STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health at Charlotte	2616 East 5th Street Charlotte, NC 28204

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews with the resident, staff, Responsible Party (RP), Wound Nurse Practitioner, and Medical Director, failed to recognize the severity of the injury, the extent of bleeding, and the resident's increased risk for bleeding due to her daily anticoagulant medication (helps prevent blood from forming clots). On 01/20/26 Nurse Aide #1 pulled Resident #25 backwards alongside the bed hitting the Resident's lower left leg against the corner of the footboard. Resident #25's footboard was damaged, and the outer layer of protective laminate was gone, and pressboard was exposed (pressboard is a dense, stiff engineered material). Resident #25 immediately cried out in pain, and her lower left leg was bleeding. Resident #25 reported a pain scale of 10 on a scale of 1 to 10 (0 being no pain and 10 being the worst possible pain. Nurse #1 observed a 1-inch laceration to the residents left lower extremity, applied pressure for 5 minutes to stop the bleeding and applied a pressure dressing. Despite this known risk factor and the presence of active bleeding Emergency Medical Services (EMS) were not initiated by facility staff. The resident's RP arrived at the facility after being called by the resident who reported pain and the RP observed blood on the outside of the pressure dressing and called EMS. Resident #25 was subsequently transported to the hospital emergency department (ED) for evaluation and treatment. The ED physician noted Resident #25 had a large soft tissue hematoma (a localized collection of clotted or partially clotted blood, trapped in tissue caused by a ruptured blood vessel from an injury) measuring 16.2 centimeters (6.3 inches) to her left lower extremity. Laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 (normal range 11.5 to 15) over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic (dead or dying tissue), requiring operative evacuation (surgically removing a collection of blood from inside of the body) of the hematoma and surgical debridement of the necrotic tissue, with placement of a wound vacuum-assisted closure (VAC) device. The facility's failure to assess the severity of the injury, consider the impact of anticoagulant therapy, and initiate emergency medical intervention placed Resident #25 at risk for serious complications related to acute blood loss. Resident #25 was discharged back to the nursing facility on 02/05/26 with orders for oxycodone 5 milligrams (mg) one tablet every 6 hours as needed for severe pain and wound care orders. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #25).Immediate Jeopardy began on 01/20/26 when Nurse #1 failed to recognize the severity of the injury and Resident #25's increase risk of bleeding due to her use of an anticoagulant. Immediate Jeopardy was removed on 02/25/26 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure the monitoring systems put into place are effective and education is completed. The findings included:Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, fracture of the right tibia, hypertension, muscle weakness, osteoporosis, history of a deep vein thrombosis (DVT- a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body), and physical debility. A physician's order dated 11/02/25 revealed an (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	order for Eliquis 5 milligrams, one tablet by mouth twice a day, for the prevention of deep vein thrombosis (DVT), a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body. Eliquis is a blood thinning medication that reduces blood clotting. Manufacturer's guidelines for the medication Eliquis 05/2025 indicated the medication can cause serious side effects including bleeding which could be serious and may lead to death. The guidelines further stated to call your healthcare provider with any severe bleeding. A quarterly Minimum Data Set assessment dated [DATE] revealed Resident #25 was cognitively intact and dependent upon two staff members for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. Resident #25 was coded for receiving an anticoagulant during the assessment period.A care plan revised on 01/19/26 revealed a focus area related to anticoagulant usage. Resident #25 was noted to be at risk for bleeding and bruising related to use of an anticoagulant. The goal was for the resident to have no complications related to anticoagulant usage through the next review date. Interventions included observing for any abnormal bleeding or bruising. On 02/23/26 at 12:54 PM, an interview and observation were conducted with Nurse Aide (NA) #1. During the interview, she stated she was responsible for Resident #25 on 01/20/26 during the 7:00 AM to 3:00 PM shift. NA #1 explained she was assisting Resident #25 with a bed bath when the resident requested to get up to her wheelchair. She explained that after placing Resident #25 in her wheelchair, with both feet positioned on pillows on top of the wheelchair leg rests, she turned the wheelchair and pulled it backward along the side of the bed. While NA #1 was pulling Resident #25's wheelchair backward along the side of the bed and the resident's left lower leg hit the corner of the footboard. She stated the bed was in a low position and Resident #25 began to yell out in pain. NA #1 indicated she realized Resident #25's left leg had hit the corner of the footboard and had begun to bleed. NA #1 re-enacted this action to the surveyor by pulling the resident's wheelchair backward along the side of the bed. NA #1 explained obtained paper towels from the sink and placed them on the resident's leg in an attempt to stop the bleeding. She stated, It was bleeding bad. NA #1 the paper towels were saturated, so she then placed a regular bath towel over the leg and yelled for Nurse #1, who entered the room, applied pressure, and placed a dressing on the wound. She stated after Nurse #1 placed the dressing on the resident's leg the resident remained in her wheelchair with her legs elevated. NA #1 did not go back into the room until EMS arrived and she assisted the resident onto the stretcher. NA #1 stated she did not see blood on the dressing when she assisted with the transfer of Resident #25. A Situation, Background, Assessment, Recommendation assessment dated [DATE] at 11:30 AM, written by Nurse #1, revealed Resident #25 had received a skin tear to her left lower leg. A dressing was applied, and the Wound Nurse, Nurse Practitioner, or Medical Director were to evaluate. Recommendations included that Resident #25 be sent to the Emergency Department. New orders documented included: Patient to Emergency Department per her request related to skin tear to left leg. Vital signs included the following: blood pressure 132/77 (normal 120/80), pulse 97 (normal range 60-90), respiration 22 (normal range 12/20), temperature 98.2 (normal range 97-99.0), pulse oximetry 97% (normal range >92%) on room air. A pain scale was not included in the documentation.A late entry nursing progress note dated 01/20/26 at 3:00 PM, written by Nurse #1, revealed the note was a late entry for 11:30 AM. Nurse #1 was informed Resident #25's leg was bumped during transfer. Resident #25 was assessed and noted to have a one-inch slit in the middle of her left leg. The resident's anticoagulant was held at that time. Increased bleeding was noted related to Resident #25's anticoagulant therapy. Pressure was applied to the injury site for a duration of five minutes, and then a pressure dressing was applied.A late entry nursing progress note dated 01/20/26 at 3:29 PM, written by Nurse #1, revealed Resident #25's Responsible Party (RP) was present in the facility. Upon the RP's arrival, Resident #25 began to scream and yell, I'm hurting. Nurse #1 left the resident's room to check physician orders and obtain medication. Upon returning, the RP stated, I called 911 services for Resident #25. Resident #25 stated, I want to go to the hospital. Bleeding was noted to have stopped. Emergency Medical Services (EMS) arrived at the facility at 1:35 PM. A mechanical lift was used with two staff members to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/24/26 the Director of Nursing began education for all licensed nurses, including agency nurses, on the recognition and assessment of abnormal bruising and bleeding (including excessive, uncontrolled bleeding) for residents receiving anticoagulant therapy. Education consisted of utilizing the e-interact tools (a specialized clinical workflow tool to assist facilities in identifying, assessing, and managing resident conditions) to identify residents that may need a higher level of treatment, notifying the Medical Director (MD) or Nurse Practitioner (NP) for residents that receive anticoagulant therapy that have sustained an injury, and to seek higher level of treatment for any resident on anticoagulant therapy that has continued bleeding after 15 minutes of applying pressure with a pressure dressing. Education was provided in person and via electronic education system. After 2/24/26 newly hired nursing staff including agency nurses will receive this education during the orientation process by the DON or designee also via electronic education at onboarding. The DON/ADON will be responsible for tracking and maintaining education record to ensure that staff receive this education prior to start of their next shift. The DON was made aware of this responsibility by the Administrator on 2/24/26.Education began with all nurse aids on 2/24/26 by the DON on recognizing changes in resident conditions, including excessive bleeding. Education included utilization of the Stop and Watch Tool, an early warning tool that prompts Nurse Aids to alert nursing staff to a change in a resident's condition. Education included completion of the tool and providing it to the Licensed Nurse immediately. All newly hired nursing staff, including agency, will be educated on this process in orientation by the DON or designee. The DON was made aware by the Administrator of this responsibility on 2/24/26. The Administrator is responsible for the execution of this plan of Credible Allegation. Date of IJ removal: 2/25/26The facility's credible allegation of immediate jeopardy removal was validated on 3/02/26. An interview conducted with the Assistant Director of Nursing (ADON) indicated she completed full body skin assessments for all residents receiving anticoagulant medications on 2/24/26 and no concerns were identified. A review of the skin assessments revealed they were completed on 2/24/26 for all residents receiving anticoagulant medications and no abnormal bruising or new skin concerns were identified. Interviews conducted with licensed nurses revealed they received education on the importance of completing a thorough assessment for residents receiving anticoagulant medication that sustained an injury, identifying the need for a higher level of treatment when there was uncontrolled bleeding, notifying the Medical Director or NP of changes in condition and reporting the full extent of any resident injury. The facility's immediate jeopardy removal date of 2/25/26 was validated on 3/02/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health at Charlotte	2616 East 5th Street Charlotte, NC 28204

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, record review, and interviews with the resident, staff, Responsible Party, Wound Nurse Practitioner, and Medical Director, the facility failed to provide care in a safe manner and ensure a resident's environment remained free of an accident hazard for a dependent resident on Eliquis (an anticoagulant medication that prevents blood from clotting). On 01/20/26 Nurse Aide (NA) #1 transferred Resident #25 using a mechanical lift from the bed to the Resident's wheelchair. Nurse Aide #1 proceeded to pull Resident #25 backwards alongside the bed hitting the Resident's lower left leg against the corner of the footboard. Resident #25's footboard was damaged, and the outer layer of protective laminate was gone, and pressboard was exposed (pressboard is a dense, stiff engineered material). Resident #25 immediately cried out in pain, and her lower left leg was bleeding. Resident #25 complained of a pain, on a scale of 10 with 10 being the worst possible pain. She sustained a 1-inch laceration to the leg. Resident #25 was transported to the hospital on [DATE]. Upon evaluation, she was noted to have a large superficial soft tissue hematoma (a localized collection of clotted or partially clotted blood, trapped in tissue caused by a ruptured blood vessel from an injury) measuring 16.2 centimeters (6.3 inches) to the left lower extremity. Hospital laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 (normal range 11.5 to 15.1) over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic (dead or dying tissue), requiring operative evacuation (surgically removing a collection of blood from inside of the body) of the hematoma and surgical debridement of the necrotic tissue, with placement of a wound vacuum-assisted closure (VAC) device. Resident #25 was discharged back to the facility on [DATE]. The facility staff also allowed a resident to use a grab bar that was not secure resulting in a fall in the shower room (Resident #20), the facility failed to follow their smoking policy and allowed residents to keep their smoking materials on their person and in their rooms rather than locked up at the nurses' station (Resident #8, Resident #18 and Resident #65). The deficient practice affected 5 of 8 residents reviewed for supervision to prevent accidents (Resident #25). Immediate Jeopardy began on 01/20/26 when Nurse Aide #1 hit Resident #25's outer lower left leg against a damaged footboard. Immediate Jeopardy was removed on 02/25/26 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the monitoring systems put into place are effective and education is completed.Example 2, 3, 4, 5 are being cited a lower scope and severity of an E. The findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, fracture of the right tibia, hypertension, muscle weakness, osteoporosis, history of a deep vein thrombosis (DVT- a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body), and physical debility. A care plan dated 09/05/25 revealed a focus area related to Activities of Daily Living (ADL) care. Resident #25 required assistance with her ADLs. The goal was for the resident to maintain their current level of function through the next review date. Interventions included two staff member assistance with transfers. A physician's order dated 11/02/25 revealed an order for Eliquis 5 milligrams (mg), one tablet by mouth twice a day, for the prevention of deep vein thrombosis (DVT), Manufacturer's guidelines for (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the medication Eliquis 05/2025 indicated the medication can cause serious side effects including bleeding which could be serious and may lead to death. The guidelines further stated to call your healthcare provider with any severe bleeding. A Physical Therapy evaluation dated 11/14/25 signed by Physical Therapist #1 revealed Resident #25 demonstrated decreased bilateral lower extremity range of motion due to contractures and weakness. She demonstrated decreased functional with bed mobility and wheelchair mobility. Resident #25 was noted to be limited by contracture and malalignment of the right lower extremity due to a chronic break. The assessment revealed Resident #25 did not tolerate upright positioning for long and was unable to sit in a wheelchair without bilateral lower extremities elevated on pillows and leg rests. On 02/25/26 at 5:00 PM, an interview was conducted with Physical Therapist #1. During the interview, she stated she had worked with Resident #25 during sessions in November 2025 and December 2025. She explained Resident #25's range of motion was severely decreased in bilateral lower extremities and her legs remained elevated on pillows and leg rest. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact and dependent upon two staff members for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. Resident #25 was coded as having no impairment to the upper or lower extremities and no use of mobility devices during the assessment period. Resident #25 was coded as receiving anticoagulants during the assessment period. On 02/23/26 at 12:54 PM, an interview and observation were conducted with Nurse Aide (NA) #1. During the interview, she stated she was responsible for Resident #25 on 01/20/26 during the 7:00 AM to 3:00 PM shift. NA #1 explained she was assisting Resident #25 with a bed bath when the resident requested to get up to her wheelchair. She explained that after placing Resident #25 in her wheelchair, with both feet positioned on pillows on top of the wheelchair leg rests, she turned the wheelchair and pulled it backward along the side of the bed. While NA #1 was pulling Resident #25's wheelchair backward along the side of the bed the resident's left lower leg hit the corner of the damaged footboard. She stated the bed was in a low position and Resident #25 began to yell out in pain. NA #1 indicated she realized Resident #25's left leg had hit the corner of the footboard and had begun to bleed. NA #1 re-enacted this action to the surveyor by pulling the resident's wheelchair backward along the side of the bed. NA #1 explained obtained paper towels from the sink and placed them on the resident's leg in an attempt to stop the bleeding. She stated, It was bleeding bad. NA #1 stated the paper towels were saturated, so she then placed a regular bath towel over the leg and yelled for Nurse #1, who entered the room, applied pressure, and placed a dressing on the wound. She stated after Nurse #1 placed the dressing on the resident's leg the resident remained in her wheelchair with her legs elevated. NA #1 did not go back into the room until Emergency Medical Services (EMS) arrived and she assisted the resident onto the stretcher. NA #1 stated she did not see blood on the dressing when she assisted with the transfer of Resident #25. A Situation, Background, Assessment, Recommendation assessment dated [DATE] at 11:30 AM, written by Nurse #1, revealed Resident #25 had received a skin tear to her left lower leg. A dressing was applied, and the Wound Nurse, Nurse Practitioner, or Medical Director were to evaluate. Recommendations included that Resident #25 be sent to the Emergency Department. New orders documented included: Patient to Emergency Department per her request related to skin tear to left leg. Vital signs included the following: blood pressure 132/77 (normal 120/80), pulse 97 (normal range 60-90), respiration 22 (normal range 12/20), temperature 98.2 (normal range 97-99.0), pulse oximetry 97% (normal range >92%) on room air. A pain scale was not included in the documentation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A late entry nursing progress note dated 01/20/26 at 3:00 PM, written by Nurse #1, revealed the note was a late entry for 11:30 AM. Nurse #1 was informed Resident #25's leg was bumped during transfer. Resident #25 was assessed and noted to have a one-inch slit in the middle of her left leg. The resident's anticoagulant was held at that time. Increased bleeding was noted related to Resident #25's anticoagulant therapy. Pressure was applied to the injury site for a duration of five minutes, and then a pressure dressing was applied. The Wound Nurse was informed and aware of the situation. A late entry nursing progress note dated 01/20/26 at 3:29 PM, written by Nurse #1, revealed Resident #25's Responsible Party (RP) was present in the facility. Upon the RP's arrival, Resident #25 began to scream and yell, I'm hurting. Nurse #1 left the resident's room to check physician orders and obtain medication. Upon returning, the RP stated, I called 911 services for Resident #25. Resident #25 stated, I want to go to the hospital. Bleeding was noted to have stopped. Emergency Medical Services (EMS) arrived at the facility at 1:35 PM. A mechanical lift was used with two staff members to transfer Resident #25 onto the stretcher for EMS. On 02/23/26 at 1:45 PM, an interview was conducted with Nurse #1. She stated she was an agency nurse working in the facility for the first time 01/20/26. She recalled NA #1 calling for assistance on 01/20/26 around 11:30 AM and entering the room to find Resident #25's left leg bleeding with a one-inch laceration located on her left lower leg. Due to the increased bleeding that saturated a towel NA #1 applied, she applied pressure for approximately 5 minutes to stop the bleeding and notified the Wound Nurse and Nurse Practitioner #1. She stated, I didn't think she needed to go to the hospital; I just notified Nurse Practitioner #1. She explained she did not recall if she administered pain medication to Resident #25 but if she put it into her written note from that date then she would have given pain medication. She didn't know why it wasn't on the Medication Administration Record (MAR). Nurse #1 stated because she was an agency nurse it was difficult to remember the situation and all of the specific details and to refer to her notes of what occurred on 01/20/26. On 02/23/26 at 2:10 PM, an interview was conducted with Resident #25's Responsible Party. He stated Resident #25 called him on 01/20/26 and reported a Nurse Aide had hit her leg on the footboard while the NA was backing her wheelchair beside the bed. During the call Resident #25 did not complain of pain but asked him to come. Upon arrival, he observed red blood on a white dressing on her left lower leg and stated, The facility wasn't sending her, so I called 911. The interview revealed there was no blood noted in the room when he arrived other than on the resident's dressing and Resident #25 was complaining of pain. EMS arrived shortly after he called and transported her to the hospital. On 02/23/26 at 3:14 PM, an interview was conducted with NA #4. She stated she worked both first and second shift on 01/20/26. NA #4 assisted with transferring Resident #25 onto the EMS stretcher. She reported Resident #25 was yelling in pain and that her legs remained straight and did not bend. The interview revealed assisting with the transfer onto the EMS stretcher was the first time NA #4 had been in Resident #25's room during the shift. Emergency Medical Services (EMS) records dated 01/20/26 revealed EMS was called at 1:27 PM and arrived at Resident #25's bedside at 1:42 PM. The nurse reported to EMS that Resident #25 was transferred from her, wheelchair to her bed when her leg was hit on a rounded corner, causing a 1 to 2-inch laceration to her left lower leg. Nurse #1 stated to EMS she had controlled the bleeding with gauze and tape and had administered pain medication. The resident's RP arrived approximately 30 minutes after the incident and requested Resident #25 be transported to the hospital for further evaluation. Resident #25 was noted to be in emotional distress due to pain with bilateral lower (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	extremity swelling. Resident #25's left lower leg was noted to have bruising and swelling where she was injured but no obvious deformity. EMS did not remove Resident #25's dressing to her left lower extremity. Vital signs revealed an elevated blood pressure of 182/110 (normal 120/80) and an elevated heart rate of 123 (normal 60–90). Resident #25 continued to complain of pain to her left lower extremity while en route to the hospital with a pain level of 10, on a 0-10 scale (0 being no pain, 10 being the worst pain). She was administered pain medication (acetaminophen) along with a diuretic (torsemide), and muscle relaxant (methocarbamol). Hospital records dated 01/20/26 revealed Resident #25 presented to the Emergency Department (ED) from the nursing facility for evaluation of a hematoma and laceration to the left lower leg. She reported moderate to severe pain. The ED note indicated difficulty controlling bleeding at the nursing facility, and due to swelling, she was referred for further evaluation. Assessment of the left lower extremity revealed a 2 cm skin tear with a small amount of drainage coming from the area. She also had an associated large hematoma measuring approximately 4 x7 inches distally a small distance from the laceration. A picture 01/20/26 was taken while Resident #25 was in the Emergency Department. The picture shows Resident #25 lying in bed with her left leg elevated on a pillow. Blood was observed under her left knee pooled onto the bed and also on the pillow under the residents left leg. Ice was placed to assist with pain and swelling along with 2mg of morphine (a strong opioid pain medication use to treat moderate to severe pain) administered intravenously. Blood is also visualized on the residents left surrounding the laceration. Upon admission on [DATE], she was noted to have a large superficial soft tissue hematoma measuring 16.2 cm (6.38 inches). Laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic, requiring operative evacuation of the hematoma, surgical debridement of necrotic tissue, and placement of a wound vacuum-assisted closure (VAC) device. Resident #25 was discharged back to the nursing facility on 02/05/26 with orders for oxycodone 5 milligrams (mg) one tablet every 6 hours as needed for severe pain and acetaminophen 650 mg every 8 hours as needed for pain. Wound care discharge instructions included daily dressing changes to the left lower extremity with petroleum gauze an abdominal pad and gauze wrap. On 02/25/26 at 10:02 AM an interview was conducted with the Maintenance Director. During the interview he stated he had been working in the facility since April 2025. He explained he was notified by the Administrator on 02/23/26 of an issue with Resident #25's footboard. Once in the room he observed the outer layer of laminate was gone exposing the press board. He stated that was not how the beds were supposed to be and immediately changed the footboard. The interview revealed the facility kept extra footboards in stock and he had received no work orders or mention of the damaged footboard from staff. On 02/24/26 at 8:45 AM, a telephone interview was conducted with the Medical Director. He stated Resident #25 was prescribed a high dose of an anticoagulant (Eliquis), which contributed to the blood loss following the incident. He explained anticoagulation increased her risk of bleeding. He stated he was not aware a Nurse Aide had struck Resident #25's leg on the footboard and had only been told about the injury, not how it occurred. He stated he would have sent her to the hospital on [DATE] due to her increased bleeding risk however, it sounded like she was sent out anyway due to a Responsible Party request for her to be evaluated so the outcome would have been the same. On 02/24/26 at 9:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that, from her recollection, NA #1 had transferred Resident #25 to her wheelchair on 01/20/26 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and the resident's leg struck either the wheelchair or bed. She was notified of the incident by Nurse #1 after it occurred. The DON stated Nurse #1 had called Nurse Practitioner #1 and obtained orders to hold the anticoagulant; however, Resident #25 was already at the hospital per the Responsible Parties request to send the resident to the hospital. The DON explained it was her understanding Resident #25 did not need to go to the hospital and she wanted orders to hold the next dose of anticoagulant for that night. She stated, everything just happened so quickly. The interview revealed the DON was in the facility on 01/20/26 when the incident occurred however she did not go into the room nor did she look at the wound to Resident #25's left lower extremity. On 02/23/26 at 2:27 PM, an interview was conducted with the Administrator. She stated she was notified after staff had addressed the incident on 01/20/26. She was informed that NA #1 had bumped Resident #25's leg on the footboard. She stated the Nurse Practitioner was notified and a pressure dressing was applied. On 02/24/26 at 10:17 AM, an interview was conducted with the Wound Care Nurse Practitioner. She stated she had evaluated Resident #25 weekly after the resident's discharge from the hospital on [DATE]. She confirmed Resident #25 sustained a hematoma requiring surgical intervention at the hospital. She explained large hematomas can result in pooled blood, which may become necrotic. After reviewing hospital records, she stated the hospital monitored the area for several days before surgically evacuating the hematoma, debriding necrotic tissue, and applying a wound VAC. Once Resident #25 returned to the facility she had received daily wound care with weekly evaluations. The Wound Care Nurse Practitioner stated the wound was improving; however, it would be difficult to fully heal due to the surface area. She stated she was considering an allograft (a type of tissue taken from a donor to replace damaged tissue) to cover the area to the residents left lower leg since it remained an open area and probability of skin healing was low. On 02/25/26 at 11:11 AM an observation was conducted of Resident #25's wound to the left lower leg. Resident #25 was observed to have a large reddened open area to her left lower extremity with areas of black (necrotic) tissue. Resident #25 was pre-medicated with pain medication prior to the wound care observation. The Wound Nurse was observed cleansing the left lower leg with normal saline solution, patting the area dry with gauze and applying santyl (a prescription medication used to remove dead tissue and promote healing) ointment to the necrotic areas of the wound, followed by moisten gauze with dakins (antiseptic cleaning agent for wounds) solution. The area was covered with an abdominal pad and wrapped with kerlix. The Administrator was notified of the immediate jeopardy on 02/24/25 at 2:00 PM. The facility provided the following credible allegation of immediate jeopardy removal. F689 Credible Allegation: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #25 (on anticoagulant therapy) suffered a serious adverse injury following the incident on 1/20/26. Nurse Aide (NA) #1 completed a 1-person mechanical lift transfer prior to injury. While Nurse Aide (NA) #1 was maneuvering resident's wheelchair, NA#1 bumped residents' left leg on the foot board (that was damaged and the outer layer of material was gone and press board was exposed) of the bed causing a laceration, hematoma and pain to Resident #25's left lower leg. NA #1 received 1 on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1 education on 2/24/26 by the Director of Nursing (DON) on the expectation of following the mechanical lift policy that includes utilizing 2-person assistance with all mechanical lift transfers and safe movement of residents in their room and environment. NA #1 immediately (1/20/26) applied pressure to the laceration on Resident #25's left lower leg and notified Nurse #1 of the incident. Nurse #1 assessed the wound, applied pressure dressing and notified Nurse Practitioner (NP) #1. NP #1 gave order for anticoagulant to be held and to monitor laceration on 1/20/26. NP #1 was notified on 1/20/26 by Nurse #1 of the incident. Resident #25 notified her own Responsible Party (RP) via phone on 1/20/26 that she received an injury to her lower leg. Responsible party arrived at facility and discussed with nurse prior to resident going out via Emergency Medical Services (EMS). Resident #25 was sent to the Emergency Department and admitted on [DATE]. Resident #25 was admitted to the hospital from [DATE]-[DATE]. Resident #25's RP notified EMS of the need for transfer to the hospital. Nurse #1 notified NP #1 that resident was transferred to ED at the request of RP on 1/20/26. Other residents on anticoagulants were at risk of serious adverse outcomes (e.g., uncontrolled bleeding, significant bruising) due to the identified practice gaps. On 2/24/26 the Assistant Director of Nursing (ADON) completed an audit of the electronic health record order listing report to identify all residents receiving anticoagulant therapy. 21 residents were noted to receive anticoagulant therapy. This is an ongoing audit that is updated with each admission. All residents requiring mechanical lift transfers were at risk for serious injury due to a failure of staff to consistently perform required twoˆperson assist procedures and inadequate staff adherence to safeˆtransfer practices prior to corrective actions. 100% audit of Resident Kardex (an electronic reference to individualized plan of care, to include method of transfer) was conducted by the Assistant Director of Nursing on 2-24-2026 to determine the residents who required a Mechanical lift and 35 residents were identified. Transfer status is evaluated by the Inter Disciplinary Team upon admission, readmission, significant change, and quarterly to establish safe transfer method at which time the resident care plan is updated as needed and populated to the Kardex by the Minimum Data Set Nurse (MDS) or designee. A review of all incidents and accident log was conducted on 2/24/26 for the last 30 days by the DON to identify any other residents that may have sustained an injury while being maneuvered in their wheelchair in their environment. No other incidents were identified. Resident #25's care plan was reviewed by MDS Nurse, Administrator, and DON on 2/24/26. No changes were needed at this time. On 02/24/2026, the Maintenance Director inspected resident furniture for all residents —including the bed frame and bedside table—to ensure no rough edges or hazardous surfaces were present. No concerns were noted with any other bed frames or footboards. Resident #25's footboard was replaced on 2/23/26 by the Maintenance Director. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Root Cause Analysis was completed on 2/24/26 that included the DON, ADON, Administrator and MDS Coordinator. It was identified that NA #1 did not follow facility policy with 2-person mechanical lift transfers as well as lack of education with safely maneuvering residents in their environment. NA #1 had received prior education on the policy for 2 person mechanical lift transfer, however, continued to proceed with the transfer independently. 02/24/2026: All nursing staff, including nurses, nursing assistants as well as therapy department, and agency nurses and nurse aides, were in-serviced by the Director of Nursing (DON) on safe transfer requirements, emphasizing the mandatory twoˆperson assist for all mechanical lift transfers. All staff who did not receive education on 2-24-2026 will be educated prior to their next shift by the DON or designee. Education was provided in person and via electronic education system. New staff will be educated during orientation by the DON or designee. The DON was made aware of this responsibility on 2/24/26 by the Administrator. Education was provided using facility policy on Safe Lifting of Residents. Education included safe maneuvering of residents in wheelchairs while in their room with a focus on environmental surroundings and the ability to avoid bumping furniture in room, awareness of recognizing potential in room hazards, such as poor condition of furniture (exposed pressboard, sharp edges on furniture). Education was also provided on 02/24/26 on by the DON reporting any potential hazards or need for equipment changed via the TELS system (an electronic platform for reporting environmental and maintenance concerns directly to Maintenance Director). Once the Maintenance Director has received the TELS notification via electronic alert on cellular device, lap top and or desk top, as well as verbal communication of TELS entry, completion of repair is expected within the same day if it involves a resident safety concern. Hoyer Lift competencies were completed on 02/24/2026 for all onˆduty nursing staff (nurses and Nurse Aides) by the DON and Rehab Director. Any staff not present on 02/24/2026 are required to complete their competency prior to their next scheduled shift. Competency Evaluations will be completed by DON, ADON and Unit managers. DON/ADON will be responsible for tracking and maintaining education record to ensure that staff receive this education prior to start of their next shift. The DON and ADON were made aware of this responsibility on 2/24/26 by the Administrator. NA #1 was re-educated on the Kardex with emphasis on location of resident transfer on 2/24/26. Education was provided by the DON. All Na's, including agency, were educated on 2/24/26 by the DON on where to locate the Kardex in the Point of Care platform that details resident care specific information, including transfer status, and reviewing of Kardex at the beginning of their shift. All NA's not educated on 2/24/26, including agency and new hires, will be educated prior to the start of their next shift and during the orientation process by the DON, ADON, or Unit Manager. The DON was made aware of this responsibility by the facility Administrator on 2/24/26. The DON made ADON and Unit Manager aware of this responsibility on 2/24/26. An ad hoc QAPI was held on 2/24/26 with the facility Administrator, DON, Medical Director, and Nurse Managers to review the deficient practice and plan of correction. Maintenance will be responsible for assessing, repairing, or replacing damaged foot boards with visible hazards of press board immediately upon notification via TELS. The Administrator notified Maintenance Director of this responsibility on 2/24/26. The Administrator is responsible for the execution of this plan of Credible Allegation. Date of IJ removal: 2-25-2026 (continued on next page)

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	345201	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health at Charlotte	2616 East 5th Street Charlotte, NC 28204

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's credible allegation of immediate jeopardy removal was validated on 3/02/26. An interview conducted with the DON revealed she and the Rehabilitation Director provided education to nurses and NAs on the facility's policy regarding safe resident transfers and had them perform return demonstration using the mechanical lift to ensure all competencies were met on the skills checklist which included reviewing the Kardex to verify a resident's transfer status, review of the mechanical lift skills checklists that were completed for nurses and NAs on 2/24/26 revealed all competencies were marked as met and no concerns were identified. Interviews conducted with nurses and NAs revealed they received education on the facility's safe resident transfer policy and were observed performing return demonstrations using the mechanical lift. An interview conducted with the Maintenance Director revealed on 2/23/26 and 2/24/26 he completed an audit of all the residents' rooms and any furniture that was damaged or broken was immediately replaced. Observations conducted in the residents' rooms revealed no broken or damaged headboards or footboards on the beds, the furniture was in good repair, and there were no safety concerns identified. An observation conducted of two NAs transferring a resident using the mechanical lift revealed the facility's safe transfer policy was followed and no concerns were identified. The facility's IJ removal date of 2/25/26 was validated on 3/02/26. 2. Resident #20 was admitted to the facility on [DATE] with diagnoses which included rheumatoid arthritis, generalized muscle weakness and diabetes mellitus. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #20 was cognitively intact. Resident #20 was her own responsible party. Resident #20 required supervision to minimum assistance with bathing, dressing and transfers from bed to wheelchair. Resident #20 used a wheelchair for mobility and could propel herself independently. Resident #20's care plan dated 4/23/2025 had a focus area which indicated Resident #20 had a risk to fall due to impaired physical mobility, lower extremity weakness, psychoactive medication (medication that can alter mood, cognition, and behavior and can cause sedation or altered consciousness) use and visual impairment. Goals included Resident #20 would not have any falls through the review period. Interventions included staff to anticipate Resident #20's needs as able (hunger, thirst, toileting, and temperature), keep the bedside table/personal items within reach, place the bed in low position, and remind Resident #20 to use the call light when assistance was needed. An interview on 2/22/2026 at 2:12 PM with Resident #20 revealed she had worked with Physical Therapy (PT) and Occupational Therapy (OT) during April 2025 while preparing for discharge to the community. On 4/24/2025, she went to the shower room on the East hallway of the facility with OT #1 and PT #1 to be checked off on showering as part of her discharge goals. Resident #20 did not recall the exact time but knew the shower took place in the morning approximately around 10:00 AM. Resident #20 stated the shower had been going well and PT #1 left to go get Resident #20's clothes from her room just down the hallway. OT #1 asked Resident #20 to stand to rinse off. Resident #20 reported when she touched the shower grab bar it moved a little and she stated to OT #1, This is loose. Resident #20 stated OT #1 did not respond and asked her to rinse off. Resident #20 stood up and when she pulled on the shower grab bar, the bar moved quite a bit which scared her and she fell back, hit the edge of the shower chair with her buttocks and then slid onto the floor onto her buttocks. Resident #20 stated she could not get up with the help of OT #1 and PT #1 due to chronic knee/leg weakness and the floor was wet and slippery. The therapists notified nursing of the fall. The therapists used the mechanical lift to get her up and into her wheelchair. Resident #20 stated she finished the therapy session in her room and was able to dress herself. Resident #20 reported she did (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not feel any new pain at the time of the fall as she had chronic knee, leg and back pain until later in the day. Resident #20 went to the hospital on 4/24/2025 for an evaluation. Resident #20 indicated she had a sprain in her knee but no fractures. Resident #20 stated after the fall she was scared to use the [

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to close the trash receptacle door, remove loose garbage, boxes, and debris and failed to prevent standing water from around 1 of 1 trash receptacle and 1 of 1 recycling receptacle located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests and rodents.The findings included:An observation of the outdoor trash receptacle area with the Head [NAME] on 2/22/26 at 11:30 AM revealed three used disposable gloves and one clear trash bag which contained trash on the ground to the left of the trash receptacle and one clear trash bag which contained small amounts of trash hanging out of the open trash receptacle door. There were five collapsed cardboard boxes that were floating in standing water approximately 5 inches deep in the trash and recycling receptacles area, which was approximately 15 to 20 feet wide. One blue trash bag which contained trash was floating in the standing water between the trash receptacle and the recycling receptacle. One empty carboard carton was observed under the front of the recycling receptacle. An interview with the Head [NAME] on 2/22/26 at 11:33AM revealed many staff members at the facility used the dumpster area and staff continuously forgot to close the receptacle doors. She stated that when it rained, water pooled under the dumpster area and didn't drain, which caused the standing water. A second observation of the outdoor trash receptacle area was completed on 2/23/26 at 11:57 AM. One used purple glove was observed on the ground to the left of the trash receptacle. The trash receptacle door was open and one clear trash bag which contained trash hung out of the receptacle. Two collapsed cardboard boxes were floating in standing water approximately 3 inches deep (approximately 6 feet wide) between the trash receptacle and the recycling receptacle and one empty carton was observed under the front of the recycling receptacle. An interview with Regional Housekeeping Supervisor on 2/23/26 at 2:10 PM revealed many staff members in multiple departments used the dumpster area and staff were continually reminded to keep the doors closed to the trash receptacle. She also stated the trash pick-up service which came a couple times a week caused a lot of the materials to fall out of the receptacles such as the collapsed cardboard boxes that were observed. A tour and third observation of the trash receptacle area was completed with the Dietary Manager and Administrator on 2/23/26 at 2:53 PM and included interviews. The trash receptacle was not full, and the door was open and one clear trash bag which contained trash hung out of the door. Two collapsed cardboard boxes were observed in approximately an inch of standing water next to the recycling receptacle and an empty carton was under the front of the recycling receptacle. The Administrator stated she was not aware of the standing water, and she would have the area cleaned up to see if there was a drain present under the receptacles. The Administrator expected the area to be maintained by all staff who took out trash. The Dietary Manager revealed the trash pick-up company dumped items out of the dumpster when they picked up the trash and the items were not placed back in the receptacles by the trash pick-up company.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and resident and staff interviews, the facility failed to honor a resident's request to return to bed after arrival to the facility from dialysis services. The resident stated to a staff member that waiting for over an hour for assistance to return to bed after dialysis treatment made her feel lightheaded and even more tired. This deficient practice affected 1 of 4 residents reviewed for choices (Resident #22). The findings included: Resident #22 was readmitted to the facility on [DATE]. Her diagnoses included chronic kidney disease stage 4 with hemodialysis and type 2 diabetes mellitus. Resident #22's physician order dated 8/12/25 revealed Resident #22 received hemodialysis every Tuesday, Thursday, and Saturday. Resident #22 had a dialysis care plan in place dated 8/12/25 which revealed she was at risk for complications requiring hemodialysis; dialysis treatment days were scheduled every Tuesday, Thursday, and Saturday. Resident #22's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. Resident #22 was dependent on staff for transfers via mechanical lift. The MDS further indicated that it was very important for Resident #22 to choose her bedtime. Resident #22 was coded as receiving dialysis An interview was conducted on 2/22/26 (a non-dialysis treatment day) at 11:59 AM with Resident #22. Resident #22 stated she would typically return to the facility around 10:50 AM from dialysis services. She stated she would notify staff when she returned from dialysis services as she passed the nurses' station or the dialysis transport driver would inform the staff that she (Resident #22) was back from dialysis services if staff were not at the nurses' station. Resident #22 explained she pressed her call light to notify staff she was ready to return to bed. Resident #22 verbalized she gauged the time while watching The Price is Right (a television program that started at 11:00 AM and ended at 12:00 PM) or by looking at the clock on her personal cell phone. Resident #22 also had a clock on her wall next to the bathroom door that she gauged time with. Resident #22 stated there were times she would wait until after lunch (between 12:30 PM and 1:30 PM) to be placed back into bed after her return from dialysis treatment. Resident #22 voiced that her day began at 2:00 AM in preparation for her dialysis treatment. Resident #22 expressed that after her dialysis treatments, she was extremely tired and ready to return to bed once she arrived back at the facility. On 2/24/26 at 10:40 AM, a continuous observation was conducted of Resident #22 returning from dialysis services via external transportation. Once Resident #22 was delivered to her room, the call light was activated by Resident #22 at 10:43 AM. Resident #22's call light was turned off by Nurse Aide (NA) #10 at 10:45 AM. At 10:51 AM, an interview was completed with Resident #22. Resident #22 stated NA #10 entered her room and deactivated her call light, then informed Resident #22 that she was completing rounds and would return. Resident #22 verbalized that she did not have a chance to let NA #10 know what she required or needed. Resident #22's call light remained off. At 11:25 AM, the call light was reactivated by Resident #22. At 11:28 AM, NA #7 answered the call light and deactivated it. At 11:34 AM, NA #7 attempted to assist Resident #22 but needed another nurse aide or staff person to assist her during a mechanical lift transfer. NA #7 verbalized to Resident #22 that she had requested assistance from another staff member. At 11:40 AM, the call light was reactivated by Resident #22. At 11:43 AM, the call light was turned off by the Certified Occupational Therapist Assistant (COTA) #1 and NA #7 as they returned to Resident #22's room. COTA #1 and NA #7 were observed transferring Resident #22 with the mechanical lift with no concerns back to bed.On 2/24/26 at 2:55 PM an interview was conducted with Nurse Aide #10. NA #10 stated she was assigned to Resident #22 that day and was responsible for assisting with upper and lower body bathing and dressing. NA #10 stated she answered Resident #22's call light after she returned from dialysis and Resident #22 voiced that she was ready to lay down. NA #10 stated she was in the process of assisting another resident located on a different hall with dressing and transferring to a wheelchair at that time. NA #10 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that she did not notify or request assistance from other staff members. NA #10 explained that, as an agency nurse aide, she had a designated assignment and stated it was not the responsibility of other staff members to address needs for residents on her assignment. NA #10 stated she completed walking rounds at the beginning of her shift; however, she was not aware of any request or preference that Resident #22 should be placed in bed upon returning from dialysis services. NA #10 revealed she did not receive a full report prior to taking the hall and beginning her assignment and did not recall receiving report regarding Resident #22. NA #10 stated she did not return to Resident #22's room after she assisted another resident on a different hall. On 2/24/26 at 2:29 PM an interview was conducted with Nurse Aide #7. NA #7 revealed she answered the call light initially and turned off call light. NA #7 indicated she explained to Resident #22 that she needed to get someone to assist her with the mechanical lift transfer. NA #7 explained that it was normal to have two staff members present with mechanical lift transfers. NA #7 then proceeded to come out of Resident #22's room to get someone to assist her, which was COTA #1. NA #7 stated that Resident #22 expressed that she was tired from dialysis treatment. Resident #22 also stated to NA #7 that she had waited a little minute, but NA #7 could not give a definite time frame. NA #7 stated that the nurse aides were aware that when Resident #22 returned from dialysis treatment she liked to go to bed as soon as possible. NA #7 confirmed that the nurse aides who were usually scheduled on the unit were aware of Resident #22's request and would put her to bed upon her return to the facility from dialysis treatment. NA #7 added, if the aides were in the middle of something, then it would typically be 10 to 15 minutes (depending on what they were completing) to assist her to bed. NA #7 was not certain why it took so long to assist Resident #22 back to bed after her dialysis treatment and return to the facility.On 2/24/26 at 2:22 PM, an interview was completed with the Certified Occupational Therapy Assistant (COTA) #1 who stated she worked at the facility for approximately 6 years. She confirmed that Resident #22 was on Occupational Therapy (OT) caseload and no other therapies at the time. COTA #1 explained she responded to Resident #22's call light around 11:40 AM and went to look for NA #10 to assist with getting Resident #22 back into bed. NA #10 verbalized she needed assistance with another resident, so COTA #1 assisted NA #10 with the resident NA #10 was working with and then returned to Resident #22's room to assist with getting her back to bed. COTA #1 stated NA #7 assisted with putting Resident #22 back to bed via mechanical lift per Resident #22's transfer status. COTA #1 verbalized that Resident #22 informed her she was very tired and lightheaded from her dialysis treatment. Resident #22 also informed COTA #1 that she had been waiting over 45 minutes. COTA #1 stated staff was aware that when Resident #22 returned from dialysis treatment she liked to go to bed. COTA #1 explained that because a different nurse aide was assigned to the hall, Resident #22's routine and preferences must not have been communicated with NA #10. On 2/24/26 at 2:42 PM, an interview was conducted with the Unit Manager. The Unit Manager stated that nurse aides were to respond immediately to call lights and notify staff if any additional assistance was required. The Unit Manager further explained that staff were aware that Resident #22 preferred to go to bed upon return to the facility after dialysis treatments. The Unit Manager stated Resident #22 should not have had to wait over an hour to be assisted back to bed and that NA #10 should have anticipated Resident #22's need and made sure she was put to bed immediately upon her return from dialysis treatment. If NA #10 could not assist Resident #22 then NA #10 should have requested assistance from other staff on the unit that were available. On 2/25/26 at10:10 AM, an interview was completed with the Director of Nursing (DON). The DON confirmed Resident #22 was alert, oriented and could clearly communicate regarding her preferences and choices. Resident #22 could make the request to return to bed after she arrived back at the facility after dialysis treatment. The DON indicated NA #10 was not aware of Resident #22's preferences as she was agency staff. The DON further stated that if NA #10 was in the middle of care with another resident, then the appropriate process would have been to return to Resident #22 as soon as possible or NA #10 should have followed up and provided an update as to when she would be able to assist her. The DON explained that the facility attempted to (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accommodate Resident #22's preferences and choices when she returned from dialysis treatment to be placed back to bed. On 2/25/26 at 4:33 PM, an interview with the Administrator revealed that staff should have responded to Resident #22's call light immediately or within 5 minutes to 10 minutes at maximum to assist with Resident #22's request. The Administrator stated that waiting 45 minutes to go to bed after dialysis services was not acceptable and staff should have acknowledged Resident #22's request by returning her to bed after dialysis treatment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, and staff interviews, the facility failed to maintain the footboards on beds in a resident room in good repair (Residents #25 and #27). The deficient practice affected 1 of 21 rooms on 1 of 4 halls observed for a safe and homelike environment. The findings included:An observation conducted on 2/23/26 at 1:15 PM in the shared room of Residents #25 and Resident #27 revealed that the footboards on both residents' beds were in disrepair. Resident #25's footboard was missing the banding which left an exposed, rough area of particle board approximately 3 to 4 inches in length. Resident #27's footboard exhibited multiple damaged areas, each approximately 6 inches long, with rough, exposed particle board. The laminate covering was missing from the footboard. A review of the facility's online maintenance work order system from March 2025 to February 2026 revealed no documented requests for repair of the bed footboards for Resident #25 or Resident #27. An interview and observation were conducted with Nurse Aide (NA) #1 on 2/23/26 at 12:54 PM revealed that the outer coating on Resident #25's bed footboard was missing, which exposed a rough area of particle board. She confirmed that the footboards for both Resident #25 and Resident #27 had exposed particle board. The interview revealed both footboards had been damaged for some time, but she had not notified any staff members. An interview with Nurse #4 on 2/24/26 at 11:36 AM revealed she had observed damage to the outer coating of Resident #25's and Resident #27's bed footboard. She reported that, as an agency staff member, she assumed Maintenance was already aware of the issue. Nurse #4 stated she did not know how long the footboard had been in that condition but had observed the damage a couple of weeks earlier. An interview with the Maintenance Director on 2/24/26 at 10:02 AM revealed he had been at the facility since April of last year and on 2/23/26, he stated the Administrator called him on 02/24/26 and notified him of an issue with the footboards in a resident room. He stated he noticed the laminate covering had been rubbed off on the bottom of Resident #25 and Resident #27 footboards. He stated Resident #27's bed was replaced and Resident #25's bed, looked like the banding was coming off and the particle board was exposed. The Maintenance Director stated that was not how the beds were supposed to look and it was warranted for the footboards to be changed. He stated when he was notified about the situation, verbally by the Administrator, he immediately went and changed them as he keeps extra footboards and headboards in the maintenance shop. The Maintenance Director stated if staff saw beds in disrepair, he expected them to put in a work order to have it changed out. The interview revealed he was not aware of the damage to the footboards until the Administrator called him. A combined telephone interview with the Director of Nursing (DON) and Administrator occurred on 2/26/26 at 10:36 AM. The DON stated she had the expectation that all nursing staff to put in a work order for anything that needs to be repaired by maintenance. The Administrator stated NAs have access in their point of care system to request any maintenance concerns 24 hours a day. The Administrator stated there were many items in the facility which needed attention and some had been marked as urgent requests. The Administrator stated maintenance, checked Resident #25 and Resident #27's beds and did not find anything on them that was rough and he did not see anything urgent in replacing them until after the State Surveyor pointed out the concern. The footboards were replaced by the maintenance department on 2/24/26. The Administrator and DON both stated they were not aware of any damage to Resident #25 or Resident #27's footboards until it was brought to their attention during the survey on 02/24/26.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of range of motion and mobility devices for 1 of 21 sampled residents (Resident #25).The findings included:Resident #25 was admitted to the facility on [DATE] with diagnoses of fracture of the right tibia, muscle weakness and physical debility. A care plan dated 09/05/25 revealed a focus area related to Activities of Daily Living (ADL) care. Resident #25 required assistance with her ADL. The goal was for the resident to maintain their current level of function through the next review date. Interventions included two staff member assistance using a mechanical lift with transfers. A Physical Therapy evaluation dated 11/14/25 signed by Physical Therapist #1 revealed Resident #25 demonstrated decreased bilateral lower extremity range of motion due to contractures and weakness. She demonstrated decreased function with bed mobility and wheelchair mobility. Resident #25 was noted to be limited by contracture and malalignment of the right lower extremity due to a chronic break. The assessment revealed Resident #25 did not tolerate upright positioning for long and was unable to sit in a wheelchair without bilateral lower extremities elevated on pillows and leg rests. On 02/25/26 at 5:00 PM, an interview was conducted with Physical Therapist #1. During the interview, she stated she had worked with Resident #25 during sessions in November 2025 and December 2025. She explained Resident #25's range of motion was severely decreased in her bilateral lower extremities and her legs remained elevated on pillows and leg rests with use of a wheelchair as a mobility device.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact and dependent upon two staff members for personal and toileting hygiene, showering/bathing and upper and lower body dressing. Resident #25 was coded as having no range of motion impairment to the upper or lower extremities and no use of mobility devices during the assessment period. An interview with the MDS Coordinator was conducted on 02/25/26 at 4:58 PM. She confirmed she had completed Resident #25's 11/24/25 MDS. She indicated after reviewing the Physical Therapy notes from 11/14/25 Resident #25 did have bilateral lower extremity impairment and did use a wheelchair as a mobility device. The MDS Coordinator explained that the MDS was completed incorrectly and should have been coded for use of a wheelchair and bilateral lower extremity range of motion impairment.An interview conducted with the Administrator on 03/02/26 at 10:00 AM revealed Resident #25's MDS should have been coded to accurately reflect her range of motion and mobility devices.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident, staff and Nurse Practitioner interviews, the facility failed to secure medications found at the bedside for 1 of 2 residents reviewed for medication storage (Residents #8). The findings included:Resident #8 was admitted to the facility on [DATE] with diagnoses which included acute systolic heart failure.An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact.A review of Resident #8's physician's orders revealed an order dated 2/10/26 for a 20 milliequivalents (mEq) potassium oral capsule (Potassium Citrate) one time a day for hypokalemia. Additionally, Resident #8 did not have any past or current physician's orders to self-administer medications.A review of Resident #8's Electronic Medical Record (EMR) revealed no care plan areas or assessments for self-administering medications.An observation on 2/22/26 at 12:02 PM revealed a large white pill in a cup on the bedside table to the left of Resident #8's bed. Resident #8 was lying in bed at the time of the observation. An observation and interview with Nurse #3 on 2/22/26 at 12:08 PM revealed she was the medication nurse for Resident #8 and had administered Resident #8's medications that morning. She observed the medication cup with the large white pill on Resident #8's bedside and stated Resident #8 took all her other pills, but she wanted to wait a little bit on this one. Nurse #3 verified the large white pill was the potassium citrate capsule. Nurse #3 stated Resident #8 liked to take it later. Nurse #3 stated she did not normally leave the pill by the bedside and would always take the remaining pill back to her medication cart. Nurse #8 stated another staff member called her for a concern that morning and she left the pill next to Resident #8's bedside. An interview with Resident #8 on 2/22/26 at 12:15 PM revealed she didn't like to take the large white pill with all her other medications, so she left it for later and Nurse #3 did not take it away. An interview with the Nurse Practitioner (NP) on 2/24/26 at 1:57 PM revealed Resident #8 didn't like to take the potassium citrate, and she typically did not like to take a lot of medications at the same time. She stated Resident #8 has never had an order to self-medicate and she would not be able to self-medicate. The NP stated Nurse #3 should not have left the pill at Resident #8's bedside and the pill should have been returned to the medication cart when Resident #8 didn't take it. She stated no medications should ever be left at the bedside.A combined telephone interview with the Director of Nursing (DON) and the Administrator on 2/26/26 at 10:44 AM revealed the Administrator had the expectation that Nurse #3 should have taken the pill back to the medication cart to be destroyed after Resident #8 refused it. The DON indicated Resident #8 did not have an order to self-medicate although she had a history of asking staff to leave her medications at her bedside all the time. The Administrator stated she had the expectation for Nurse #3 to follow the protocol for medication refusal, and the medication should have been destroyed and the DON notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health at Charlotte	2616 East 5th Street Charlotte, NC 28204

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and staff interviews, the facility failed to keep a fire compression tank clean of debris and keep the floor grout lines clean of greasy residue and food debris. These practices occurred in 1 of 2 food preparation areas and had the potential to affect food served to residents.The findings included:An initial tour of the main kitchen occurred 2/22/26 at 11:10 AM with the Head Cook. The following concerns were identified:-Visible dirt and grime build-up present on a large fire suppression tank and its tubing. The tank and the associated equipment were attached to the wall and ceiling in a food preparation area above the toaster. -Visible food debris and grease build-up was present in the grout lines of the floor tiles in front of the cooking range.An interview with the Head [NAME] occurred on 2/22/26 at 11:25 AM. She stated the housekeeping department oversaw the cleaning of the floors in the kitchen, however, she was unsure of the cleaning schedule. The Head [NAME] stated grease and food debris would build up in the grout around the floor tiles and she was unaware of the visible dirt and grime build-up on the fire suppression tank. An interview with the Housekeeping Supervisor was conducted on 2/23/26 at 2:10 PM. The Housekeeping Supervisor stated the kitchen floor was pressure washed on 2/20/26 and a new degreasing cleaning product was ordered with a new cleaning supply company. The Housekeeping Supervisor stated the old degreasing cleaning product they used didn't get everything as clean as it needed to be. A telephone interview with the Administrator on 2/26/26 at 10:57 AM revealed the kitchen floors had just been pressure cleaned and the new cleaning products were ordered but had not come in yet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 record reviews, observations and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when Nurse #4 did not wear Personal Protective Equipment (PPE) while providing urinary catheter care for Resident #5. In addition, Nurse Aide (NA) #9 failed to wear PPE while providing urinary catheter care and transferring Resident #33 from wheelchair to bed. These deficiencies occurred for 2 of 10 staff members observed for infection control practices (Nurse #4 and NA #9). The findings included:A review of the facility's policy that was undated titled Enhanced Barrier Precautions, indicated: Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present. a. An observation of urinary catheter care for Resident #5, provided by Nurse #4, was made on 2/25/2026 at 12:10 PM. Resident #5's room had an Enhanced Barrier Precautions (EBP) sign posted on the front of the door, and personal protective equipment (PPE) was hanging behind the door. The EBP sign located on Resident #5's door revealed gloves and a gown should be worn when providing high- contact care such as urinary catheter care. Nurse #4 entered the room without wearing a gown. She cleansed her hands with hand sanitizer gel and put on gloves. After completing Resident #5's urinary catheter care, she discarded any unused supplies and her gloves, then proceeded to wash her hands with soap and water at the sink.An interview with Nurse #4 on 2/25/2026 at 12:30 PM revealed she was aware that Resident #5 was on Enhanced Barrier Precautions. Nurse #4 stated she was not aware she needed to wear a gown while providing urinary catheter care.b. An observation of NA #9 transferring Resident #33 and emptying his urinary catheter was completed on 2/25/2026 at 1:35 PM. Resident #33's room had an Enhanced Barrier Precautions sign posted outside the door stating that staff should wear a gown and gloves for high-contact activities such as urinary catheter care and transfers. PPE was hanging on the back of Resident #33's door. NA #9 applied hand sanitizer to both hands and placed gloves on her hands. She did not put on a gown. NA #9 assisted Resident #33 with a stand-pivot transfer from his wheelchair to his bed. She then moved Resident #33's urinary catheter bag from the wheelchair to a hook on the side of the bed. NA #9 emptied the urinary catheter bag into a urinal and disposed of the urine in the toilet. She cleaned the urinal, disposed of her gloves, and washed her hands.An interview with NA #9 at 2:00 PM on 2/25/2026 was completed. NA #9 stated she was not aware that Resident #33 was on Enhanced Barrier Precautions. She stated she did not notice the sign on Resident #33's door because it was a dark gray printed sign, and she was accustomed to the light blue Enhanced Barrier Precautions signs with red stop signs. NA #9 reported she was not aware that a gown was required to transfer and provide care for residents with urinary catheters.An interview with the Director of Nursing (DON)/Interim Infection Preventionist was completed on 2/25/2026 at 3:52 PM. The DON stated that all employees were trained on infection control and proper use of PPE during orientation upon hire, and agency staff received infection control training online prior to working in the facility. The DON stated that staff should wear the appropriate PPE according to the enhanced barrier precaution signs posted for each resident.An interview with the Administrator was completed on 2/25/2026 at 4:12 PM. The Administrator stated she expected all staff members to use the appropriate PPE according to the enhanced barrier precaution signs posted for each resident.