STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	4801 Randolph Road Charlotte, NC 28211

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, the facility failed to ensure a dependent resident could access the call light device for 1 of 2 residents reviewed for accommodation of needs (Resident #5).The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses that included cervical spinal cord injury and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. An observation was conducted on 9/10/2025 at 2:15 PM of Nurse Aide (NA) #1 providing catheter care to Resident #5. The call button was not in view during the observation. NA #1 completed catheter care and began to exit Resident #5's room without providing Resident #5 with a call button. Surveyor asked if Resident #5 had a way to call staff for assistance. NA #1 looked behind Resident #5's nightstand and retrieved the call button. NA #1 set the call button on the right side of Resident #5's head and asked him to press the button. Resident #5 pressed the button with the right side of his head. NA #1 checked to see if the indicator light was activated on the outside of Resident #5's room prior to leaving the room. An interview was conducted with NA #1 on 9/10/2025 at 2:45 PM. NA #1 stated that she did not normally work with Resident #5; however, was familiar with the special call button and Resident #5 used his head to activate the button. NA #1 stated she was distracted by completing catheter care for survey observation and forgot to give Resident #5 his call button prior to Surveyor asking about the call button. Another observation was conducted on 9/10/2025 at 8:10 PM. While Surveyor stood in the lobby of the facility, Resident #5 was heard yelling for help from his room at the end of the hall. Upon entry to Resident #5's room, the call button was observed hanging off the right side of his bed, out of Resident #5's reach. NA #3 was observed in the hall transporting a resident in a wheelchair. NA #3 entered Resident #5's room, asked Resident #5 how he could assist and gave Resident #5 his call button. NA #3 assisted Resident #5 in removing dentures and confirmed that Resident #5 could access his call button. An interview was conducted with Resident #5 on 9/8/2025 at 11:00 AM. Resident #5 stated that staff did not like to give him his call button. Resident #5 stated that he could not care for himself because he was paralyzed from the chest down to his feet and that he depended on staff for assistance. An interview with NA #3 revealed that he was assigned as Resident #5's NA. NA #3 reported he forgot to give Resident #5 his call button because he was trying to get all his residents in bed, and he knew that he would return to Resident #5 shortly after placing another resident in bed. NA #3 stated that he normally gave Resident #5 his call button prior to leaving Resident #5's room. An interview was conducted with the Director of Nursing (DON) on 9/12/2025 at 1:45 PM. The DON stated she expected staff to be attentive to residents' environment and ensure that each resident had access to call for assistance if needed. DON stated that NA #1 and NA #3 should have given Resident #5 his button prior to leaving Resident #5's room. During an interview with the Administrator on 09/12/2025 at 2:05 PM, she stated she expected staff to ensure each resident had a call bell in reach prior to leaving the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, residents and staff interviews, the facility failed to fill the gaps around the packaged terminal air conditioners (PTACs) to separate the exterior environment from the interior of the residents' rooms and failed to secure the seal around the PTACs (rooms #108, #110, #135, #151) for 4 of 8 rooms on 3 of 4 halls reviewed for homelike environment. The findings included:a. An observation conducted on 9/12/25 at 9:32 AM in room [ROOM NUMBER] revealed the PTAC unit did not align against the wall and there was an approximately one-inch gap across the top of PTAC unit where the remaining insulation was observed to be in a crumbled condition. Through the gap daylight from the exterior of the building was visible from the interior of the resident room.b. An observation conducted on 9/12/25 at 9:43 AM in room [ROOM NUMBER] revealed the PTAC unit did not align with the wall across the top of the unit. The PTAC unit stuck out approximately one inch from the wall which created a gap where the resident room was not sealed from the outside. Through the gap daylight from the exterior of the building was visible from the interior of the resident room. c. An observation conducted on 9/12/2025 at 9:48 AM in room [ROOM NUMBER] revealed there was a two-inch gap across the top of the PTAC unit and the wall. The PTAC unit was not aligned with the wall and the top portion of the unit leaned inwards towards the room. There was a large open area on the right side of the unit where the unit was not sealed to the wall. There were wet, soiled towels and sheets at the time of the observation with brown stains on them, present underneath the PTAC unit. d. An observation on 9/12/25 at 9:58 AM in room [ROOM NUMBER] revealed the PTAC unit had a two-inch gap across the top of the unit and the wall. The insulation in the gap was observed to be crumbled as evidenced by smaller pieces of the insulation in the vicinity of main piece of insulation. A second observation of rooms 108, 110, 135, and 151 and facility tour with the Maintenance Director, Regional Maintenance Director, and the Administrator occurred on 9/12/25 at 10:58 AM. The PTAC unit placement in each resident room remained unchanged from the first observation. The Maintenance Director, Regional Maintenance Director and the Administrator explained they were not aware of the PTAC unit gaps in rooms 108, 110, 135, or 151. During the facility tour, the Regional Maintenance Director indicated the PTAC unit electrical cords had been replaced recently and the PTAC units were removed from the wall and put back into place. The PTAC units had a middle, top and bottom screw attachment and after the plugs were replaced, only the middle screws were secured when the units were re-installed. The Regional Maintenance Director indicated the PTAC unit in room [ROOM NUMBER] was leaning to the point that water was leaking form the unit and that was why there were towels and sheets underneath the PTAC unit.An interview with the Administrator on 9/12/25 at 11:15 AM revealed she expected the PTAC units to be installed correctly in residents' rooms and that the Maintenance staff would make the repairs in the appropriate rooms.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, responsible party, and staff interviews, the facility failed to protect a resident's right to be free from resident to resident sexual abuse when Nurse Aide #7 and Floor Technician #1 observed Resident #22, a male resident, fondle a severely cognitively impaired female resident (Resident #27) when he placed his hand under her shirt near/on her bare breast. Resident #27 did not have the cognitive capacity to consent to this intimate sexual contact. This deficient practice affected 1 of 3 residents reviewed for resident-to-resident abuse (Resident #27).The findings included:Resident #22 was admitted to the facility on [DATE] with diagnoses which included encephalopathy (a broad term for any brain disease that alters brain function or structure) and cognitive communication deficit.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #22 was cognitively intact. Resident #22 propelled himself independently in his wheelchair.A Nurse Practitioner progress note dated 6/3/2025 at 7:55 AM indicated Resident #22 was alert and oriented to person, place and time. Resident #22 was stable with no acute concerns.A Psychiatric-Mental Health Nurse Practitioner follow up assessment note dated 6/3/2025 at 10:13 AM revealed Resident #22 was alert and oriented to person, place, time and situation. Resident #22's concentration/attention span, immediate, recent and remote memory were within normal limits. Resident #22's abstract reasoning was assessed as within normal limits.A review of Resident #22's active care plan as of 6/9/2025 indicated the resident had no care plan related to sexually inappropriate behaviors.Resident #27 was admitted to the facility on [DATE] with diagnoses which included a history of a cerebral infarction, dementia, and cognitive communication deficit.A quarterly MDS assessment dated [DATE] indicated Resident #27 had both short- and long-term memory deficits and severely impaired cognitive skills for daily decision making. She could feed herself with set up/supervision but otherwise required total assistance with all Activities of Daily Living (ADL). Resident #27 was dependent on staff for mobility as she could not propel herself in a wheelchair.A review of the 24-hour Initial Allegation Report dated 6/9/2025 at 11:55 AM indicated a Nurse Aide (NA) (NA #7) had notified the Administrator that a male resident (Resident #22) had been observed fondling a female resident (Resident #27). The NA immediately separated the residents and notified the Administrator. The State Agency was notified on 6/9/2025 at 12:37 PM. Local law enforcement was notified on 6/9/2025 at 1:30 PM. The initial report was signed by the Administrator.A review of a local Law Enforcement Incident Report dated 6/9/2025 at 4:12 PM revealed on 6/9/2025 at 1:20 PM the reporting person (the facility Administrator) reported the victim (Resident #27) had been sexually battered by the known suspect (Resident #22). Resident #22 had used his hand to fondle the outer exterior area of Resident #27's upper private regions. Resident #27 had various cognitive developments, physical disability, and poor health/illness. The case was exceptionally cleared (the law enforcement agency had identified an offender and gathered sufficient evidence to support an arrest and charge, but an external factor beyond the agency's control prevented the arrest or formal prosecution of the offender) on 6/12/2025 as Resident #27/Resident #27's representative chose not to prosecute Resident #22.A Psychiatric Mental Health Nurse Practitioner follow up assessment note dated 6/10/2025 at 10:03 AM revealed Resident #27 was alert and oriented only to person. Resident #27 appeared to be calm and relaxed while sitting in her wheelchair. Staff reported no mood issues, no behavioral issues and no new concerns. Resident #27's concentration/attention were assessed as impaired. Resident #27's immediate memory, recent memory and remote memory were all assessed as impaired. Plan was to follow up in 4 weeks.A social services note dated 6/11/2025 at 11:07 AM indicated Resident #27 had been observed over the past couple of days participating in activities, laughing and watching television. Overall, Resident #27's mood appeared to be good.A review of the 5 Day Investigation Report dated 6/13/2025 at 12:25 PM indicated the Administrator was notified on 6/9/2025 at 11:55 AM by Nursing Aide (NA) #7 that she had observed Resident #22 sitting in the hallway rubbing Resident #27's breast. NA #7 immediately removed Resident #27 from the situation and notified the Administrator. Resident #22 was immediately taken to the Administrator's office and interviewed. A review of the interview statement dated 6/9/2025 indicated Resident #27 stated he did not fondle Resident #22 but was rubbing her arm because she was rubbing his arm. Resident #22 was asked if Resident #27 had given him permission to rub her arm and Resident #22 did not answer the question and stated he had rubbed her arm because she had rubbed his arm. The interview statement was signed by the Administrator, the Director of Nursing and the Social Worker. Resident #22 was placed under constant supervision by the Administrator

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to report an allegation of resident to resident sexual abuse to Adult Protective Services (APS) for 1 of 3 residents reviewed for resident to resident abuse (Resident #27).The findings included:The facility's abuse policy revised on 10/20/2022 indicated all alleged violations involving abuse are reported immediately, but no later than 2 hours after the allegation is made, to APS where state law provides for jurisdiction in long-term care facilities in accordance with State law. Resident #27 was admitted to the facility on [DATE].The 24-hour Initial Allegation Report dated 6/9/2025 at 11:55 AM indicated a Nurse Aide (NA) #7 had notified the Administrator that a male resident (Resident #22) had been observed fondling a female resident (Resident #27). The State Agency was notified on 6/9/2025 at 12:37 PM. Local law enforcement was notified on 6/9/2025 at 1:30 PM. The initial report was signed by the Administrator.The 5 Day Investigation Report dated 6/13/2025 at 12:25 PM indicated the Administrator was notified on 6/9/2025 at 11:55 AM by NA #7 that she had observed Resident #22 sitting in the hallway rubbing Resident #27's breast. The incident was not reported to the Department of Social Services/APS. The 5 Day Investigation Report was signed on 6/13/2025 by the Administrator.An interview with the Administrator on 9/12/2025 indicated she did not know she was required to report allegations of abuse to Adult Protective Services or she would have done so.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of the resident's discharge home for 1 of 3 residents reviewed for discharge (Resident #88). The findings included: Resident #88 was admitted to the facility on [DATE]. A nursing note dated 7/22/25 at 10:11 AM stated Resident #88 was discharged from the facility to his home on 7/22/25 at 10:00 AM with his family member. Education on self-care provided and understanding was verbalized. A review of Resident #88's electronic medical record (EMR) revealed no transfer or discharge notice was issued to Resident #88. A telephone interview on 9/10/25 at 10:41 AM with the Ombudsman revealed she had not received a transfer or discharge list from the facility since May 2025 and was not familiar with Resident #88's discharge home. A telephone interview on 9/12/25 at 3:36 PM with the former Social Worker (SW) revealed she was employed at the facility from June 2025 to the end of August 2025 and was still in training for her position during that time. The former SW indicated she did not send notifications of transfers or discharges to the Ombudsman and did not know about this requirement. The former SW indicated the Administrator handled the details for transfers and discharges in the facility. A telephone interview on 9/15/25 at 3:35 PM with the Administrator revealed the facility currently did not have a SW, but she had the expectation that the facility would communicate with the Ombudsman a list of transfers and discharges. The Administrator indicated she has since been in contact with the Ombudsman and sent her transfer and discharge lists. A telephone interview on 9/17/25 at 1:13 PM with the former Director of Nursing (DON) indicated that Resident #88 had been at the facility for long term antibiotic treatment, which he completed and had a planned to discharge home. She indicated the former SW was responsible for communicating information to the Ombudsman regarding all transfers and discharges.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and family and staff interviews, the facility failed to provide treatment to a resident's bilateral legs for arterial and venous ulcers (an ulcer due to inadequate blood supply) as specified in the physician orders for 1 of 2 residents reviewed for arterial and venous wounds (Resident #2). In addition, the facility failed to ensure transportation was arranged for a resident to attend a scheduled appointment with a Gastroenterologist (doctor who specializes in gastrointestinal issues). This occurred for 1 of 3 residents reviewed for medical appointments (Resident #97). The findings included: Resident #2 was admitted to the facility on [DATE] diagnoses which included peripheral vascular disease, peripheral arterial disease, edema, and muscle weakness. Review of Resident #2’s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and required assistance with most activities of daily living. The assessment also indicated he had wounds to his bilateral lower extremities and required wound care. Review of Resident #2’s care plan dated 03/31/25 and revised on 07/31/25 revealed a focus area for the resident having skin impairment upon admission of bilateral lower extremities. The goal was for the resident’s wounds to resolve without complications. The interventions included: Enhanced barrier precautions Refer to wound physician as needed Treatment as ordered Weekly skin observations Review of a physician order dated 04/07/25 read: bilateral unna boots (a semi-rigid compression bandage often called a boot made of zinc oxide-impregnated gauze that hardens as it dries, applied from the foot to below the knee to treat venous leg ulcers) from toes to knees per vascular surgeon appointment on 04/07/25, resident is to have wound cleanser to bilateral lower legs, wrapped with unna boots from toes to knees, then apply self-adherent wrap, changed on Mondays and Thursdays every day shift and as needed (PRN) for soiled or off. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/10/25 at 12:01 PM of wound care performed by the Wound Nurse on Resident #2 was made. The Wound Nurse gathered her supplies and proceeded into Resident #2’s room to provide his wound care to his bilateral lower legs. Upon entering the room, Resident #2 was sitting in his recliner with his feet dependent on the floor and there was no dressing on his bilateral legs. The Wound Nurse instructed Resident #2 to sit back in his recliner and lift the foot rest of his recliner. Resident #2 lifted his foot rest and the Wound Nurse proceeded to put a clean towel under his right foot on the foot rest. The Wound Nurse with gloves on dabbed the open ulcers on his leg with wound cleanser-soaked gauze and then proceeded to apply the unna boot to the right leg. The right leg was not cleaned with wound cleanser to clean the dry skin patches noted on his lower right leg before the Wound Nurse applied the unna boot. The unna boot was completed on the right leg and the self-adherent wrap (a brand of self-adherent wrap, a type of elastic bandage that sticks only to itself, not to skin, hair or other materials) wrapped around the unna boot for mild compression and taped into place. The Wound Nurse then moved to the left leg and placed a clean towel under the leg and proceeded with gloves on and dabbed the open areas with the wound cleanser-soaked gauze and then proceeded to apply the unna boot to the left leg. The left leg was not cleaned with wound cleanser to clean the dry skin patches noted on his lower left leg before the Wound Nurse applied the unna boot. The unna boot was completed on the left leg and the self-adherent wrap wrapped around the unna boot for mild compression and taped into place. An interview was conducted with Wound Nurse on 09/11/25 at 3:46 PM. The Wound Nurse stated she was not used to doing Resident #2’s wound care and said she “didn’t feel comfortable doing his wounds” on 09/10/25. The Wound Nurse further stated she had been taught when doing unna boots to only cleanse the open areas so that is what she had done. She indicated the order for the wound care was not clear to her and she should have called the surgeon’s office and clarified the order so she would know if the entire lower legs had to be cleansed with wound cleanser or just the open areas. An interview was conducted with the Director of Nursing (DON) who also served as the Infection Preventionist (IP). The DON reported that she started in October 2024 as the IP. The DON stated the Wound Nurse should have cleansed Resident #2’s? the entire lower extremities prior to applying the unna boots and further stated if the Wound Nurse was not clear about the orders she should have contacted the surgeon’s office and clarified the order. The DON indicated she expected the Wound Nurse to follow the physician’s order for wound care. An interview with the Administrator on 09/12/24 at 2:23 PM revealed it was her expectation for the Wound Nurse to follow the physician’s order when performing wound care on Resident #2. She stated if the Wound Nurse was not clear about the orders she should have contacted the surgeon’s office and clarified the order prior to providing wound care to Resident #2. 2. Resident #97 was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness and dysphagia (difficulty swallowing food or liquids) and was discharged on 3/07/25. Resident #97’s admission minimum data set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired, dependent for all care and mobility and was coded for having a feeding tube. A care plan dated 11/27/24 revealed Resident #97 had a goal to remain free of side effects or complications related to tube feeding. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #97’s electronic medical record revealed a physician’s order entered on 1/5/25 for a GI consultation (medical consultation with a gastroenterologist). There was no physician progress note that explained the need for the consultation. Review of the facility appointment book revealed Resident #97’s name written in on 1/15/25 at 10:40 AM for a “gastro” appointment and “EMS” (Emergency Medical Services). On 9/10/25 at 9:59 AM a phone interview with Family Member #1 revealed she was aware that Resident #97 had missed her gastroenterology appointment, but no explanation was given as to why transportation had not been set up for the appointment. A phone interview on 9/11/25 at 3:42 PM with the appointment scheduler at the gastroenterologist’s office revealed Resident #97 had an appointment on 1/15/25 at 11:00 AM and no one showed up for the appointment or had called to cancel it. She indicated Resident #97 did not have any other appointments scheduled with their office. An interview with the facility Transportation Scheduler on 9/15/25 at 1:39 PM revealed he did not schedule appointments for residents but did schedule transportation to appointments. He indicated his process was to look through the facility appointment book daily and make transportation arrangements for residents who had appointments scheduled. The Transportation Scheduler did not recall Resident #97, did not recall making transportation arrangements for her to attend her appointment on 1/15/25 and did not know why she didn’t get scheduled for transportation. The Transportation Scheduler indicated that if he saw an appointment in the book with EMS written beside it, he didn’t do anything as he didn’t schedule for EMS transportation and did not know who was supposed to be doing the scheduling for EMS transportation. He further voiced he transported residents to dialysis appointments in the facility van and used contracted transportation services for all other appointments. An attempt made on 9/16/25 at 11:11 AM to speak with former Social Worker #2 who was employed at the time of the missed appointment on 1/15/25 was unsuccessful. An interview on 9/17/25 at 11:28 AM with the former Assistant Director of Nursing (ADON) who was the ADON at the time of the missed appointment and the current Director of Nursing revealed she recalled Resident #97 but did not recall any issues with her feeding tube and didn’t know why she was not scheduled for transportation to her appointment. She indicated the Social Worker would make appointments for residents and write them in the appointment book and the Transportation Scheduler would make the necessary transportation arrangements. A phone interview with the Administrator on 9/15/25 at 3:46 PM She indicated she was not the administrator at the time of Resident #97’s missed appointment on 1/15/25 but her expectation was residents would have transportation scheduled to not miss appointments. The Administrator revealed it would have been the Social Worker at the time who scheduled appointments and wrote them in the appointment book. Attempts to speak with the former Medical Director on 9/12/25 at 11:22 AM and 9/16/25 at 11:40 AM were unsuccessful.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family member, staff, Nurse Practitioner, wound care physician, and Assisted Living Facility Executive Director interviews, the facility failed to identify, assess, and obtain wound care orders for a wound on the left ankle for 1 of 5 residents reviewed for wound care (Resident #89).The findings included: Review of Resident #89's hospital Discharge summary dated [DATE] revealed Resident #89 would be discharged to the facility but had no documentation of any wounds when discharged from the hospital. Resident #89 was admitted to the facility on [DATE] with diagnoses that included: diabetes mellitus (DM), and vascular dementia. Review of the facility's admission nursing assessment dated [DATE] at 9:15 PM by Nurse #3 revealed Resident #89 had bilateral upper extremity bruising and bruising to her left ankle. Review of the facility's admission nursing note dated 02/06/2025 at 9:15 PM by Nurse #3 revealed Resident #89 arrived at the facility via wheelchair. Resident #89 was alert and oriented, pleasant with calm affect, and able to make her needs known. Scattered bruising was noted to Resident #89's bilateral upper extremities (arms) and Resident #89's left ankle was covered with a brace, and some was bruising noted. Review of Resident #89's physician orders from 02/06/2025 to 02/24/2025 revealed there were no physician orders for wound care. The admission Minimum Data Set (MDS) assessment dated [DATE] and the discharge MDS dated [DATE] revealed Resident #89 had moderately impaired cognition and required moderate assistance with bathing, and maximum assistance with toileting, dressing, bed mobility, and transfers. The 5-day admission MDS and the discharge MDS revealed Resident #89 had no pressure ulcers or wounds. Review of the daily skilled nursing notes dated 02/08/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/14/2025, 02/15/2025, 02/16/2025, 02/17/2025, and 02/19/2025 revealed Resident #89 had no skin conditions. Review of the Physical Therapy note dated 02/13/2025 at 2:32 PM by the Director of Rehabilitation revealed Resident #89 was assessed for her left lower extremity brace for fit and comfort. The brace was adjusted for fit due to it being too tight. The Director of Rehabilitation doffed (removed) the brace to inspect Resident #89's skin. Resident #89's skin was intact. The Director of Rehabilitation reviewed the hospital records to see any indications for the brace; no indications for the brace were found. The Director of Rehabilitation telephoned Resident #89's family member to inquire about the brace. The family member stated that Resident #89 had an old fracture in September 2024, and the brace was provided by her orthopedic doctor. The family member stated that Resident #89 could bear full weight on both legs and only used the brace occasionally. Review of Resident #89's weekly skin assessment dated [DATE] by Nurse #3 revealed no abnormal skin issues were identified. There was not a weekly skin assessment documented on 2/24/25. Review of Resident #89's care plan dated 02/17/2025 revealed Resident #89 was at high risk for pressure ulcer development and skin impairment related to advanced age, chronic health conditions, cognitive impairment, dry fragile skin, immobility, and impaired healing from diabetes. The interventions included to assess Resident #89 for risk of skin breakdown, assist with turning and positioning, keep skin clean and dry, utilizing pressure reducing mattress, and perform weekly skin assessments. The care plan did not reveal any abnormal skin conditions, pressure ulcers, or wounds. Review of a nursing note dated 02/24/2025 at 4:09 PM by Nurse #3 revealed Resident #89 was discharged to an assisted living facility. There was no documentation about any abnormal skin conditions, pressure ulcers, or wounds. Multiple unsuccessful attempts were made to contact and interview Nurse #3. An interview was conducted with Nurse Aide (NA) #2 on 09/11/2025 at 1:13 PM who routinely worked on the hallway where Resident #89 resided. NA #1 stated that he did not recall or remember anything about Resident #89. An interview was conducted with NA #3 on 09/11/2025 at 3:15 PM who routinely worked on the hallway where Resident #89 resided. NA #2 stated that she did not remember Resident #89. An interview was conducted with the facility's Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated she was not aware that Resident #89 had any skin issues or areas of breakdown. The Wound Nurse explained that she had not seen or treated Resident #89 for any type of skin concerns or wounds. An interview was conducted with the Wound Care Physician on 09/09/2025 at 2:15 PM. The Wound Care Physician stated that she had not been consulted to evaluate or treat Resident #89 for any wounds. The Physician explained that she had not seen or treated Resident #89 for any type of skin concerns or wounds and Resident #89 had never been on her wound care case load. An interview was conducted with the Director of Rehabilitation on 09/11/2025 at 4:10 PM. The Director of Rehabilitation stated that Resident #89 had a left ankle brace due to an old left ankle fracture. The Director of Rehabilitation stated that she had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	4801 Randolph Road Charlotte, NC 28211

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident, and Nurse Practitioner (NP) interviews and record review, the facility failed to assess resident's feet to determine if nail care was needed, ensure resident's toenails were trimmed and podiatry services were arranged for 2 of 2 residents reviewed for foot care (Resident #3 and Resident #2). The findings included: 1. Resident #3 was admitted to the facility on [DATE]. Resident #3 had diagnoses which included cerebral infarction (occurs when blood flow to the brain is interrupted causing damage to brain tissue) with hemiplegia (a condition that causes paralysis on one side of the body), and diabetes mellitus (DM). Resident #3’s care plan dated 02/17/2025 and revised on 08/03/2025 revealed Resident #3 was care planned for activities of daily living (ADL) self-care performance deficits related to her disease processes. The goals included total staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff to provide grooming and personal hygiene. Review of Resident #3’s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was severely cognitively impaired and was rarely/never understood. The MDS also revealed Resident #3 was dependent for all ADL. Review of Resident #3’s weekly skin assessments from 05/01/2025 through 09/12/2025 revealed no notation that her toenails were long and thick and needed trimmed. Review of the facility’s podiatry clinic schedule for 08/18/2025, revealed Resident #3 was not seen by the podiatrist. Review of the facility’s podiatry clinic schedule for 10/28/2025 revealed Resident #3 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #3’s Electronic Medical Record (EMR) that she had been seen by a podiatrist. An observation of Resident #3’s feet was conducted on 09/08/2025 at 3:10 PM. Resident #3’s toes revealed thick, long toenails that extended ½ inch beyond the tip of her toes and were curled downward. Resident #3 also had a light brown crusty material located underneath her toenails. An interview and observation of Resident #3’s feet were conducted with Nurse #1 on 09/11/2025 at 9:25 AM. Nurse #1 stated that Resident #3 toenails were too long and very thick and beginning to curl downward. Nurse #1 also revealed that Resident #3 would need to be seen by the podiatrist because she was diabetic. An interview was conducted with the Director of Nursing (DON) on 09/11/2025 at 11:01 AM. The DON stated that she was unaware that Resident #3 needed to see the podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON also stated that the facility’s Social Worker (SW) was responsible for scheduling residents for podiatry services, but the facility had not had a SW for about a month, and some residents may not have gotten placed on the upcoming podiatry schedule. The DON also explained that the podiatry clinic was held every 3 months. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 09/15/2025 at 9:01 AM. The Administrator stated that she expected all residents to receive podiatry services as needed and depending on the situation, the resident could be sent out for an outpatient podiatry appointment, if need. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #3’s toenails were long and thick, but she did try to check all diabetic resident’s feet during her assessments. The NP also stated that the nursing staff should not attempt to cut or trim Resident #3’s toenails but should have had Resident #3 seen by the podiatrist. The NP stated that all diabetic residents should be referred to the podiatrist for care and treatment of their toenails. 2. Resident #2 was admitted to the facility on [DATE] with diagnoses which included polyosteoarthritis, peripheral vascular disease, peripheral arterial disease, and muscles weakness among others. Resident #2’s care plan dated 03/31/2025 and revised on 07/31/2025 revealed Resident #2 was care planned for requiring assistance with activities of daily living (ADL) related to chronic health conditions, congestive heart failure and muscle weakness. The goal was for the resident to maintain his current level of function as able through the review date. The interventions included provide ADL assistance as needed, independent for transfers, provide setup for meals and independent for bed mobility. Review of Resident #2’s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact The MDS also revealed Resident #2 required substantial to moderate assistance with bathing and showering and personal hygiene. Review of Resident #2’s weekly skin assessments from 03/21/2025 through 08/22/25 revealed no notation that his toenails were long and thick and needed trimmed. Review of the facility’s podiatry clinic schedule for 08/18/2025, revealed Resident #2 was not seen by the podiatrist. Review of the facility’s podiatry clinic schedule for 10/28/2025 revealed Resident #2 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #2’s Electronic Medical Record (EMR) that he had been seen by a podiatrist. An observation of Resident #2’s feet was conducted on 09/08/2025 at 11:58 AM. Resident #2’s toes revealed thick, long pointed toenails that extended ¼ inch beyond the tip of his toes and were jagged on most of his toes. Resident #2 also had a light brown crusty material located underneath his toenails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #2 on 09/09/2025 at 11:00 AM. Resident #2 stated he would like for his toenails to be trimmed but said he could not get down to reach his toes and trim them. Resident #2 stated he could ask his sister to cut them but said he would prefer for the facility staff to cut them for him or be seen by a podiatrist to get them cut. An interview and observation of Resident #2’s feet was conducted with Nurse #1 on 09/11/2025 at 2:06 PM. Nurse #1 stated that Resident #2 toenails were long and very thick. Nurse #1 also revealed that Resident #2 would need to be seen by the podiatrist even though he was not diabetic because they were too thick to be cut by the nurse. An interview and observation was conducted with the Director of Nursing (DON) on 09/12/2025 at 3:37 PM. The DON stated that she was unaware that Resident #2 needed to see the podiatrist. The DON also stated that the facility’s Social Worker (SW) was responsible for scheduling residents for podiatry services, but the facility had not had a SW for about a month, and some residents may not have gotten placed on the upcoming podiatry schedule. The DON also explained that the podiatry clinic was held every 3 months. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 09/15/2025 at 9:01 AM. The Administrator stated that she expected all residents to receive podiatry services as needed and depending on the situation, the resident could be sent out for an outpatient podiatry appointment, if needed. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #2’s toenails were long and thick, but she did try to check all resident’s feet during her assessments. The NP also stated that the nursing staff should not attempt to cut or trim Resident #2’s toenails if they were thick but should have had Resident #2 seen by the podiatrist. The NP stated that all residents with thick toenails should be referred to the podiatrist for care and treatment of their toenails.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to provide safe mechanical lift transfers when the lift swung and hit the resident on the forehead resulting in a hematoma (collection of blood outside of a blood vessel) (Resident #56). In addition, staff failed to follow manufacturer guidelines for the use of a mechanical lift (Resident #5). This affected 2 of 3 residents reviewed for free of accident hazards, supervision and devices (Resident #56 and Resident #5). The findings included: A review of the undated Safe Lifting of Residents policy revealed that floor based and overhead full-body sling lifts (i.e. mechanical lift) required a minimum of two person assist, and the manufacturer’s guidance/instructions would be followed on all other types of lifts. 1. Resident #56 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (a condition when a person experiences the partial or total loss of function and feeling in all four limbs and torso), history of seizure, history of traumatic brain injury and chronic respiratory failure. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #56 was cognitively intact. Resident #56 had impaired range of motion (ROM) in all extremities. Resident #56 could feed herself and perform oral hygiene with set up assistance using her left hand but was dependent with all other Activities of Daily Living (ADL). Resident #56 was dependent for all transfers which required a mechanical lift. Resident #56 was not taking an anticoagulant on [DATE] as this medication had been on hold since [DATE] due to the pre-surgical protocol for a planned surgery later in [DATE]. A review of Resident #56’s care plan dated [DATE] revealed a focus area for a risk to fall related to deconditioning and quadriplegia with a goal of Resident #56 being free of falls through the review period. Interventions included anticipating and meeting the resident’s needs, always have the call bell within reach and resident needed 2 persons with bed mobility and transfers. A nursing note dated [DATE] at 9:20 PM revealed Nurse #4 was called into Resident #56’s room on [DATE] at 7:31 PM and observed Resident #56 lying on the floor near her bed with the mechanical lift pad underneath her. Nurse Aide (NA) #5 stated there was a mechanical lift failure during the transfer so Resident #56 was eased/lowered to the floor. Resident #56 was observed with a hematoma on her forehead. Resident #56 reported she did not fall, she was lowered to the floor and said the hematoma on her forehead was obtained when the mechanical lift hit her in the head. No other apparent injury noted at the time of the assessment. Neurological checks were initiated. The Nurse Practitioner (NP) was notified at 7:35 PM and provided orders to send Resident #56 to the hospital for evaluation. The Responsible Party (RP) was contacted. Emergency Medical Services (EMS) arrived and transported Resident #56 to the hospital at 8:00 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on [DATE] at 11:13 AM with Nurse #4 revealed she had been called to the Resident #56’s room on the evening of [DATE]. Nurse #4 stated when she arrived in the room, Resident #56 was on the floor, lying on the mechanical lift sling. NA #5 reported the battery had failed on the mechanical lift and NA #5 had lowered Resident #56 who was still in the sling attached to the mechanical lift to the floor. Resident #56 stated she did not fall, that the mechanical lift had swung and hit her in the forehead. Nurse #4 immediately noted the hematoma on Resident #56’s forehead and notified the provider who gave orders to send Resident #56 to the hospital. Nurse #4 stated she did not know if NA #5 had performed the mechanical lift transfer alone as she had been called after Resident #56 was already on the floor. An Incident Witness Statement dated [DATE] taken by the former Director of Nursing from NA #5 indicated he was transferring Resident #56 back to bed with the assist from another NA (NA #6). When the mechanical lift battery died and while trying to maneuver the lift machine, the geriatric recliner fell over and the resident hit her head on the lift machine. NA #5 lowered Resident #56 to the floor due to the battery being dead. The statement was signed by the former Director of Nursing. A telephone interview on [DATE] at 5:11 PM with NA #5 indicated he had previously worked at the facility. He stated he recalled Resident #56. When NA #56 was asked about what happened on [DATE] with the mechanical lift, NA #5 disconnected the call. A redial attempt was not answered. Several attempts to reach NA #5 again were not successful. An Incident Witness Statement dated [DATE] taken by the former Director of Nursing from NA #6 indicated that NA #6 was not present during the transfer of Resident #56 on the noted incident date ([DATE]). The statement was signed by the former Director of Nursing. A telephone interview on [DATE] at 11:04 AM with NA #6 revealed she was previously employed at the facility and recalled Resident #56. NA #6 stated on [DATE] in the evening, NA #5 had come to the room where NA #6 and the Scheduler (who was working as an NA at that time) were assisting another resident. NA #6 told NA #5 that she would help him with Resident #56 and the mechanical lift transfer when she had finished care with the resident she was currently with. She stated a few minutes passed and NA #5 was back at the doorway and stated he needed help quickly with Resident #56. NA #6 went to the doorway of Resident #56’s room and observed Resident #56 on the floor. NA #5 was the only staff member in the room. NA #6 immediately called Nurse #4. NA #6 stated that NA #5 had asked her to say she was with him during the mechanical lift transfer but NA #6 stated she would not do that. NA #6 found out that NA #5 had told the Director of Nursing (DON) that NA #6 had been with him during the mechanical lift transfer. NA #6 stated she provided her own statement to the DON that she had not been present during the mechanical lift transfer with Resident #56. An interview on [DATE] at 9:15 AM with the Scheduler indicated on the evening of [DATE] she was with NA #6 performing care with another resident when NA #5 had asked for assistance with Resident #56. NA #5 had been told to wait for assistance. The Scheduler and NA #6 had just finished care when NA #5 came back asking for help. The Scheduler went to Resident #56’s room and observed Resident #56 on the floor, lying on the mechanical lift sling. No other staff was present in the room. She noted the injury to Resident #56’s forehead and Nurse #4 was notified. The Scheduler stated NA #6 had been assisting her the entire time and was not involved in the mechanical lift transfer for Resident #56 on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hospital emergency department records dated [DATE] at 8:41 PM indicated that both Emergency Medical Services (EMS) and Resident #56 reported that Resident #56 had been hit in the head by the mechanical lift while being transferred back to bed by the mechanical lift. Resident #56 had been lowered to the floor and stayed on the floor until EMS arrived and transported Resident #56 to the hospital. Resident #56 had an obvious hematoma to her forehead and complained of a headache of 7 on a 0 to10 pain scale. Resident #56 was not on any anticoagulants, had no nausea or vomiting and denied seeing double. Resident #56 did not lose consciousness during the incident. A review of the Computed Tomography (CT) of the head and CT of the facial bones dated [DATE] at 9:19 PM indicated soft tissue swelling of the forehead and a hematoma on the forehead. No acute fracture of the maxillofacial bones noted. No intracranial hemorrhage or other injuries were noted. No new orders were noted. A nursing note dated [DATE] at 11:45 PM indicated Resident #56 had returned to the facility from the hospital. There were no new orders regarding care of the hematoma on Resident #56’s forehead. A Nurse Practitioner progress note dated [DATE] at 8:17 AM indicated Resident #56 had been sent to the hospital on [DATE] after being hit in the head by the mechanical lift during a mechanical lift transfer. A Computed Tomography (CT) scan was performed and no acute fracture noted. The small hematoma on her forehead was being monitored and pain management provided as needed. A nursing note dated [DATE] at 9:52 PM indicated Resident #56 was alert and oriented with no acute distress noted. The bruise remained on Resident #56’s forehead but no complaints of pain or discomfort when touched. Resident #56 continued on neurological checks and all were within normal limits. No other concerns noted. A telephone interview on [DATE] at 2:43 PM with the Nurse Practitioner (NP) revealed she had been called on [DATE] and notified of the mechanical lift transfer accident. Resident #56 had been sent to the hospital and returned to the facility later that night. The NP had seen Resident #56 on [DATE], [DATE] and [DATE] to monitor the status of the forehead hematoma, Resident #56’s cognition and neurological status. Nursing continued to perform neurological checks during this time and provided pain management as needed. An interview on [DATE] at 11:03 AM with Resident #56 revealed she required a mechanical lift transfer into the geriatric recliner when she chose to get out of bed. Resident #56 stated a few months ago there had been a mechanical lift accident when Nursing Aide (NA) #5 had tried to use the lift by himself. On the evening of the accident, Resident #56 stated she had requested to get back into bed after sitting up in the geriatric recliner. NA #5 had used the mechanical lift without a second staff member present. Resident #56 stated the mechanical lift battery had stopped working and NA #5 was trying to move the sling closer to the bed which got caught on the geriatric recliner and caused the bar to swing and hit Resident #56 in the forehead resulting in a hematoma. NA #5 lowered Resident #56 to the floor and went to seek assistance. Resident #56 stated she was transferred to the hospital for an assessment. Resident #56 indicated she now knew two staff members were required for mechanical lift transfers at all times. Resident #56 stated since the accident there have always been two staff members present when using the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 3:59 PM with Nurse #1 revealed she was not working when the mechanical lift accident occurred but she had heard about it. Nurse #1 stated staff had been educated over and over regarding proper mechanical lift procedure and that two trained staff members should be present for all mechanical lift transfers. An Interdisciplinary Team (IDT) note dated [DATE] indicated the IDT met and discussed educating staff on the importance of ensuring that the mechanical lift battery was fully charged and worked properly prior to transferring a resident as NA #5 had reported the battery stopped working when he was transferring Resident #56 on [DATE]. An interview on [DATE] at 3:02 PM with the Administrator revealed that two issues were investigated regarding the mechanical lift accident. The first issue was whether or not there were two staff members present for the mechanical lift transfer performed on [DATE] with Resident #56. The Administrator stated NA #5 had reported in his statement that NA #6 had been present. NA #6 reported in her statement that she had not assisted with the mechanical lift transfer and was not in the room at the time of the mechanical lift accident. The Administrator indicated that until [DATE], Resident #56 had always told the Administrator that there were two staff members in the room on [DATE] when the mechanical lift was used. When the Administrator spoke with Resident #56 on [DATE], Resident #56 stated there was only one staff member present. The second issue addressed during the investigation was that NA #5 indicated that the battery on the mechanical lift had stopped during the mechanical lift transfer and had slowly lowered Resident #56 to the floor. The Administrator stated the mechanical lift had been inspected and no obvious issues were noted but the facility had deemed that the lift not to be used in the future to be extra cautious. The Administrator stated the facility developed a Plan of Correction (POC) to reeducate staff regarding mechanical lift use and the need for staff to check if the battery was fully charged prior to use to ensure resident safety. A follow-up interview on [DATE] at 2:45 PM with the Administrator revealed there should be two staff members present for all mechanical lift transfers and staff should check to ensure the battery is fully charged prior to use. An interview on [DATE] at 2:30 PM with the Director of Nursing (DON) indicated she was not working in the facility at the time of the mechanical lift accident. The DON stated there should always be two staff members assisting with a mechanical lift transfer. Several attempts to reach the former Director of Nursing (DON) were unsuccessful. 2. Review of the mechanical lift user manual without a date provided by the facility, revealed in section 7.1 titled “Lifting the Patient”, Step 1. With the legs of the base open and locked, use the steering handle to push the patient lift into position. Step 2. Lower the patient lift for easy attachment of the sling. “WARNING”: The legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. Resident #5 was admitted to the facility on [DATE] with diagnoses which included cervical spinal cord injury and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5’s care plan dated [DATE] included the goal to provide assistance with activities of daily living (ADL) related to quadriplegia. The interventions included Resident #5 requires a mechanical lift for all transfers and the use of two people. An observation of a mechanical lift transfer for Resident #5 was conducted on [DATE] at 11:30 AM. Nurse Aide (NA) #2 and #5 were observed as they transferred Resident #5 from his wheelchair to his bed using a mechanical lift. NA #5 locked the wheels to Resident #5’s wheelchair as NA #2 positioned the mechanical lift around Resident #5’s wheelchair without widening/opening or locking the base of the mechanical lift. The mechanical lift was pushed tightly around Resident #5’s wheelchair causing the base of the lift to get stuck in the wheelchair. NA #2 and NA #5 attached Resident #5’s mechanical lift sling support to the mechanical lift. NA #1 and NA #2 tried to move the lift to Resident #5’s bed and could not pull the mechanical lift away from Resident #5’s wheelchair. The East Unit Manager maneuvered Resident #5’s wheelchair from side to side to release the wheelchair from the mechanical lift. NA #1 and NA #2 transferred Resident #5 from the mechanical lift to his bed without widening the mechanical lift base or locking the base of the mechanical lift. An interview was conducted on [DATE] at 5:45 PM with NA #5. NA #5 reported while using a mechanical lift and transferring residents, the base of mechanical lift should be widened as needed for the size of the chair and the wheels to the mechanical lift should be locked. NA #5 reported she connected the sling to Resident #5 and guided his legs while NA #2 controlled the lift and did not think to look at the lift to assure the base was in a widen position or if the wheels were locked while connecting the resident to the lift. A phone interview was conducted on [DATE] at 3:22 PM with NA #2. NA #2 stated the procedure when transferring a resident using a mechanical lift should include widening the base of the mechanical lift, placing the lift around the wheelchair and locking the wheels to the lift. NA #2 reported she could not recall opening the base or locking wheels to the mechanical lift. An interview was completed on [DATE] at 6:06 PM with the East Unit Manager. The East Unit Manager stated she recalled pulling Resident #5’s wheelchair from side to side because the mechanical lift was tight around the wheelchair. The East Unit Manager stated if the base was in widened position, she could have removed the wheelchair with more ease. The East Unit Manager reported she did not think to widen the base of the mechanical lift or lock the wheels to the mechanical lift at the time. An interview with the Director of Nursing (DON) on [DATE] at 5:30 PM revealed the staff were just educated on [DATE] regarding Mechanical lift transfers. The DON stated NA #2, NA #5, and the East Unit Manager should have widened the base and locked the wheels to the mechanical lift when transferring Resident #5 on [DATE] at 11:30 AM. An interview was conducted on [DATE] at 2:18 pm with the Administrator. The Administrator stated staff received education about mechanical lifts and transfers upon hire and on an as needed basis. The Administrator stated she expected staff to follow the policy for mechanical lift transfers.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to empty urinary drainage bag and secure urinary catheter tubing with anchoring device to prevent trauma to urinary opening or dislodgment of the catheter. The deficient practice occurred for 1 of 2 residents reviewed for urinary catheter care (Resident #5). The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses which included cervical spinal cord injury and neurogenic bladder (a disorder or problem with the nerve control of continence and voiding function). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. He was documented as having an indwelling urinary catheter. Resident #5's care plan dated 9/8/25 included the goal to provide urinary catheter to Resident #5 for neurogenic bladder. The interventions included catheter anchor/securement device, and provide catheter care every shift. An observation was conducted on 9/08/2025 at 1:22 PM. Resident #5's urinary bag was 100% full and hanging below his bladder level on the left side of Resident #5's bed on a hook. The urine drainage bag capacity was 2000 milliliters, and urine was observed backed up halfway in the tubing. An interview with Resident #5 was conducted on 9/08/2025 at 1:23 PM. Resident #5 stated that he had seen staff come in his room once or twice a day to empty his urine bag. Resident #5 reported he had not noticed urine in the urine drainage tubing. Resident #5 reported that he had not noticed a device to secure the urinary device tubing in place and could not tell if the urinary device was pulling. On 9/8/2025 at 3:15 PM another observation revealed Resident #5's urinary drainage bag was empty. An observation was conducted on 9/09/2025 at 12:30 PM when the Medication Aide (MA) #1 provided catheter care to Resident #5. Resident #5 had an indwelling urinary catheter connected to a bedside urinary drainage bag that was half full. Resident #5's urethral opening had a healed split at the base of the urethra opening. There was no observation of a leg strap or urinary anchor to secure the indwelling catheter tubing in place. The MA #1 emptied the urine drainage bag when she completed the catheter care. An interview was conducted with the MA on 09/09/2025 at 12:50 PM. The MA stated Resident #5 had not had a catheter anchor when she provided catheter care in the past. MA #1 reported Resident #5 had an issue with catheter becoming dislodged when the catheter was placed last year which caused a slit at the urinary opening. The MA reported that the staff try to empty Resident #5's urine bag during rounds if full and at the end of each shift. MA reported she tried to ensure that Resident's #5's urinary devices was not pulling on Resident's #5 urinary opening when providing care. MA #1 reported she was not aware that Resident #5 required a urinary catheter anchor and would make sure she adjusted the urinary device tubing to assure the catheter tubing did not cause tension on Resident #5's urethral (urinary opening). A follow-up observation was conducted on 09/10/2025 at 1:03 PM of Resident #5's indwelling urinary drainage system when the Wound Nurse provided Resident #5's wound care with the assistance of the [NAME] Unit Manager. The bedside drainage bag was positioned below his bladder hanging on the side of his bed. The urine bag appeared to be a quarter full, and Resident #5 did not have a leg strap or anchor in place to secure the urinary catheter tubing. The [NAME] Unit Manager confirmed that there was not a urinary securement device on Resident #5. The nurse assigned to Resident #5 on 9/10/25 from 7:00 AM to 3:00 PM was unable to be interviewed during the survey. The Wound Nurse was accompanied to Central Supply room on 09/11/2025 at 8:38 AM where one urinary leg strap and three adhesive urinary securement devices were observed. An observation on 9/11/2025 at 10:15 AM revealed Resident #5 had a leg strap securement device to his left leg to secure urinary catheter tubing. An interview was completed with Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated she had been assigned to Resident #5 in past and was only assigned to complete Resident #5's wound care for 09/10/2025. The Wound Nurse reported that the assigned nurse for Resident #5 should obtain a urinary securement device from Central Supply and apply to Resident #5. An interview was completed with Nurse Aide (NA) #3 on 09/10/2025 at 3:45 PM. NA #3 confirmed he was assigned to Resident #5 and reported he would empty urine collection bags during his rounds every 2 hours and would empty urine bag prior to transferring Resident #5 to avoid extra tension pulling on Resident #5's catheter tubing. NA #3 stated he had not noticed a securement device for Resident #5's catheter tubing and just made sure the urinary catheter tubing was not pulling on Resident #5's urinary opening. An interview with the Director of Nursing (DON) was conducted on 9/11/2025 at 2:40 PM. The DON reported she began working at the facility in October 2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to follow procedure for labeling a continuous gastrostomy tube (a tube surgically placed in the stomach to provide nutrition, hydration, and medications) feeding. This deficient practice was for 1 of 2 residents reviewed for enteral (the administration of nutrients directly into the gastrointestinal tract through a tube) feeding management (Resident #3). The findings included: Resident #3 was admitted to the facility on [DATE]. Resident #3 had diagnoses which included chronic respiratory failure with hypoxia, diabetes mellitus (DM), and gastrostomy tube status. A review of Resident #3's Physician orders revealed:1. 01/20/2025 Nothing by mouth (NPO).2. 01/30/2025 Change enteral feeding pump tubing, solution, and piston syringe (used for flushing gastrostomy tubes) nightly. 3. 01/30/2025 Water flush of 200 milliliters every 3 hours via feeding pump.4. 04/07/2025 Enteral nutritional feeding continuously via gastrostomy tube at 45 milliliters (ml)/hour (rate of infusion for the continuous feeding). A review of Resident #3's care plan dated 02/17/2025 and revised on 08/03/2025 revealed a plan for risk of malnutrition due to gastrostomy tube as the primary source of nutrition. The stated goal was to prevent weight loss. Interventions included elevated head of bed at 45 degrees during and thirty minutes after tube feed. Monitor for any signs of aspiration (fever, shortness of breath), dislodged feeding tube, infection at g-tube site, g-tube malfunction, abnormal lung sounds, abdominal pain or distension, constipation or fecal impaction, diarrhea, or nausea and vomiting. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was rarely/never understood, had severely impaired cognitive skills for daily decision making, and was dependent for all activities of daily living. The MDS also revealed Resident #3 was unable to eat by mouth and received all her nutrition through her gastrostomy tube. An observation of Resident #3 was conducted on 09/08/2025 at 11:47 AM. Resident #3 was lying in bed with the head of bed elevated. Resident #3's enteral feeding was infusing at 45 ml/hour via a feeding pump. The enteral feeding bag contained a light tan liquid and was labeled with 09/08/2025. No other information was noted on the enteral feeding bag. An additional observation of Resident #3 was conducted on 09/09/2025 at 1:06 PM. Resident #3 was lying in bed with the head of bed elevated. Resident #3's enteral feeding was infusing at 45 ml/hour via a feeding pump. The enteral feeding bag contained a light tan liquid and was labeled with 09/09/2025 and Resident #3's room number. No other information was noted on the enteral feeding bag. An observation and interview were conducted on 09/10/2025 at 2:06 PM with Nurse #1 who was assigned to Resident #3 on 09/08/2025, 09/09/2025, and 09/10/2025 during the 7:00 AM to 3:00 PM shift. Nurse #1 stated that night shift changed the tube feeding solution, the tubing, and the piston syringe every morning at 6:00 AM. Nurse #1 stated that the night shift nurse had asked her to label Resident 3's tube feeding during her shift report, but she had not had time to label the feeding yet. Nurse #1 stated that all tube feedings should have a white label on the bag or bottle which included the resident's name and room number, the type of feeding solution, if any additives were added, the name of the nurse who prepared the tube feeding, and the rate and method of infusion. Multiple unsuccessful attempts were made to contact the night shift nurse. An interview was conducted with the Director of Nursing (DON) on 09/11/2025 at 11:47 AM. The DON stated that she was new to the facility and that she had recently put together a list of responsibilities for the night shift which included changing tube feeding set ups and proper labeling of the tube feeding set up. The DON stated that all tube feedings should be labeled with the resident's name and room number, the type of feeding solution and the rate and method of infusion, and the name of the nurse who prepared the feeding set up. The DON further stated that she expected all tube feeding preparations be labeled appropriately. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #3's enteral feeding had not been labeled. The NP stated that all enteral feedings should be labeled with the type of nutritional formula used and if any additives or medications were added to the feeding solution. The NP further explained that it was important to note the type of feeding the residents were receiving because some residents were diabetic and required a special diabetic formula for their enteral feeding.

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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, record reviews, and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for 1 of 4 residents reviewed for respiratory care and services (Resident #3). The findings included:Resident #3 was admitted to the facility on [DATE]. Resident #3 had diagnoses which included chronic respiratory failure with hypoxia and cerebral infarction (occurs when blood flow to the brain is interrupted causing damage to brain tissue) with hemiplegia (a condition that causes paralysis on one side of the body). Review of Resident #3's electronic medical record (EMR) revealed a physician's order dated 01/29/2025 for oxygen at 2 liters per minute (LPM) via nasal cannula continuously. Review of the care plan revised on 08/03/2025 revealed Resident #3 was at risk for respiratory complications secondary to chronic respiratory failure with hypoxia requiring supplemental oxygen. The interventions included to administer oxygen as ordered and to observe for signs and symptoms of respiratory complications. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was rarely/never understood and the Brief Interview for Mental Status (a cognitive screening tool used to assess a resident's memory and orientation) (BIMS) assessment was unable to be conducted. Resident #3's cognitive skills for daily decision making was severely impaired. The MDS also revealed Resident #3 was dependent for all activities of daily living (ADL). The MDS indicated Resident #3 was receiving oxygen. Observations of Resident #3 were completed on 09/08/2025 at 11:49 AM, 09/09/2025 at 2:45 PM, 09/10/2025 at 12:12 PM, and 09/11/2025 at 7:59 AM. During each of the observations Resident #3 was observed in bed with her nasal cannula in her nostrils and the oxygen concentrator was set at 1 LPM. An interview was completed on 09/11/2025 at 9:01 AM with Nurse #1 who was assigned to care for Resident #3 on 09/08/2025, 09/09/2025, 09/10/2024, and 09/11/2025 during the 7:00 AM to 3:00 PM shift. Nurse #1 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the flow rate. Nurse #1 also stated the flow rate on the oxygen concentrator should be set as ordered by the physician. Nurse #1 further stated she reviewed Resident #3's physician's orders and stated that Resident #3 should be on 2 LPM of continuous oxygen via her nasal cannula. Nurse #1 further explained that she had not checked Resident #3's oxygen flow rate on the morning of 09/11/2025 and she did not remember checking Resident #3's oxygen flow rate on 09/08/2025, 09/09/2025, or 09/10/2024. Nurse #1 stated that she should have checked Resident #3's oxygen flow rate every morning during her initial assessment to ensure Resident #3 was receiving the correct prescribed rate of oxygen. An interview was completed on 09/11/2025 at 11:01 AM with the Director of Nursing (DON). The DON stated Resident #3 was dependent with all ADL and she was unable to change the flow rate on the oxygen concentrator. The DON stated she expected the nursing staff to check the physician's order for the prescribed oxygen flow rate and check to make sure residents were receiving the correct oxygen flow rate. The DON further explained that four days of observations for an incorrect oxygen flow rate was not acceptable nursing practice.A telephone interview was conducted on 09/15/2025 at 9:01 AM with the Administrator. The Administrator stated she expected all staff to follow the physician's order for oxygen settings. A telephone interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated all residents receiving oxygen required an active physician's order for the prescribed liters per minute of oxygen they were to receive. The NP further stated nursing staff should follow the physician's orders for providing oxygen including the correct prescribed flow rate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and staff interviews, the facility failed to follow their Enhanced Barrier precaution policy when Nurse #2 did not don (put on) a gown to administer medications via gastrostomy (tube in the stomach) tube and Nurse Aide (NA) #1 did not don a gown to provide care to a urinary catheter for Resident #5. Additionally, the facility did not follow their hand hygiene policy or their clean dressing policy when the Wound Nurse failed to clean and sanitize her hands while preparing for a wound dressing after coming in contact with unclean surfaces. The deficient practice occurred for 3 of 10 staff (Nurse #2, NA #1, and Wound Nurse) observed for infection control. The findings included: The findings included: 1. Review of the facility’s infection control policy titled, Enhanced Barrier Precautions (EBP) dated 03/28/2024 read in part, “Criteria for implementing EBP include residents with indwelling medical devices including feeding tubes. EBP will be utilized to provide targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility”. An observation on 09/10/2025 at 4:01 PM revealed Nurse #2 sanitized her hands and put on clean gloves but did not put on a gown to administer medications to Resident #72 via his gastrostomy tube (g-tube) (a tube surgically placed in the stomach to deliver nutrition, fluids, and medications). The EBP sign was posted above Resident #72’s bed and there was no personal protective equipment (PPE) located in or outside of Resident #72’s room. An interview was conducted with Nurse #2 on 09/10/2025 at 4:10 PM. Nurse #2 stated that she did not see the EBP sign located above Resident #72’s bed. Nurse #2 further stated that the EBP sign should be placed on Resident #72’s door so the sign could be seen when entering the room. Nurse #2 stated that she knew about EBP, but she did not realize caring for feeding tubes required the use of gowns. An interview was conducted with the Director of Nursing (DON) who also served as the facility’s Infection Preventionist on 09/11/2025 at 11:47 AM. The DON stated that she was aware of the regulation and the Center for Disease Control’s (CDC) recommendations for EBP. The DON explained that she was new to the facility, and the previous DON had taken all the EBP signs off of the resident’s doors and placed them above the resident’s beds due to privacy concerns. The DON further explained that the previous DON had also removed all of the PPE which had been located in the hallways to a storage room on each hallway. The DON further stated that she was in the process of placing all EBP signs on the resident’s doors and returning the PPE to the hallways so the staff would have easier access to the PPE. The DON further explained that she expected staff to follow EBP guidelines for appropriate PPE usage. Multiple unsuccessful attempts were made to contact the previous DON. A telephone interview was conducted with the Administrator on 09/15/2025 at 9:15 AM. The Administrator stated that she knew about the regulation concerning EBP and that she expected staff to follow the guidelines on the EBP signage. The Administrator further explained that she did expect the facility to be in compliance with all infection control regulations including the implementation of EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility’s infection control policy titled, “Enhanced Barrier Precautions (EBP)” dated 03/28/2024 read in part, “Criteria for implementing EBP include residents with indwelling medical devices including feeding tubes and indwelling catheters. EBP will be utilized to provide targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility.” An observation on 09/09/2025 at 12:30 PM revealed Nurse Aide (NA) #1 sanitized her hands with soap and water but did not put on gown to provide urinary catheter care for Resident #5. There was no available personal protective equipment (PPE) observed inside or outside Resident #5’s room. The EBP sign was on the wall behind the head of Resident #5’s bed. NA #1 read aloud the EBP sign after she completed the catheter care. An interview was completed with NA #1 on 09/09/2025 at 12:50 PM. NA #1 stated that after she read the EBP sign above Resident #5’s bed, she had forgotten to put on a gown before providing catheter care. NA #1 stated she normally would obtain gown and any other PPE from the Central Supply room before providing care to Resident #5. An interview with the Director of Nursing (DON) who also served as the facility’s Infection Preventionist was completed on 09/12/2025 at 2:17 PM. The DON stated she was aware of the EBP policy and NA #1 should have worn a gown while providing urinary catheter care. An interview with the Administrator on 09/12/2025 at 2:25 PM revealed that she expected NA #1 to follow the EBP policy and infection control regulations to prevent the spread of any multidrug-resistant organisms. 3. Review of the facility’s policy without a date, titled “Clean Dressing” included “Clean technique involves meticulous handwashing, maintain a clean environment by preparing a clean field, using clean gloves and preventing direct contamination of materials and supplies. Review of the facility’s infection control policy without a date titled, “Hand Hygiene” read in part: “Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of health care providers.” “Specific Procedures/Guidance” 1. All staff are responsible for following hand hygiene procedures: d. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 09/10/25 at 10:30 AM of wound care being provided to Resident #93 for her sacral pressure wound. The Wound Nurse was observed preparing wound supplies outside of Resident #93’s room on top of the treatment cart. The Wound Nurse applied alcohol-based hand sanitizer to both hands, opened drawer of the treatment cart and placed a wax paper barrier on top of treatment cart. Next, she opened two other drawers to remove a stack of gauze, wound cleanser, one calcium alginate dressing, and one 4 x 4-inch border gauze dressing. The Wound Nurse filled a 30 milliliter (ml) medicine cup with wound cleanser. The Wound Nurse did not sanitize her hands after gathering supplies and touching the outside of the treatment cart and the Wound Nurse used her ungloved index and middle fingers to press the gauze down into the wound cleanser. The Wound Nurse proceeded into the room with her supplies on wax paper and laid the supplies on the wax paper onto the overbed table. The overbed table had visible spills that had not been cleaned prior to placing the supplies on the table. The Wound Nurse washed her hands with soap and water and donned gown and clean gloves and proceeded to use the wound cleanser-soaked gauze she had prepared with her two fingers without gloves to clean the inside of Resident #93’s sacral wound. The Wound Nurse then proceeded to use gauze to dry the wound and to apply the calcium alginate in the wound and secured it with a bordered foam dressing. The Wound Nurse then gathered her supplies and trash, doffed her gloves and gown, washed her hands with soap and water and left the resident’s room. An interview was conducted with Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated that her hands were cleaned with alcohol-based hand sanitizer prior to preparing the wound care supplies. The Wound Nurse reported she had always prepared her wound cleanser and gauze solution without gloves and that “it had never been a problem in the past”. The Wound Nurse reported she wore gloves to complete Resident #93’s wound care once she was in the resident’s room. An interview was conducted on 09/12/2025 at 2:17 PM with the Director of Nursing (DON) who also served as the Infection Preventionist (IP). The DON reported that she started in October 2024 as IP. The DON stated that the Wound Nurse should have sanitized her hands and worn gloves when touching wound cleanser solution to clean the residents’ wounds. An interview with the Administrator on 09/12/2025 at 2:23 PM revealed that she expected the Wound Nurse to follow infection control and clean dressing policies and procedures to prevent the spread of any multidrug-resistant organisms.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, and staff interviews, the facility failed to ensure the call light system was functioning properly for 1 of 2 residents who required assistance for activities of daily living (Resident #66). The findings included:Resident #66 was admitted on [DATE] with diagnoses including cerebral infarction, hypertensive heart disease and dysphagia.Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was assessed as cognitively intact and needed partial assistance from staff with bed to chair and toilet transfers. In addition, the quarterly MDS assessment indicated he was occasionally incontinent of bowel and coded Resident #66 as having an indwelling catheter. Review of the care plan focus area for activities of daily living revised on 6/18/25 described Resident #66 as requiring assistance with his activities of daily living (ADL). Interventions put in place included partial assistance with transfers, supervision assistance with bed mobility and bathing. An observation of the call light for Resident #66 was made on 9/10/25 at 8:42 PM. The call light at the bedside was engaged. The light above the room entry door lit up but no alarm sounded. The communication panel at the nurse's station lit up, but no sound was audible when the bedside alarm was engaged. There was not a manual hand bell present for Resident #66's use.An interview was conducted on 9/10/25 at 8:42 PM with Nurse Aide (NA) #8. NA #8 stated the call bell system at the facility had not worked correctly for quite some time. She explained the system was supposed to ring or alarm at the room when the call bell was engaged and the light up on the panel at the nurse's station and the light above the door of each room was supposed to go off, but they didn't always work. NA #8 stated she just rounded very two hours to check on the residents since the bells did not work correctly. An interview with Resident #66 on 9/10/25 at 8:43 PM revealed he was able to locate and engage the call light at the bedside but did not hear a noise when he pressed the button. He stated that sometimes it took a long time for staff to respond to help him when he pressed his call light. He was not aware that his call bell did not make a sound to alert staff. Resident #66 also stated he had never had a manual handbell to use to call staff for assistance. An interview with Nurse #1 on 9/12/25 at 11:30 AM revealed the call system in the facility had been giving them trouble for quite a while and was not working properly. She stated the system did not work properly in certain rooms such as Resident #66's room. She stated since the system was not working properly, the staff just checked on the residents when rounding. An interview was conducted on 9/11/25 at 9:36 AM with the Regional Maintenance Director. The Regional Maintenance Director explained the facility had been having issues with the call bell system for quite some time with certain rooms not lighting up and other rooms not making alarm sounds. He explained they were in process of obtaining quotes from three different companies to replace and upgrade the system in the building. He stated after the quotes were obtained, he would then forward the quotes to his upper management for approval. The Regional Maintenance Director explained he used TELS (a web-based maintenance software) and if there were concerns, any staff member could alert the Maintenance staff when there was a concern. The Regional Maintenance Director indicated the call bell system was an ongoing concern in the building. A review of three quotes from different call bell companies was completed. These quotes were obtained on 8/20/25, 8/28/25, and 9/12/25.A facility tour was conducted on 9/12/2025 at 10:58 AM which included the Maintenance Director, Regional Maintenance Director, Administrator and Administrator in Training. The concerns with the call bell system in Resident #66 room were discussed. The Surveyor brought to the group's attention that no manual handbell was placed in Resident #66's room.A telephone interview was conducted on 9/15/2025 3:29 PM with the Administrator. She stated she expected any staff member to report any concerns regarding the call bell system to Maintenance. The Administrator stated she was aware the call bell system was not functioning correctly and stated residents would be given a hand bell to use to call staff. She also stated they were working on quotes to replace the call bell system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345134	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	4801 Randolph Road Charlotte, NC 28211

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident, staff and Pest Control Technician interviews, the facility failed to maintain an effective pest control program to prevent the presence of roaches and/or flies that were observed in 1 of 1 conference room, 1 of 1 lobby, 2 of 2 resident hallways (East and [NAME] hallways), and 4 of 4 resident rooms (Rooms 108, 109, 113, and 134). The findings included: A review of the pest control Commercial Services Agreement dated 12/24/24 revealed service for roaches, common ants, rats and mice and common spiders, and the service would occur two times per month. A review of the semi-monthly pest control service report dated 7/30/25 read: Inspected and serviced interior as requested. Left monitor boards (glue traps), applied gel bait throughout requested areas. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not specified, and no pest activity or problem areas were noted. A review of the semi-monthly pest control service report dated 8/12/25 read: Inspected and services business as requested, general pest treatment throughout interior of business, inspected requested rooms, left monitoring boards, inspected kitchen areas, and common areas for general pest activity. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not specified, and no pest activity or problem areas were noted. A review of the semi-monthly pest control service report dated 8/19/25 read: Treated business per scope. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not specified, and no pest activity or problem areas were noted. a. An observation of the East hallway next to the housekeeping closet on 9/08/25 at 11:18 AM revealed a roach approximately one inch long, dark brown, thin, and had antennae that were approximately half an inch long crawling along the baseboard. The roach crawled under the door of the housekeeping closet. b. An observation of the conference room, which was located on the East Hallway next to resident rooms on 9/09/25 at 2:23 PM revealed a roach crawling across the table. The roach was pea-sized, dark brown and had antenna. c. An observation of the [NAME] Hallway on 9/10/25 at 10:34 AM revealed a roach approximately two inches long, dark brownish red, with wings and antennae approximately one-inch-long crawling across the floor. The [NAME] Unit Manager attempted to kill the roach with her shoe when it crawled up the wall. d. An observation of room [ROOM NUMBER] on 9/10/25 at 11:32 AM revealed a roach crawling across the floor and disappearing underneath the Packaged Terminal Air Conditioner (PTAC) unit affixed to the outer lower wall of the room. The roach was approximately one inch long, dark brown with wings and antennae approximately half an inch long. e. An observation of the front lobby on 9/10/2025 at 2:19 PM revealed several flies, too numerous to count, flying around the lobby area around residents who were sitting in their wheelchairs. f. An observation of room [ROOM NUMBER] on 9/10/25 at 8:24 PM revealed a roach approximately two inches in length on the floor next to Resident #23's nightstand. The roach was dark brown, approximately one inch in length with antennae approximately one inch in length. g. An observation of room [ROOM NUMBER] on 9/11/25 at 9:12 AM revealed a large roach crawling on the floor along the baseboard. The roach was dark brown, approximately one inch in length with antennae approximately one inch in length. An interview on 9/10/25 at 8:24 PM with Resident #23 who lived in room [ROOM NUMBER] revealed there were always roaches and bugs in the facility and his room, especially at night. An interview on 9/12/25 at 9:32 AM with Resident #6 revealed he had been seeing lots of roaches near his PTAC unit, but none were observed at this time.An interview and observation in room Resident #66 on 9/12/2025 at 9:43 AM revealed a glue trap on the floor next to the PTAC unit covered in dead ants and roaches in numbers too numerous to count. Resident #66 indicated he had seen lots of small bugs near his bed. An interview with the Pest Control Technician on 9/11/25 at 11:16 AM revealed the company he worked for was contracted to provide services at the facility twice a month and when there were call-backs for pest sightings in between those visits. He indicated on each of the two monthly visits he would spray the common areas, kitchen, and office areas and check the rodent bait traps around the exterior of the facility. He stated he sprayed the resident rooms on the East hallway rooms one visit, and the resident rooms on the [NAME] hallway the next visit. He indicated spraying a room included spraying the bathroom, under beds, dressers, nightstands, and under the PTAC unit. The Pest Control Technician stated there were gaps in the seals around the PTAC units in almost all the resident rooms that would allow pests to enter the building, so he placed glue traps