STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, and Nurse Practitioner (NP) interviews, the facility failed to notify the physician or the NP of a [MEDICAL TREATMENT] treatment that could not be rescheduled which resulted in 2 missed [MEDICAL TREATMENT] treatments for 1 of 2 residents (Resident #3) reviewed for notification. Findings included: Resident #3 was readmitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #3's admission Minimum (MDS) data set [DATE] revealed he had intact cognition and had received [MEDICAL TREATMENT] services. Resident #3 had a plan of care in place dated 6/19/2020 related to [MEDICAL TREATMENT]. Interventions were inclusive of [MEDICAL TREATMENT] treatment as scheduled and medications as ordered. Resident #3's hospital discharge summary dated 8/8/2020 revealed he was hospitalized for [REDACTED]. Discharge medications included direction to administer [MEDICATION NAME] 0.5 milligrams (mg) every 12 hours for 14 days for anxiety. Review of Resident #3's August 2020 electronic physician orders [REDACTED]. Review of the medical record for 8/08/2020 through 8/13/2020 revealed Resident #3 received [MEDICAL TREATMENT] treatment on 8/12/2020. An interview was completed with Nurse Aide (NA) #1 on 8/12/2020 at 8:46 AM. NA #1 explained Resident #3 had refused [MEDICAL TREATMENT] treatment on 8/10/2020 because he did not get his [MEDICATION NAME] and he always refused [MEDICAL TREATMENT] if he did not get it. She recalled the same thing happening on 8/11/2020 and was not certain if transport showed up. NA #1 indicated she informed the nurse on 8/10/2020 and 8/11/2020 of his refusal to go to [MEDICAL TREATMENT] because he had not received his [MEDICATION NAME]. An interview and observation was completed on 8/12/2020 at 8:51 AM of Resident #3. He was observed lying in his bed at the time. He expressed he was not going to his [MEDICAL TREATMENT] appointment if he did not receive his [MEDICATION NAME]. He explained he became extremely anxious on [MEDICAL TREATMENT] days and the medication allowed him to relax. Resident #3 continued to verbalize he was able to relax and tolerate his [MEDICAL TREATMENT] treatment once medicated. He did not understand why the nurses refused to administer the medication. He could not recall the last time he received [MEDICAL TREATMENT] treatment. He did not realize he had missed 2 [MEDICAL TREATMENT] treatments. A nursing note written by Nurse #2 dated 8/10/2020 documented Resident #3's transportation to [MEDICAL TREATMENT] did not arrive. Nurse #2 notified Unit Manager (UM) #2 and the NP. The NP gave Nurse #2 verbal orders for Resident #3 to receive [MEDICAL TREATMENT] either at the [MEDICAL TREATMENT] center or send him to the hospital for [MEDICAL TREATMENT] treatment on 8/10/2020. An interview was completed with Nurse #2 at 11:15 AM on 8/12/2020. Nurse #2 reported on 8/10/2020 the NA informed her that Resident #3's [MEDICAL TREATMENT] transportation did not arrive. Nurse #2 explained she did not realize Resident #3 required [MEDICAL TREATMENT] until the NA reported the transportation issue. Nurse #2 explained Resident #3 requested [MEDICATION NAME] which was not administered because it was not on the eMAR. Nurse #2 reported she was not aware Resident #3's refusal was linked to the medication. At the direction of UM #2, Nurse #2 notified the NP. Nurse #2 reported the NP gave verbal orders to send Resident #3 to the hospital for [MEDICAL TREATMENT] if the [MEDICAL TREATMENT] center could not accommodate Resident #3 that day (8/10/2020). Nurse #2 informed the UM #2 of the NP's verbal orders. Nurse #2 was not aware of any [MEDICAL TREATMENT] arrangements for Resident #3. Nurse #2 reported Resident #3 had not gone to [MEDICAL TREATMENT] when she left duty at 3:00 PM on 08/10/2020. A nursing note written by Nurse #4 dated 8/11/2020 documented Resident #3 refused [MEDICAL TREATMENT] because he could not receive [MEDICATION NAME]. Nurse #4 documented Resident #3 did not have a [MEDICATION NAME] order. The NP received notification and ordered an emergency room evaluation. Nurse #4 prepared Resident #3 for ED transfer. A telephone interview was completed on 8/13/2020 at 11:52 AM with Nurse #4. She explained she worked with Resident #3 on 8/11/2020. She stated the NA had informed her Resident #3 refused [MEDICAL TREATMENT] treatment due to not receiving his [MEDICATION NAME] on 8/11/2020. She recalled there was no [MEDICATION NAME] ordered on the eMAR for Resident #3. Nurse #4 notified the NP of Resident #3's refusal of [MEDICAL TREATMENT] and inability to recall his last [MEDICAL TREATMENT] treatment date. Nurse #4 verbalized the NP gave verbal orders to send the resident to emergency room for evaluation. Nurse #4 verbalized she prepared Resident #4 for ED transfer. A late entry nursing note written by UM #2 dated 8/12/2020 for 8/10/2020 documented UM #2 notified the NP of Resident #3's rescheduled [MEDICAL TREATMENT] appointment on 8/11/2020 at 9:30 AM. An interview was completed on 8/12/2020 at 12:00 PM with Unit Manager (UM) #2. He stated Resident #3 was scheduled to go out to [MEDICAL TREATMENT] on 8/10/2020 but did not make his appointment. UM #2 expressed he was not notified of the missed appointment until the afternoon of 8/10/2020 by Nurse #3. UM #2 explained he contacted Resident #3's [MEDICAL TREATMENT] unit to determine if he could be seen the evening of 8/10/2020 but they could not accommodate this request but scheduled Resident #3 for [MEDICAL TREATMENT] at 9:30 AM on 8/11/2020. UM #2 explained he was not aware of any other orders given by the NP to send Resident #3 out to the hospital if [MEDICAL TREATMENT] could not be completed on 8/10/2020. UM #2 communicated when a resident refused [MEDICAL TREATMENT] treatment, nurse management should be notified immediately, physician or NP notification made and determination made for alternative arrangements and/or further physician orders. A telephone interview was completed on 8/12/2020 at 1:05 PM with the NP. She expressed she would have expected to have been notified of Resident #3's refusal of [MEDICAL TREATMENT] treatment scheduled for 8/10/2020. The NP does not recall being contacted by facility staff on 8/10/2020 regarding Resident #3 not being able to receive [MEDICAL TREATMENT] treatment that day. The NP verbalized she would not have agreed to a [MEDICAL TREATMENT] appointment on 8/11/2020 because she understood Resident #3 had not been dialyzed since 8/5/2020. The NP explained the facility should have followed the verbal orders given on 8/10/2020 which directed them to obtain a [MEDICAL TREATMENT] appointment for 8/10/2020 or send the resident to the ED for evaluation and treatment. An interview was completed on 8/12/2020 at 12:19 PM with the Interim Director of Nursing (DON) who revealed follow up notification should have been made to the physician or NP by nursing staff. Nurses should notify nurse management, in addition to, the physician or NP when residents refused [MEDICAL TREATMENT] treatment.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interview, and record review, the facility failed to provide oxygen therapy per physician order [REDACTED].#3 was readmitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #3 admission Minimum (MDS) data set [DATE] revealed he had intact cognition. Resident #3 was coded as receiving oxygen therapy. Resident #3 had an alteration in respiratory status plan of care in place revised on 6/12/2019. Interventions were inclusive of monitoring oxygen flow rate and response. Review of the August 2020 physician orders [REDACTED]. An observation and interview was completed on 8/10/2020 at 8:11 AM with Resident #3. He was resting in bed watching television. His nasal cannula was applied to nares. A portable oxygen tank was observed which revealed the gauge in the red area which indicated the portable oxygen tank was empty. Resident #3 stated he was having difficulty breathing. The portable oxygen tank was set at 2 liters. An observation and interview was completed on 8/10/2020 at 8:26 AM with Nurse #1. He stated he last checked on

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.

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #3 around 4:00 AM. He did not recall any concerns with Resident #3's portable oxygen tank. An oxygen saturation level was obtained which revealed a reading of 91% to 92%. Nurse #1 checked the portable oxygen tank and verbalized the portable oxygen tank was empty. Nurse #1 verbalized Resident #3 would need another portable oxygen tank that was full. He indicated there were no in-room oxygen concentrators available. Nurse #1 went to retrieve a full portable oxygen tank for Resident #3. An interview was completed on 8/10/2020 at 12:03 PM with Unit Manager (UM) #2. He stated residents that were in their rooms should be connected to an in-room oxygen concentrator versus a portable oxygen tank. Those residents on oxygen therapy should have their respiratory status checked throughout the shift by nursing. Nursing staff should ensure oxygen therapy was in place at the ordered liter and their equipment was functional. An additional observation was completed of an oxygen saturation level obtained on 8/10/2020 at 12:12 PM by the UM of Resident #3. The reading obtained was 96%. Resident #3 indicated he was breathing better. A telephone interview was completed on 8/11/2020 at 11:45 AM with the Administrator. She explained staff should ensure oxygen tanks were full and functional when applying to the residents. She further expressed staff should check to ensure the oxygen therapy was effective in increasing the oxygen saturation for the resident. The Administrator communicated for those resident's that remained in their rooms, the preference would be to utilize an in-room oxygen concentrator versus a portable oxygen tank. She voiced the facility had in-room concentrators available for resident use. She verbalized she also ordered an additional 15 in-room oxygen concentrators for resident use.

F 0760

Level of harm - Actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on resident, staff, nurse practitioner, physician and Nephrologist interviews, and record review, the facility failed to administer anti-anxiety medication to 1 of 3 sampled residents who received psychoactive medications (Resident #3). The omissions of the anti-anxiety medication caused Resident #3 to refuse [MEDICAL TREATMENT] which resulted in emergency room treatment for [REDACTED]. The findings included: Resident #3 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #3's admission Minimum Data Set ((MDS) dated [DATE] documented an assessment of intact cognition. The MDS indicated Resident #3 received [MEDICAL TREATMENT] treatments. The care plan for Resident #3 dated 06/19/2020 indicated interventions for [MEDICAL TREATMENT] care included scheduled [MEDICAL TREATMENT] treatment and administration of medications as ordered. The care plan indicated Resident #3 required encouragement to go for [MEDICAL TREATMENT] treatment. A Nurse Practitioner (NP) note dated 07/06/2020 documented Resident #3 experienced anxiety and required [MEDICATION NAME] (an anti-anxiety medication) to aid in compliance with [MEDICAL TREATMENT] treatment. The NP continued the use of [MEDICATION NAME] 0.5 milligrams (mg.) one tablet every 12 hours as needed for anxiety for 14 days. On 07/16/2020, the NP documented Resident #3 continued to experience anxiety. The NP increased the frequency of the [MEDICATION NAME] 0.5 mg. to every 8 hours as needed for anxiety with reevaluation to occur in 14 days. A NP note dated 07/23/2020 documented Resident #3 requested an increase in dosage for continued anxiety. The NP increased the [MEDICATION NAME] to 1 mg. every 8 hours as needed for anxiety for 14 days with reevaluation to occur in 14 days. A hospital discharge summary dated 08/08/2020 documented Resident #3 was hospitalized from [DATE] to 08/08/2020 for treatment of [REDACTED]. Resident #3 received [MEDICAL TREATMENT] during his hospital stay. Discharge medications included [MEDICATION NAME] 0.5 mg. every 12 hours for 14 days. Resident #3's August 2020 electronic Medication Administration Record [REDACTED]. A nursing note dated 08/12/2020 as late entry for 08/08/2020 documented the admitting nurse, Nurse #3, informed Unit Manger (UM) #1 of the change of frequency of the [MEDICATION NAME] dose. UM #1 documented the NP gave verbal orders to discontinue the [MEDICATION NAME].

Resident #3's physician's orders did not contain an order to discontinue the [MEDICATION NAME]. Nurse #3 did not return telephone calls and was not able to be interviewed. Interview with UM #1 on 08/12/2020 at 1:45 PM revealed the NP was contacted upon Resident #3's readmission on 08/08/2020 and discontinued the [MEDICATION NAME] order. UM #1 could not provide a reason for the lack of a written order to discontinue the [MEDICATION NAME]. Telephone interview on 08/13/2020 at 9:46 AM with the NP specified in the readmission note of 08/08/2020 revealed the NP was not contacted by the facility on 08/08/2020. The NP explained she was not aware of Resident #3's 08/02/2020 hospitalization until 08/12/2020. The NP reported she did not discontinue the [MEDICATION NAME] on 08/08/2020. A nursing note dated 08/10/2020 written by Nurse #2 documented Resident #3's transportation to [MEDICAL TREATMENT] did not arrive. Nurse #2 informed Unit Manager (UM) #2 and notified the NP. The NP directed Resident #3 to receive [MEDICAL TREATMENT] either at the [MEDICAL TREATMENT] treatment center or the hospital. A late entry nursing note dated 08/12/2020 for 08/10/2020 documented UM#2 notified the NP of Resident #3's rescheduled [MEDICAL TREATMENT] appointment on 08/11/2020 at 9:30 AM. A nursing note dated 08/11/2020, written by Nurse #4, documented Resident #3 refused [MEDICAL TREATMENT] because he could not receive [MEDICATION NAME].

Nurse #4 documented Resident #3 did not have an [MEDICATION NAME] order. The NP received notification and ordered an emergency room evaluation. The emergency room evaluation dated 08/11/2020 revealed Resident #3 received treatment for [REDACTED]. The physician documented [MEDICAL CONDITION] with a potassium level of 6.1 Millimoles per liter (mmol/L) with a normal reference range of 3.5 mmol/L to 5.1 mmol/L. Resident #3's EKG (electrocardiogram) had no significant changes. Resident #3's blood pressure measured 204/92 millimeters of mercury. (mmHg.). Resident # 3 received oral medications to lower the potassium level, blood pressure and anxiety. Resident #3 returned to the facility. During an interview with Resident #3 on 08/12/2020 at 8:51 AM, Resident #3 explained he became extremely anxious on [MEDICAL TREATMENT] days. Resident #3 reported the [MEDICATION NAME] enabled him to go to [MEDICAL TREATMENT]. Resident #3 explained he needed the [MEDICATION NAME] and did not understand the refusal by nurses to administer the medication. Interview with Nurse Aide (NA) #1 on 08/12/2020 at 8:46 AM revealed Resident #3 refused to go to [MEDICAL TREATMENT] if [MEDICATION NAME] was not administered. NA #1 reported Resident #3's [MEDICAL TREATMENT] refusal due to lack of [MEDICATION NAME] to Nurse #2 on 08/10/2020 and to Nurse #4 on 08/11/2020. Interview with Nurse #2 on 08/12/2020 at 11:15 AM revealed Resident #3 requested [MEDICATION NAME] the morning of 08/10/2020. Nurse #2 explained to Resident #3 that there was not an order for [REDACTED].#2 reported Resident #3 had [MEDICATION NAME] available for administration but did not have an order. Continued interview with Nurse #2 revealed NA #1 informed her at approximately 1:00 PM or 1:30 PM on 08/10/2020 that transportation did not arrive to take Resident #3 to [MEDICAL TREATMENT]. Nurse #2 reported she did not know Resident #3's refusal of [MEDICAL TREATMENT] was connected to the [MEDICATION NAME]. At the direction of UM #2, Nurse #2 notified the NP. Nurse #2 reported the NP directed her to send Resident #3 to the hospital for [MEDICAL TREATMENT] if the [MEDICAL TREATMENT] center could not dialyze Resident #3 that day (08/10/2020). Nurse #2 informed UM #2 of the NP's order. Nurse #2 reported Resident #3 had not gone to [MEDICAL TREATMENT] when she left duty at 3:00 PM on 08/10/2020. Telephone interview with Nurse #4 on 08/13/2020 at 11:52 AM revealed NA #1 informed her of Resident #3's refusal of [MEDICAL TREATMENT] transportation due to not receiving [MEDICATION NAME] on 08/11/2020. Nurse #4 explained there was no [MEDICATION NAME] ordered on the eMAR for Resident #3. Nurse #4 notified the NP of Resident #3's refusal of [MEDICAL TREATMENT] and Nurse #4's inability to determine the most recent date of [MEDICAL TREATMENT] treatment. The NP ordered emergency room evaluation. A telephone interview with the NP on 08/12/2020 at 1:06 PM revealed Resident #3 should have received the [MEDICATION NAME] as ordered on the discharge summary dated 08/08/2020. The NP explained she did not know Resident #3's refusal of [MEDICAL TREATMENT] was connected to the [MEDICATION NAME] when notified on 08/10/2020. The NP explained she ordered an emergency room evaluation on 08/11/2020 when informed of Resident #3's missed [MEDICAL TREATMENT] sessions and request for [MEDICATION NAME]. The NP reported the nurse (Nurse #4) could not be precise in the number of missed sessions so the NP did not want to order [MEDICATION NAME] until after Resident #3 received the emergency room evaluation. During an interview with UM #2 on 08/12/2020 at 11:59 AM, UM #2 explained he did not know Resident #3 refused [MEDICAL TREATMENT] because of [MEDICATION NAME] omission until 08/11/2020. UM #2 did not know Resident #3's discharge summary contained an order for [REDACTED].#3 should have received the [MEDICATION NAME] as ordered. The interim DON explained Resident #3 required the [MEDICATION NAME] prior to [MEDICAL TREATMENT] treatments. The interim DON described Resident #3 as extremely anxious on [MEDICAL TREATMENT] days. Telephone interview with Resident #3's physician on 08/12/2020 at 12:45 PM revealed Resident #3 should have received [MEDICATION NAME] as ordered especially since the omissions caused [MEDICAL TREATMENT] refusal and emergency room evaluation. A telephone interview was conducted with Resident #3's Nephrologist on 08/13/2020 at 2:32 PM. The Nephrologist explained omission of [MEDICAL TREATMENT] caused elevated potassium but could not be certain if Resident #3's elevated potassium was due to the omitted session on 08/10/2020. The Nephrologist reported Resident #3 should have received the [MEDICATION NAME] as ordered.