report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and idressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to nents are sustained. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy,	F	86	7		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/31/2024 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345134	B. WING		_		C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PELICAN	HEALTH RANDOLPH LL	с		801 RANDOLPH ROAD HARLOTTE, NC 28211	I		
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	33	F 867				
	resident events, analy implement preventive	nedical errors and adverse					
	distinct performance i number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas	s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs					
	§483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under t	reports to the facility's esignated person(s) rning body regarding its aplementation of the QAPI ler paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on					

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345134	B. WING		0	C 4/24/2024
	ROVIDER OR SUPPLIER HEALTH RANDOLPH LL	c		STREET ADDRESS, CITY, STATE, ZIP C 4801 RANDOLPH ROAD CHARLOTTE, NC 28211		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 867	by: Based on observatio family member, physi staff interviews, the fa and Performance Imp (QAPI) failed to main procedures and moni committee put into pla recertification survey 2/28/2023. This was fa areas of F554 Self-Ad and F689 Supervision These deficiencies w complaint investigatio continued failure of th federal surveys of rec facility's inability to su program. The findings included This tag is cross refer F554: Based on obse resident and staff inte assess whether the s medications was clini resident (Resident #1 a medication at bedsi	is not met as evidenced ins, record review, resident, ician, nurse practitioner, and acility's Quality Assurance provement committee tain implemented itor the interventions that the ace in following the of 11/22/2021 and for 2 deficiencies in the dministration of Medications in to Prevent Accidents. ere recited on the current on survey of 3/13/2024. The he facility during two or more cord shows a pattern of the ustain an effective QAPI I: rred to: ervations, record review, erviews, the facility failed to ically appropriate for 1 of 1) who was observed to have ide. tion survey of 2/28/2023 the	F 8	Corrective Action A. Address how corrective accomplished for those ress have been affected by the operative. Facility Administrator conduct Assurance and Improveme meeting on 03/12/2024 to operation of tag F554 and F B. Address how the facility other residents having the paffected by the same deficite All residents residing at the the potential to be affected. C. Address what measure into place or systemic chara ensure that the deficient pra- recur. Facility Administrator and F Clinical Nurse Consultant re Interdisciplinary team and r Quality Assurance and Perf Improvement Committee of regarding accurately report revising current action plan	idents found to deficient ucted a Quality nt Committee discuss the F689. Ty will identify potential to be ent practice. If facility have es will be put actice will not Regional e-educated the members of the formance n 3/12/24 ing and s as well as	
	self-administer medic reviewed for self-adm	es the ability of a resident to cations for 1 of 2 residents ninistration of medications. rd review, observation,		developing and implementi plans to assure state and fe compliance in the facility. A Interdisciplinary Team Mem not received the Quality As Performance Improvement	ederal ny iber that has surance and	

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	/PLETED
			A. DOILDING			С
		345134	B. WING			4/24/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7/27/2027
				4801 RANDOLPH ROAD		
PELICAN	HEALTH RANDOLPH LL	C		CHARLOTTE, NC 28211		
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
- 007						
F 867	Continued From page		F 86			
		orted from dialysis back to		he/she has received the Qualit	У	
	-	24. Transporter #1 pulled		Assurance and Performance		
		of the dialysis center and hair tipped over, and he hit		Improvement education.		
		ad. Transporter #1 pulled the		All new Interdisciplinary Team	Members	
		er to a parking lot, where		newly hired will be educated o		
		upon Transporter #1 sitting		Assurance and Performance	in Quality	
		d Transporter #1 pulled the		Improvement on date of hire.		
	resident back up into					
	position. Transporter			D. Indicate how the facility pl	ans to	
		s back to the facility where		monitor its performance to mal		
		the Assistant Director of		solutions are sustained.		
	Nursing (ADON) to h	ave a bump on his head		1. The Interdisciplinary Team	n, including	
	behind his left ear an	d he reported head pain and		the facility Medical Director, wi	ll meet	
	nausea after the fall.	It was determined by the		monthly to conduct the facilitie	s Quality	
		eeded to go to the hospital		Assurance and Performance		
		was a high likelihood of a		Improvement meeting. Special	attention	
		ome for Resident #1 due to		will be given to assessing the		
		his wheelchair tipped over		effectiveness of the monitoring		
	in the transportation			deficiencies F554 and F689 as		
	-	/ed Plavix (a blood thinning		prevention of any new repeat of		
		scan completed at the		Should any interdisciplinary te		
		for head injury. This was		find that the facility may need a		
	for 1 of 3 residents re	eviewed for accidents.		Impromptu Quality Assurance		
	During the recentification	tion outprove of 11/00/0001 the		Improvement meeting for a fac		
		tion survey of 11/22/2021 the le enteral feedings and		compliance issue, the Adminis		
		0		organize a meeting and notify members in order for a revision		
		ls only to 1 of 2 sampled nsafe to consume fluids by		present action plan or for a new		
		I nectar thickened liquids to		action plan in order to maintair		
	-	sician order for nothing by		compliance in the facility. Qua		
		therapy recommendation for		Assurance monitoring will take		
		d pleasure foods and no		each QAPI meeting monthly a	•	
		litionally, the facility failed to		impromptu meetings held. This		
		ent quarterly smoking		tool will be signed off by each		
	assessments for 2 of			Interdisciplinary team member	after each	
		. These failures occurred for		meeting accepting and acknow		
	-	ents reviewed for supervision		monitoring and revisions set for		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						D: 05/31/2024 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
345134		345134	B. WING		C 04/24/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PELICAN HEALTH RANDOLPH LLC			4801 RANDOLPH ROAD CHARLOTTE, NC 28211				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE			
F 867	Continued From page	e 36	F 867				
	During the recertification survey of 2/28/2023 facility failed to supervise 1 of 4 residents reviewed for smoking. An interview was conducted with the Administrator on 3/11/2024 at 4:10 PM. The Administrator explained the QAPI committee met monthly with the physician, Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurse, Business Office Manager, Social Worker, Dietary Manager, Housekeeping/Laundry Supervisor, Activities Director, and Unit Manager, and a quarterly meeting that the Pharmacist attended. The Administrator described the function of the QAPI committee to identify issues, develop a plan of correction or a Performance Improvement Plan, review accidents, staffing issues, hospitalized residents and review any plan of correction that is in place. The Administrator reported an ad hoc QAPI meeting was conducted in January 2024 after the van accident and the plan of correction was developed. The Administrator explained she started in her position in May 2023 and the citations from the survey in 2/2023 were still being discussed and monitored. The Administrator reported the QAPI committee would discuss prior		Improvement committee. Date of Compliance date is		24		
				F554 and F689 will be reviewed a for potiential review for 6 months.			
				The Administrator is the individual responsible for compliance with this action plan.			
		hs after the areas had been					

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