

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Pelican Health Randolph LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4801 Randolph Road Charlotte, NC 28211	

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)
<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934</p> <p>Based on observation, staff interviews and record review, the facility failed to update the comprehensive person-centered individualized care plan to reflect an assessment to self-administer medications. This failure occurred for 1 of 1 sampled resident reviewed for self-administration of medications (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses that included neuralgia and neuritis (nerve pain caused by inflammation of the nerves).</p> <p>A 1/10/24 quarterly Minimum Data Set (MDS) assessment evaluated Resident #3 with adequate hearing and vision, clear speech, made self-understood, able to understand others, intact cognition, no upper extremity impairment, and no behavior symptoms.</p> <p>A review of the care plan revised on 2/28/24 for Resident #3 revealed it did not reflect that Resident#3 was approved to self-administer medication.</p> <p>A 3/11/24 Self Administration of Medications assessment, completed by the Assistant Director of Nursing (ADON) recorded that Resident #3 was assessed by the interdisciplinary team (IDT) as approved to self-administer pain relief creams.</p> <p>A 3/11/24 nurse progress note written by the ADON recorded Nurse Practitioner (NP) was aware and approved of pain relief creams that Resident #3 had ordered and requested to use.</p> <p>An observation on 4/30/24 at 12:01 PM of Resident #3's room revealed two pain relief creams were both stored on the over-bed table.</p> <p>During an interview with Resident #3 on 4/30/24 at 1:27 PM, he stated that he ordered pain relief creams that he administered to himself during the night and early in the morning for the relief of neuropathy pain (a condition that causes weakness, numbness, and pain) in his legs.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>The ADON stated in an interview on 4/30/24 at 4:42 PM that she completed the 3/11/24 Self Administration of Medications assessment for Resident #3 at his request to apply pain relief creams. The ADON stated that she educated Resident #3 on the process of administering medications to himself, but that she did not update the care plan.</p> <p>During a follow up phone interview on 5/3/24 at 12:14 PM, the ADON stated that the Self Administration of Medications assessment for Resident #3 was discussed during a clinical morning meeting, but that it was up to the MDS Nurse to decide whether or not to update the care plan as she was not the MDS Nurse and was not sure if the care plan should reflect Resident #3's Self Administration of Medications assessment.</p> <p>During a phone interview on 5/3/24 at 11:10 AM, the MDS Nurse stated that she was in the second week as the MDS Nurse for facility, this was her first position as a MDS Nurse and that she was training in her role. She stated that she had not yet been trained in the process to complete care plans, but that she would receive training on how to complete care plans later that day (5/3/24). The MDS Nurse stated that care plans were the responsibility of the IDT.</p> <p>An interview with the Director of Nursing (DON) occurred on 5/1/24 at 6:30 PM, the DON stated that the IDT, which included the DON, ADON, and MDS Nurse, discussed Resident #3's ability to self-administer medications and that he independently completed most of his activities of daily living (ADL). The DON stated his ADL care plan could have included the task that he was able to administer medications, but it did not and that he did not have a care plan to self-administer medications. She stated she could not say if the task to self-administer medications should have been added to the Resident's care plan.</p> <p>The NP stated during a phone interview on 5/2/24 at 11:26 PM that Resident #3 was competent and assessed to administer pain relief creams to himself. The NP stated that Resident #3 should have a care plan to address his ability to safely administer pain relief cream medications.</p> <p>The Administrator stated during a phone interview on 5/3/24 at 1:35 PM that the facility was not required to develop a care plan for Resident #3 to self administer medication, but rather the facility was required to complete an IDT assessment which was completed. The Administrator further stated that the NP was not the person to ask about the requirement to develop care plans.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to keep a urinary catheter drainage bag off the floor to reduce the risk of infection for 1 of 2 residents reviewed with urinary catheters (Resident 2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE]. Her cumulative diagnoses included obstructive and reflux uropathy (blockage in the urinary tract), overactive bladder, severe chronic kidney disease, stage 4, and a history of urinary tract infections (UTIs).</p> <p>Resident #2's catheter care plan revised 7/3/23 included the use of a suprapubic catheter related to her diagnosis of obstructive uropathy and history of UTIs. Staff interventions included monitoring for conditions and complications that may contribute to urinary infections.</p> <p>A 3/12/24 quarterly Minimum Data Set (MDS) assessment, indicated Resident #2 had adequate hearing/vision, able to understand and be understood, clear speech, intact cognition, and no impairment in upper body range of motion. The MDS recorded that Resident #2 required partial/moderate staff assistance with upper/lower body dressing, toileting, transfers, and personal hygiene. The MDS assessed Resident #2 with an indwelling urinary catheter.</p> <p>A continuous observation of Resident #2 occurred on 4/30/24 from 1:05 PM until 1:12 PM. During the continuous observation, Resident #2 propelled independently from the dining room to her room. While Resident #2 propelled from the dining room to her room, the catheter drainage bag was observed attached to the center section of her wheelchair underneath the seat, with approximately one inch of the bottom portion of the catheter drainage bag dragging on the floor as she propelled herself to her room.</p> <p>On 4/30/24 at 1:15 PM, the Rehab Director measured the distance from the dining room to Resident #2's room at the surveyor's request and stated the distance was 226 feet.</p> <p>Resident #2 was observed and interviewed in her room on 4/30/24 at 1:16 PM while seated in her wheelchair. Resident #2 stated that she was not aware that her catheter drainage bag was touching the floor because she could not see underneath her wheelchair. She further stated that sometimes in the past, staff have repositioned the catheter drainage bag because staff have said it was on the floor. Resident #2 said she was fine with her catheter drainage bag positioned underneath her wheelchair and stated, As long as it is not on the floor, I don't want to get an infection. She stated that sometimes staff positioned the catheter drainage bag to the side of her wheelchair to keep it off the floor, but when staff position it next to the wheel of her wheelchair, it gets caught in the wheel and she moves it. She also stated that sometimes, I move it to the side of my wheelchair when I need to get in bed or go to the bathroom, but I did not move it today, it's been in the same place since I got in my chair this morning.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of Resident #2 in her wheelchair in her room and an interview with Nurse #1 occurred on 4/30/24 at 1:20 PM. Nurse #1 stated that she worked at the facility through a staffing agency, and it was her first day as the Nurse for Resident #2. Nurse #1 observed the catheter drainage bag for Resident #2 and stated that she had not observed Resident #2 that day in her wheelchair with the catheter drainage bag touching floor. When asked by the surveyor to describe what she saw, Nurse #1 stated that the catheter drainage bag was positioned in the center section of the Resident's wheelchair underneath the seat and that it was touching the floor. Nurse #1 said that the drainage bag should be positioned below the bladder but not touching the floor for infection control prevention to prevent UTIs.</p> <p>An observation of Resident #2 in her wheelchair in her room and an interview with Nurse Aide (NA) #1 occurred on 4/30/24 at 1:22 PM. NA #1 stated she was the assigned NA to care for Resident #2 that day. She observed Resident #2 and stated that The catheter drainage bag is touching the floor, but it should not be on the floor. NA #1 further stated I put it in the middle of the chair underneath her seat at the cross bars, that's where I usually put it, she propels all around the facility and sometimes it will shift to the left or the right, when it does it will touch the floor at times, and I have to reposition it. NA #1 stated that the catheter drainage bag was still in the same position where she attached it that morning around 11:00 AM when she assisted Resident #2 to her wheelchair. NA #1 stated that she did not realize that the catheter drainage bag was touching the floor when she attached it to the wheelchair. NA #1 stated she received a recent in-service on catheters related to infection control and to keep them off the floor.</p> <p>An interview with the Infection Control Preventionist (ICP)/Assistant Director of Nursing (ADON) on 4/30/24 at 4:45 PM revealed that Resident #2 at times repositioned her catheter drainage bag because she did not like it to touch the floor or the wheels of her wheelchair. The ICP/ADON also stated that Resident #2 moved the catheter drainage bag when she transferred herself to her bed or to the commode. The ICP/ADON stated that the catheter drainage bag should be positioned below the Resident's bladder but not on the floor. She stated that the floor is an infection control issue because the floor is very dirty. The ICP/ADON stated that she provided a staff in-service on 2/21/24 on infection control related to catheters and reminded staff that the catheter drainage bag should not be on the floor. The ICP/ADON provided a copy of the 2/21/24 staff in-service and record of staff attendance which included NA #1's signature.</p> <p>Resident #2 was observed in her wheelchair in her room with the Director of Nursing (DON) on 4/30/24 at 1:25 PM. During the observation the DON stated that regarding the positioning of the catheter drainage bag, It should be higher than that and not on the floor to prevent infections or UTIs for this resident and for other residents. The DON repositioned the drainage bag to left side of the wheelchair underneath the seat, near the wheel and stated to Nurse #1, If it stays positioned there, it will not move. Resident #2 asked the DON where she positioned the catheter drainage bag and the DON stated, next to your wheel. The DON stated that Resident #2 rolled herself around the facility and when the catheter drainage bag was positioned in the center section underneath the wheelchair seat at the cross bars, it will move around. During a follow up interview with the DON on 4/30/24 at 1:45 PM, the DON stated that Resident #2 at times repositioned the catheter drainage bag when she transferred to the commode or to her bed or if it was attached next to the wheel of her wheelchair because she did not like for it to touch her wheels. The DON stated that Resident #2 had just moved her catheter drainage bag after the DON moved it because the DON positioned it near the wheel of her wheelchair.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>20934</p> <p>Based on observations, staff interviews and record review, the facility failed to post nurse staffing data at the beginning of each shift for 2 of 2 days of the survey.</p> <p>The findings included:</p> <p>On 4/30/24 at 11:00 AM nurse staffing data was observed posted for 4/28/24 and recorded the census of 85. The first shift staff was recorded as 1 Registered Nurse (RN), 5 Licensed Practical Nurses (LPN), and 9 Nurse Aides (NA). The second shift staff was recorded as 0 RN, 5 LPN, and 8 NA. The third shift staff was recorded as 0 RN, 3 LPN, and 5 NA.</p> <p>On 5/1/24 at 10:37 AM nurse staffing data was observed posted for 4/30/24 and recorded the census of 82. The first shift staff was recorded as 0 RN, 5 LPN, and 9 NA. The second shift staff was recorded as 1 RN, 5 LPN, and 8 NA. Third shift staff was recorded as 1 RN, 2 LPN, and 5 NA.</p> <p>An interview on 5/1/24 at 5:45 PM with the Scheduler revealed she typically worked from 8:30 AM or 9:00 AM until 4:30 PM or 5:00 PM. The Scheduler stated she was responsible for posting nurse staffing data daily once she arrived at work. She stated she was aware that the nurse staffing data was to be posted daily but that she was not aware of the requirement to post it at the beginning of each shift. She said she only posted the nurse staffing data once daily each day and that if there were any staffing changes, she did not adjust the data per shift on the nurse staff posting once it was posted. The Scheduler stated that she did not arrive at work until after the first shift started and usually left during the second shift. The Scheduler stated that she was on vacation Saturday 4/20/24 through Monday 4/29/24. When she returned to work on Monday (4/29/24) she arrived at work about 11:45 AM and stated that she did not remember if she paid attention to the nurse staff posting because she arrived to work so late that day. She stated, I did not pay it any attention. She stated that on Tuesday (4/30/24), she was off that morning for an appointment, so she printed the nurse staffing data for 4/30/24, the day before (4/29/24), and placed it in the sign placard behind the other postings. The Scheduler stated that when she was off or on vacation, she communicated via an email to the Receptionist, the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the Administrator to let them know she would be off and that someone would need to post the nurse staffing data in her absence. The Scheduler stated that when she came to work on 5/1/24, the nurse staffing data for 4/30/24 was posted and that she posted the nurse staffing data for 5/1/24 sometime after 10:00 AM or so that morning.</p> <p>The Receptionist was interviewed on 5/1/24 at 5:50 PM and stated that she would post nurse staffing data if she was asked to, but that she had not been asked. She stated she did not realize it was not posted correctly that morning (5/1/24) until she saw the Surveyor look at it.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>The ADON stated in an interview on 5/1/24 at 6:00 PM the Scheduler sent an email that included the ADON when she was off or absent regarding posting of the daily nurse staffing data in her absence. The ADON stated the email was sent to all the managers and that the manager who arrived at work first should post the nurse staffing data. The ADON stated that she did not typically check the posting of nurse staffing data to make sure it was posted unless she was responsible for putting the nursing assignment sheets out. The ADON stated she was aware of the requirement to post nurse staffing data at the beginning of each shift. The nursing shifts were identified as 7A to 3P, 3P to 11P, and 11P to 7A.</p> <p>The DON stated in an interview on 5/1/24 at 6:30 PM that nurse staffing data was usually posted daily by the Scheduler. The DON said she was not sure who was responsible to post the nurse staffing data in the Scheduler's absence. The DON stated that the Scheduler communicated vacation plans to the Administrator, and that staff vacations were posted on a calendar so the managers could see when staff were on vacation. The DON stated that she was not sure why the nurse staffing data was not posted daily and up to date.</p> <p>The Administrator stated on 5/1/24 at 5:37 PM in an interview that the nurse staffing data should be posted daily. The Administrator stated that the Scheduler was responsible for posting nurse staffing data daily. The Administrator reviewed the regulatory requirement during the interview and stated that she saw the requirement to post nurse staffing data at the beginning of the shift, but her expectation was for her staff to post it daily, not necessarily at the beginning of the shift.</p>		