

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Pelican Health at Charlotte		STREET ADDRESS, CITY, STATE, ZIP CODE 2616 East 5th Street Charlotte, NC 28204	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to treat Resident #1 with dignity and respect when staff engaged in a verbal argument with the resident utilizing profanity and yelling at the resident. The resident reported she felt angry with the way staff treated her. This deficient practice affected 1 of 1 resident reviewed for dignity (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact and was not coded with behaviors. Resident #1's active care plan, last revised on 1/19/2026, had a focus area regarding Resident #1 having mood symptoms and poor coping strategies due to past trauma including emotional and physical abuse. The goals included Resident #1 maintaining the ability to seek out social contact and not experiencing any acute anxiety or depressed mood through the review period. The interventions included encouraging continued family involvement; encouraging Resident #1 to participate in conversation with staff and other residents daily; helping Resident #1 to identify stressors and remove the stressors when possible; providing Resident #1 with as many opportunities as possible to give Resident #1 control over Resident #1's environment and care delivery; and providing opportunities for Resident #1 to communicate feelings. An Investigation Report dated 4/8/2026 indicated that Resident #1 reported on 4/2/2026 at approximately 6:30 PM that Nurse Aide (NA) #1 called her names and cursed her using foul language. Resident #1 stated that NA #2 yelled down the hallway, [f***] your Daddy when Resident #1 stated she was calling her father. Resident #1 stated NA #1 called her a [b****] and said repeatedly [f***] you. NA #1 and NA #2 both said, that was why she [Resident #1] was slapped by another NA, referring to an alleged incident on 3/6/2026. Both NA #1 and NA #2 were suspended pending the investigation. Interviews with staff witnesses indicated that Resident #1, NA #1 and NA #2 were cursing back and forth down the hallway. Staff witnesses indicated NA #1 and NA #2 discussed Resident #1 where other residents could hear their conversation. NA #1 and NA #2 were terminated from employment. The Investigation Report was signed by the former Administrator. The Local Law Enforcement Records Department was contacted on 4/27/2026 at 11:59 AM but the officer did not file a report for the incident. Voice mails were left for the responding officer on 4/27/2026 at 12:15 PM and 4/28/2026 at 3:10 PM. An email was sent to the responding officer on 4/29/2026 at 10:21 AM. Attempts to contact the responding officer were unsuccessful. An interview with Resident #1 was conducted on 4/27/2026 at 2:30 PM. Resident #1 stated on 4/2/2026 during the evening shift, NA #1 arrived to perform her (Resident #1's) shower. Resident #1 reported she was telling NA #1 her shower preferences and NA #1 became annoyed. Resident #1 told NA #1 she wanted someone else to assist her with her shower. Resident #1 stated NA #1 started calling her a b**** and saying f*** you. Resident #1 reported she called NA #1 names and cursed as well but could not recall exactly what she said but remembered she called NA #1 nasty, a b**** and told NA #1 to get the f*** out of my room. Resident #1 stated NA #2 came down the hallway and attempted to get NA #1 to leave her (Resident #1's) room. Resident #1 reported she (Resident #1) said she was going to call her father about how she was being treated and NA #2 yelled down the hallway, f*** your daddy. Resident #1 stated Nurse (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>#1 and the Restorative Aide also arrived in her room within approximately 3 to 4 minutes as they had heard the yelling and tried to deescalate the situation. NA #1 and NA #2 left the room but then NA #1 came back to the room within a few minutes and started yelling and cursing again at her (Resident #1) saying I'm sick and tired of this b****, that b**** is always finding a reason to cuss us out and nobody did anything to you. Resident #1 stated NA #1 referred to an incident on 3/6/2026 when Resident #1 alleged another NA had slapped her. (The 3/6/2026 incident was investigated but did not result in a deficiency). Resident #1 indicated she wished the NAs would stop talking about the incident on 3/6/2026 as Resident #1 felt the NAs were taunting her. Resident #1 went on to say that Nurse #1 and the Restorative Aide sent NA #1 out of the room a second time and the situation calmed down. Resident #1 expressed she was angry at the way NA #1 and NA #2 treated her and felt it was very disrespectful. Resident #1 stated she had not seen either NA #1 or NA #2 working in the facility since that night. A written statement dated 4/6/2026 from NA #1 indicated NA #1 believed Resident #1 made up stories when she didn't get her way. NA #1 indicated she was preparing to shower Resident #1 when Resident #1 asked where her purse was and became agitated. NA #1 reported Resident #1 stated she wanted someone else to give her a shower and called NA #1 a name and said NA #1 was nasty. Resident #1 was screaming and cursing so NA #1 stated she left Resident #1's room to answer other call lights. NA #1 indicated she put Resident #1 to bed later that night. NA #1 stated she did not ever curse at Resident #1. A telephone interview with NA #1 was attempted on 4/28/2026 at 10:24 AM. NA #1 asked if speaking with the surveyor would assist her in getting her job back at the facility. When told, No, NA #1 stated she declined to answer any questions and disconnected the call. A telephone interview with NA #2 was conducted on 4/27/2026 at 1:57 PM. NA #2 stated on 4/2/2026 Resident #1 and NA #1 began to loudly argue and curse at each other which NA #2 could clearly hear where she was sitting at the nurse's station. NA #2 went to the room to separate Resident #1 and NA #1. NA #1 walked out of Resident #1's room back to the nurse's station and stated to NA #2 that this b**** get on my nerve and this b**** don't want me to give her a shower. NA #2 stated NA #1 told her Resident #1 requested another staff member provide her with a shower. NA #2 stated NA #1 was being verbally aggressive toward Resident #1 and calling her a b****. NA #2 denied the allegation that she was talking about Resident #1 to NA #1 in an inappropriate manner in front of other residents. NA #2 stated she only responded to Resident #1 when Resident #1 was calling for the nurse by telling Resident #1 the nurse was off the hall at that moment. NA #2 stated Nurse #1 and the Restorative Aide came to the resident's room to deescalate the situation. NA #2 indicated at that time, NA #1 went back to the room and resumed yelling and cursing at Resident #1 and called her a b**** and said she was sick and tired of her. NA #2 went again to ask NA #1 to come back to the nurse's station and stop the interaction which NA #1 agreed to do. A telephone interview with Nurse #1 was conducted on 4/28/2026 at 9:38 AM. Nurse #1 stated that she was on break outside on 4/2/2026 and heard yelling back and forth between NA #1 and Resident #1. Nurse #1 reported she came inside and headed to Resident #1's room to deescalate the argument. Nurse #1 indicated that the Restorative Aide was also going to the room and they arrived together to send NA #1 out of the room. Nurse #1 reported NA #2 came to the room and pulled NA #1 out of the room. Nurse #1 went on to say that NA #1 returned to the room a few minutes later and resumed the argument with Resident #1. Nurse #1 stated she and the Restorative Aide sent NA #1 out of the room again. Nurse #1 indicated she closed the door to Resident #1's room to stop the argument and proceeded to talk with Resident #1 to calm her down as Resident #1 had been yelling back at NA #1 and NA #2 and was very upset/angry about how she felt she had been treated by NA #1 and NA #2. Resident #1 expressed to Nurse #1 that she should have been able to have someone else provide her shower without issue when she decided she did not want to work with NA #1. Nurse #1 reported she advised Resident #1 that she was working on the morning of 4/3/2026 and she would assist her with a shower at that time. Nurse #1 stated Resident #1 was agreeable with that plan and was assigned a different NA for the remainder of the shift. An interview with the Restorative Aide was conducted on 4/28/2026 at 12:04 PM. The Restorative Aide reported (continued on next page)</p>		

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