STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health at Charlotte	**2616 East 5th Street , Charlotte, North Carolina, 28204**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted on 4/27/26-4/29/26. Event ID #22FCBA-H1. The following intakes were investigated 2977248, 2981950, 2977389 and 2798716. 7 of the 7 complaint allegations did not result in a deficiency.	F0000		05/13/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550	Resident #1 was immediately protected from further exposure to the deficient practice. The allegations were thoroughly investigated by facility administration. Staff members involved in the incident, NA #1 and NA #2, were immediately suspended pending investigation and subsequently terminated from employment on 4/3/26 by the facility Administrator following substantiation of the allegations. Resident #1 was interviewed by facility management regarding the incident, provided emotional support, and reassigned alternate caregivers to prevent further concerns. On 4/30/2026, a facility-wide resident audit/interview was completed by Assistant Director or nursing, to identify any additional concerns related to abuse, verbal abuse, dignity, respect, or inappropriate staff interactions. No additional residents were found to have experienced or reported abuse, neglect, mistreatment, or violations of resident dignity. All residents residing in the facility have the potential to be affected by the alleged deficient practice related to resident dignity, verbal abuse, and staff conduct. On 4/30/2026, facility administrator or designee completed a comprehensive facility-wide audit and resident interview process to identify concerns regarding abuse, neglect, verbal altercations, inappropriate staff behavior, or resident rights violations. No additional concerns were identified during the audit process. The Administrator or designee will continue monitoring resident concerns through resident interviews, grievance review, and routine abuse prevention oversight. All facility staff, including licensed nurses, nursing assistants, agency staff, department heads, and ancillary staff, were educated on abuse prevention,	05/01/2026

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 reverse for further 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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F0550 SS = D	Continued from page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: 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 1/12/2021. An annual Minimum Data Set (MDS) assessment dated 1/6/2026 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	F0550	Continued from page 1 resident rights, dignity, appropriate communication, mandatory reporting requirements, and professional conduct expectations. New hires will be educated open hire by the Administrator or designee. Education included zero tolerance for verbal abuse, profanity, retaliation, intimidation, or inappropriate resident interactions. Education was completed by the Administrator or designee beginning 4/30/2026 with all current staff required to complete education. Any staff not educated prior to returning to work will receive education before assuming responsibilities by the Administrator or designee. The Administrator, Director of Nursing, or designee will complete weekly audits for abuse concerns for 4 weeks, then monthly for 2 months thereafter to ensure continued compliance. Findings will be reviewed during the facility Quality Assurance and Performance Improvement (QAPI) meetings for ongoing evaluation and follow-up. Any identified concerns will be addressed immediately with corrective action, including additional staff education or disciplinary action as appropriate.	05/01/2026

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F0550 SS = D	Continued from page 2 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 #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	F0550		05/01/2026

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F0550 SS = D	Continued from page 3 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.	F0550		05/01/2026

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F0550 SS = D	Continued from page 4 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 that she was walking with a resident on 4/2/2026 when she heard loud yelling and cursing. The Restorative Aide stated that she asked the resident she was walking to sit down to rest while she went to the hallway to investigate the disturbance. The Restorative Aide indicated Nurse #1 was also headed toward Resident #1's room and they both arrived at the same time. The Restorative Aide observed NA #1 and Resident #1 yelling and cursing at one another. The Restorative Aide asked NA #1 to stop arguing with Resident #1 and leave the room. The Restorative Aide indicated NA #2 had come to the room and took NA #1 to the nurse's station. The Restorative Aide reported that she and Nurse #1 were trying to calm Resident #1 down as Resident #1 was upset about how NA #1 and NA #2 had treated her when NA #1 returned to the room and started yelling and cursing at Resident #1 again, calling her a "b****." NA #1 was sent out of the room a second time. The Restorative Aide indicated Nurse #1 had control of the situation and she needed to return to the resident she was walking. As she passed the nurse's station, the Restorative Aide	F0550		05/01/2026

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F0550 SS = D	Continued from page 5 indicated she heard both NA #1 and NA #2 talking about Resident #1 being a “b****” and being a difficult resident. NA #1 and NA #2 were talking where other residents could hear their conversation. A telephone interview with the Former Director of Nursing (DON) was conducted on 4/28/2026 at 2:51 PM. The Former DON indicated the Former Administrator handled most of the investigation regarding the incident on 4/2/2026 between Resident #1, NA #1 and NA #2 but she was familiar with the incident. The Former DON expressed that NA #1 and NA #2 should not have yelled and cursed at the resident. The Former DON reported NA #1 should have stopped care and left Resident #1’s room to end the interaction and reported to the nurse what had occurred. The Former DON indicated NA #1 and NA #2 were both terminated. A telephone interview was conducted on 4/28/2026 at 10:22 AM with the Former Administrator. The Former Administrator indicated that she investigated the incident on 4/2/2026 between Resident #1, NA #1 and NA #2. The former Administrator stated NA #1 should have stopped care when Resident #1 became agitated and not engaged in an argument. Based on the investigation and staff interviews, the former Administrator stated the allegation of verbal abuse from NA #1 and NA #2 toward Resident #1 was substantiated. The former Administrator reported NA #1 and NA #2 were terminated. The facility provided a corrective action plan that was not accepted by the State Agency.	F0550		05/01/2026