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 _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 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
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		2/19/25

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

Electronically Signed | 02/21/2025

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) plan which contained the required information to meet the health, safety, and security needs of the residents and staff. This had the potential to affect all facility residents. The findings included: A review of the facility's Emergency Preparedness plan on 1/29/25 revealed: A. The EP plan had not been updated and there was no date. B. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials. C. The EP plan did not address a communication plan. D. The EP plan did not address subsistence needs for staff and residents. E. The EP plan did not address procedures for tracking staff and residents. F. The EP plan did not address policies and procedures for medical documents.	E 001	E-001 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 02/19/2025 the Administrator updated the Emergency Preparedness plan to include current names and contact information for the Ownership, Director of Nursing, Social Worker, Staff Development Coordinator, Business Office Manager, Medical Records Clerk, and any Volunteers. On 02/19/2025 the Administrator developed training and testing material based on the facility□s risk assessment and initiated training /education to the staff and providers. Documentation to be retained for record keeping. On 02/19/2025 the Administrator initiated annual education of the Emergency Preparedness plan to staff and providers that include testing exercises, activation of the Emergency preparedness plan, and	

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E 001	Continued From page 2 G. The EP plan did not address a means of sharing the EP plan with residents or responsible party (RP). H. The facility failed to develop and put into place EP training and testing plans. I. The EP plan lacked information regarding the emergency generator location. An interview was conducted with the Administrator on 1/29/25 at 10:12 AM. The Administrator stated that this was the only Emergency Preparedness plan he had and that he was aware of the need to have a comprehensive emergency preparedness plan that was specific to the EP needs of the facility. He stated there was a change in facility ownership and he could not locate any additional emergency preparedness information.	E 001	community-based exercises. Documentation to be retained for record keeping. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 02/19/2025 the Regional Director of Clinical Services and Operations re-educated the Administrator regarding the requirements on maintaining a comprehensive Emergency Preparedness Plan. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator or designee to monitor and ensure that through observation and review, a comprehensive Emergency Preparedness Plan is maintained. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 02/19/2025	

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F 000	Continued From page 3	F 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 1/26/2025 through 1/29/2025. Additional information was obtained offsite 1/30/2025 through 2/03/2025. Therefore, the exit date was changed to 2/03/2025. Event ID# EDDB11. The following intakes were investigated NC00213278, NC00221795, NC00219931, and NC00226000, NC00221624, NC00211400, NC00212299, NC00217336, NC00215511, NC00225639, NC00224235, NC00210513, NC00208563, NC00226399, NC00224946 and NC00226595. 8 of the 46 complaint allegations resulted in deficiency. Immediate jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 3/09/2024 and was removed 3/10/2024. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		2/20/25

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F 558	Continued From page 4 Based on record review, observations, staff interviews and resident interviews the facility failed to accommodate bariatric needs by using the wrong size briefs and not providing fitted sheets for 2 of 2 residents reviewed for accommodation of bariatric needs (Resident #64 and Resident #28). The findings included: 1. Resident #64 was admitted to the facility on 1/11/24 with the following diagnoses, cerebral infarction (stroke), obesity and stress incontinence. A review of Resident #64's comprehensive care plan dated 12/24/24 included the following interventions, she was bedfast all or most of the time, she required hands on dependent assistance with perineal hygiene and she was not toileted. The Minimum Data Set (MDS) dated 1/19/25 revealed that Resident #64 was cognitively intact. Resident #64 had no impairment of her upper extremities and had impairment to both lower extremities. Resident #64 was incontinent of both bowel and urine. She had no pressure ulcers but had moisture association skin damage. On 1/26/25 at 1:00 PM the initial interview and observation was conducted with Resident #64. She stated staff would run out of the correct size brief and staff would use a smaller brief on her. It was observed that Resident #64 had a bariatric bed and mattress. On 1/28/25 at 1:53 PM a second interview was conducted with Resident #64. She stated that	F 558	F558 □ Reasonable Accommodations Needs/Preferences 1. The facility failed to accommodate bariatric needs by using the wrong size briefs and not providing fitted sheets for 2 of 2 residents reviewed for accommodation of bariatric needs (Resident #64 and Resident #28). On 1/31/2025, appropriately sized bariatric briefs were purchased by the facility Administrator and provided to both residents. An observation was conducted by Director of Nursing (DON) on 2/19/2025 to ensure both residents #64 and #28 had fitted sheets in place on their beds. 2. On 2/19/2025, all facility residents who require incontinent briefs were assessed for needed brief size and an audit was completed of the current inventory of bariatric fitted sheets by the facility□s Central Supply Coordinator. This was completed to identify deficits in current supplies and establish the ideal amount of inventory needed on hand to meet resident needs. Order was placed on 2/19/2025 by the Central Supply Coordinator for all needed items identified during the audit for bariatric briefs and fitted sheets to bring the current supply to appropriate levels. 3. On 2/19/2025, the facility Administrator provided education to the Central Supply Coordinator and Housekeeping Supervisor on the	

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F 558	Continued From page 5 since admission to the facility, the facility often runs out of the 2X briefs, and the staff will use a smaller brief on her. The smaller brief was very uncomfortable and left red marks on her inner thighs. Resident #64's family member now brings in a supply of 2X briefs and wipes, so she has what she needs. Resident #64 stated that sometimes the staff will come in and ask to borrow some of her personal supplies because they can't find any large briefs. Resident #64 stated that recently she had no fitted sheet on her bed and was told by staff they ran out of linens. Resident #64 had a bariatric mattress, and stated they run out of the sheets for this type of bed often. A daily staffing sheet dated 10/25/24 for the 11PM-7AM shift stated there was no linen. On 1/27/25 at 3:30 PM an interview was conducted with Nurse Aide (NA) #4. NA #4 stated she worked the 7am-7pm shift. She stated she did not think there were sufficient supplies, especially bariatric briefs. She stated the supply clerk quit four weeks ago. NA #4 stated she knows her residents' needs and will ration out supplies. She stated that once supplies are gone, they are gone, and the staff wait until the next shipment. NA #4 stated she recently reported the supply issue but had not noticed any changes. NA #4 stated she had often run out of bariatric briefs and had no choice but to use a smaller brief. She stated linens were also an issue and often ran out of linens such as sheets. NA #4 stated that when there was no linen, she would need to make do with what she had. Sometimes using a smaller sheet for a bariatric bed, which did not work well or no sheet at all.	F 558	importance of monitoring PAR levels and keeping needed resident supplies stocked according to the resident□s appropriate brief size and fitted sheets to accommodate bariatric mattresses. The facility Administrator should be notified in the event that supply levels are low to ensure backup methods are initiated to obtain needed supplies. All newly hired Central Supply Coordinators and Housekeeping Supervisorz Will also be educated on the above. The facility Administrator will enact systemic changes to include ensuring a back-up vendor is available as needed and sister facility sharing plan is in place during inclement weather or delayed truck orders. 4. Beginning 2/24/2025, The Administrator/Director of Nursing/Designee will review the bariatric brief orders to ensure quantity is sufficient to accommodate resident needs as well as make room rounds to observe that beds have appropriate fitted sheets in place. These audits will be conducted one time a week for four weeks, followed by monthly for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify	

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F 558	Continued From page 6 On 1/29/25 at 10:01 AM an interview was conducted with NA #5. NA #5 stated that there had been several times the facility didn't have enough briefs. NA #5 stated that sometimes the shipment doesn't come in as planned and she felt Central Supply was not ordering enough briefs. On 1/29/25 at 10:25 AM an interview was conducted with NA #6. NA #6 stated she had found the facility was short on briefs a couple times each week. She stated that there had been times when the supply closet had no briefs, and she had to search all over the facility to find briefs. NA #6 stated the last two months had been worse with the facility not having enough briefs and she had to use smaller briefs on bariatric residents. NA #6 also stated the facility runs out of linens as well. NA #6's understanding of the process was the first and second shift would get a linen cart but not the third shift. NA #6 stated she worked the 7AM to 7 PM shift. She stated that sometimes when she comes in to start her shift, she will find that some of her assigned residents had no fitted sheet on their bed and was informed they had no linen for the bariatric beds. On 1/26/25 at 3:25 PM an interview was conducted with Nurse #1. She stated the clean linen was brought up in the evening around 4:00 - 5:00 PM from the laundry room. She stated that often times there was not a sufficient amount of linens and it was an ongoing issue. On 1/27/25 at 3:20 PM an interview was conducted with Nurse #4. The nurse worked the 7am-7pm shift and stated there were not enough linen. The cart will come up full and quickly be gone.	F 558	necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three months.	

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F 558	Continued From page 7	F 558		

On 1/26/25 at 3:25 PM an observation was made of the linen/supply closet. There were no linens or towels in the closet.

On 1/27/25 at 3:30 PM a 2nd observation was made of the 100-unit linen closet. The linen closet had no linens of any kind. It did have three shelves of incontinent briefs, several boxes of gloves and one package of wipes.

On 1/29/25 at 10:26 AM an interview was conducted with the Regional Housekeeping Director. She stated that the third shift does have a linen cart that was kept in her office and the third shift staff just need to come down to get it, but they never do. She felt the facility had enough linen.

2. Resident #28 was admitted to the facility on 2/3/21 with the following diagnoses, morbid obesity, chronic kidney disease and amyotrophic lateral sclerosis.

The MDS dated 10/25/24 revealed that she was cognitively intact, she had impairment on one side of her lower extremity and was frequently incontinent of bowel and urine.

A review of Resident #28's comprehensive care plan dated 11/12/24 included the following interventions, use disposable briefs after each incontinent episode, allowing her to place insert (high absorbency pad) in brief per her request and preference and she required extensive assistance of one for toileting.

On 1/28/25 at 2:58 PM an interview was conducted with Resident #28. She stated that

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F 558	Continued From page 8 every week the staff run out of 2X briefs, and the staff had to use a smaller size. The smaller brief is uncomfortable and left redness on her upper thighs. Resident #28 stated that once you see staff handing out three briefs per resident that was a sign that they were running low on supplies. Resident #28 stated that staff also ran out of wipes and had to carry wipes from room to room. Resident #28 had linen with holes in it and once went without a fitted sheet. On 1/28/25 at 3:03 PM an interview was conducted with NA #7. She stated that the facility runs out of large briefs often and sometimes will need to use a smaller size brief on a resident. NA #7 has done care for both Resident #64 and Resident #28 and had to use smaller briefs on both residents due to not having the correct size. NA #7 stated they also run out of fitted sheets and some of the sheets have holes in them. NA #7 stated that unfortunately there had been times the residents went without any fitted sheets because the facility did not have anything to use. On 1/29/25 at 2:37 PM an interview was conducted with the Administrator. He stated the facility just hired a new company to purchase briefs. The facility is trying to figure out what is needed so they can order the correct amount and the correct sizes. The facility also ordered more linens. The Administrator agreed that the residents should have supplies and sheets on their beds to accommodate resident needs.	F 558		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		2/20/25

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F 600	Continued From page 9 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and resident interviews, the facility neglected to provide a sufficient quantity of linens and size 2x incontinent briefs for 2 of 2 residents who required bariatric goods (Resident #64 and Resident #28). The findings included: Cross refer to tag F558. Based on record review, observations, staff interviews and resident interviews the facility failed to accommodate bariatric needs by using the wrong size briefs and not providing fitted sheets for 2 of 2 residents reviewed for accommodation of bariatric needs (Resident #64 and Resident #28).	F 600	F-600 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #28 and #64 was noted to be affected by this alleged non-compliance. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that	

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F 600	Continued From page 10	F 600		

the
identified issue does not re-occur in the future:
On 1/31/25 the Bari briefs were ordered and on 2/19/25, the Administrator and Director of Nursing ordered enough bariatric briefs and fitted sheets to accommodate all the residents. On 2/19/2025, the facility Administrator provided education to the Central Supply Coordinator and Housekeeping Supervisor on the importance of monitoring PAR levels and keeping needed resident supplies stocked according to the residents appropriate brief size and fitted sheets to accommodate bariatric mattresses. The facility Administrator should be notified in the event that supply levels are low to ensure backup methods are initiated to obtain needed supplies. All newly hired Central Supply Coordinators and Housekeeping Supervisors Will also be educated on the above. The facility Administrator will enact systemic changes to include ensuring a back-up vendor is available as needed and sister facility sharing plan is in place during inclement weather or delayed truck orders.

(4) Indicate how the facility plans to monitor its performance to make sure that the
solutions are achieved and sustained:
The Administrator and Director of Nursing will review the bariatric brief orders weekly to ensure quantity is sufficient and make weekly room rounds to observe the linens. This monitoring will be done weekly for 4

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F 600	Continued From page 11	F 600	weeks, and monthly x 2. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. Facility alleges compliance on 2/20/25.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of functional abilities (Resident #76) and discharge status (Resident #82) for 2 of 2 residents reviewed for accuracy of assessments. The findings included: 1. Resident #76 was admitted to the facility 8/15/24 with diagnoses including right tibia fracture, muscle weakness and cognitive communication deficit. A review of the weekly nursing summary dated 10/26/24 completed by Nurse #5 revealed	F 641	F641 □ Accuracy of Assessments 1. The facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of functional abilities for Resident #76 and discharge status for Resident #82. By 1/31/25, the facility MDS Coordinator reviewed, corrected, and resubmitted the MDS assessments for affected residents (#76 and #82) to ensure accurate coding in the areas identified. 2. On 1/29/2025, the MDS Coordinator completed audits of all resident discharge assessments for the last 3 months to	2/20/25

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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F 641	Continued From page 12 Resident #76 was totally dependent on staff for transfers. The quarterly Minimum Data Set (MDS) dated 11/07/2024 indicated Resident #76 required substantial to maximal assistance with transfers. The care plan dated 11/26/24 revealed Resident #76 had a problem area related to activities of daily living self-care performance deficit. The intervention was to provide substantial to maximal assistance with transfers but did not include the use of a mechanical lift. A phone interview was conducted with Nurse #5 on 1/31/25 at 8:46 AM indicated she was the primary nurse that worked with Resident #76 on 1st shift (7AM - 7PM). Nurse #5 stated since Resident #76 was admitted to the facility she was dependent on staff for transfers and required the use of a mechanical lift. A phone interview conducted with the MDS Nurse on 1/31/25 at 9:10 AM revealed when completing a resident MDS assessment she pulled information from the point of care which provided the NAs documentation of the level of assistance a resident required to complete activities of daily living (ADL). The MDS Nurse revealed she also interviewed direct care staff to verify the resident's level of functioning. She indicated she was unable to pull up the point of care information used to complete Resident #76's MDS dated 11/07/24 and did not recall if she interviewed the direct care staff concerning her transfer status. She stated if a resident was transferred with a mechanical lift, the transfer status should be coded as dependent on the MDS. The MDS Nurse revealed she was unsure why she did not	F 641	ensure discharge location was accurately coded for item A2105. An audit was also completed by the MDS Coordinator of all MDS assessments for residents who require total assistance with transfers to ensure functional ability was coded accurately for item GG0170E. No other errors were identified. 3. Education was completed by 2/19/2025 to MDS Coordinators and Social Worker by the Regional Director of Clinical Reimbursement on proper coding of A2105, Discharge Status should accurately reflect the resident□s discharge location and GG0170E, Chair to bed Transfer should accurately reflect the resident□s transfer status per Resident Assessment Instrument (RAI) Guidelines. All newly hired MDS Coordinators and Social Workers will be educated by Director of Nursing/designee upon hire during orientation. 4. Beginning 2/24/2025, audits of MDS coding accuracy for items A2105 and GG0170E will be conducted by the Director of Nursing or designee on 5 random resident MDS assessments 1 time a week for 4 weeks, followed by monthly for 3 months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the	

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F 641	Continued From page 13	F 641		

code Resident #76's transfer status as dependent.

A phone interview with the Director of Nursing on 1/31/25 at 11:21 AM indicated a resident that was transferred with a mechanical lift was dependent on staff for transfers and the transfer status should be coded as dependent on the MDS assessment.

2. Resident #82 was admitted to the facility on 11/18/24.

Review of the discharge Minimum Data Set (MDS) Assessment dated 11/22/24 indicated Resident #82 was discharged to a general hospital.

Review of a nursing progress note dated 11/22/24 indicated Resident #82 was discharged home with family.

An interview with the MDS Nurse on 1/29/25 at 2:20 PM was conducted. She stated the discharge MDS for Resident #82 dated 11/22/24 should have been coded as discharged home. She explained the Social Worker (SW) had inaccurately coded the MDS.

A telephone interview with the SW on 1/30/25 at 10:49 AM revealed she was responsible for coding certain areas of the MDS for all residents, which included the Identification Information section which included discharge status.

An interview with the Director of Nursing (DON) on 1/29/25 at 4:35 PM revealed residents' discharge MDS should accurately reflect their discharge location and the MDS Nurse should

Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three months.

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 641	Continued From page 14 update the MDS. During an interview with the Administrator on 1/29/25 at 5:16 PM he indicated the MDS should be completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		2/19/25

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 656	Continued From page 15 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the area of Hospice for 1 of 1 resident reviewed for Hospice (Resident #29). The findings included: Resident #29 was admitted to the facility on 12/02/2024 with diagnoses which included chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe) and respiratory failure. Review of a significant change in status Minimum Data Set (MDS) dated 12/07/2024 revealed Resident #29 was cognitively intact and received hospice services. A review of Resident #29's comprehensive care plan did not reveal a care plan in the area of Hospice. In an interview with the MDS Nurse on 01/28/25	F 656	F656 □ Develop/Implement Comprehensive Care Plan 1. The facility failed to develop a comprehensive care plan in the area of Hospice for Resident #29. On 1/28/2025 the facility MDS (Minimum Data Set) Coordinator revised resident #29□s care plan to reflect Hospice status. 2. On 1/29/2025, the facility MDS Coordinator completed an audit of care plans for all residents who receive Hospice services to ensure this was accurately reflected. No other issues were identified. 3. On 1/29/2025, education was completed by the Regional Director of Clinical Reimbursement to MDS Coordinator on the requirement that the facility must develop and implement a comprehensive person-centered care plan	

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 656	Continued From page 16 at 1:51 PM revealed she looked for Resident #29's Hospice care plan in her record and stated she did not have one. She stated she was responsible for completing the comprehensive care plan and missing the Hospice care plan was an oversight. An interview with the Director of Nursing (DON) on 01/28/25 at 1:53 PM revealed the MDS nurse was ultimately responsible for developing comprehensive care plans. She was unaware Resident #29 did not have a care plan to address Hospice services. An interview with the Administrator was conducted on 01/29/25 at 4:45 PM. The Administrator stated he was not aware Resident #29 did not have a Hospice care plan.	F 656	for each resident, consistent with the resident rights, preferences, and any specialized services provided by or arranged by the facility, including Hospice services. All newly hired MDS Coordinators will be educated by Director of Nursing/designee upon hire during orientation. 4. Beginning 2/24/2025, audits of care plan accuracy and completeness will be conducted by the Director of Nursing or designee and will focus on reviewing 5 random resident care plans, including those for residents receiving specialized or Hospice services. Audits will be conducted 1 time a week for 4 weeks, followed by monthly for 3 months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three months.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		2/20/25

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 689	Continued From page 17 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Nurse Practitioner, staff and resident interviews, the facility failed to provide a safe transfer using a mechanical lift for Resident #43. On 3/9/24 Nurse Aide (NA) #1 and NA #2 were transferring Resident #43 with the mechanical lift when a strap that was frayed on the left side of the lift pad broke, and Resident #43 fell approximately 3 feet to the tile floor hitting her head and landing on her right side. Resident #43 was assessed by Nurse #3 and was observed to have a "huge" hematoma (collection of blood underneath the skin) to the back right side of her head and reported her whole right side hurt. Resident #43 was transported to the Emergency Department (ED) for further evaluation. Computed tomography (CT) scans and x-rays obtained in the ED were negative for fracture or injury. While in the ED Resident #43 experienced acute respiratory insufficiency related to rib pain and/or narcotic administration. Resident #43 returned to the facility on 03/13/24. Resident #43 was not receiving an anticoagulant (blood thinner). Most recently on 1/15/25 Resident #43 was transferred with the mechanical lift for a shower and suffered a panic attack because she was scared of the mechanical lift. There was a high likelihood of a serious adverse outcome or injury when one of the straps on the lift pad broke when Resident #43 was being transferred with the mechanical lift. Additionally, the facility failed to secure the	F 689	0689 On 03/09/2024, Resident #43 experienced a fall during a transfer using a mechanical lift. The loop on the sling tore that connects to the mechanical lift resulting in the resident falling to the floor. The Licensed Nurse immediately assessed the resident, found unresponsive to vocal stimulation for about one minute, but responded to painful stimuli. The Licensed Nurse also observed a hematoma on the right side of the back of her head and the resident reported pain to her full right side but denied pain to her neck or back. The Nurse Practitioner was notified of the incident. Resident #43 was subsequently transferred to the hospital via EMS for further evaluation. The hospital evaluation resulted in no fractures reported from the performed imaging and the CT scan of chest, abdomen, pelvis, and spine did not show acute trauma. The resident returned to the facility on 03/13/24 with no new orders. On 03/09/2024 the Nurse Aide initially removed the damaged sling from Resident #43□s room after the incident occurred and was inspected by the	

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F 689	Continued From page 18 mechanical lift brake when transferring Resident #76. This deficient practice occurred for 2 of 6 residents (Resident #43 and Resident #76) reviewed for accidents. Immediate jeopardy began on 3/09/24 when Resident #43 was transferred using a mechanical lift and fell to the floor when the strap on the lift pad broke. Immediate jeopardy was removed on 3/10/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 is being cited a scope and severity of D. The findings included: 1. A review of the manufacturer's instruction manual for the mechanical lift provided by the facility read in part: The operator shall inspect the mechanical lift before each use checking all bolts for tightness, checking the sling hardware, making sure all lift parts are in place and checking the lift sling for any wear. Resident #43 was admitted to the facility on 3/22/21 with diagnoses including type 2 diabetes, chronic kidney disease and muscle weakness. The quarterly Minimum Data Set (MDS) dated 1/19/24 indicated Resident #43 was cognitively intact and dependent on staff for transfers. The care plan dated 2/06/24 revealed Resident	F 689	Maintenance director and Nurse Aide. Residents at risk of experiencing similar adverse outcomes would include those who rely on mechanical lifts for transfers. A facility-wide audit of all mechanical lift slings was conducted on 03/09/2024 by the facility Maintenance Director with the assistance of a nurse aide. The audit's purpose was to identify residents at risk. The lift slings were thoroughly inspected for rips, tears, and frays. No other lift slings were found to have been defective. On 3/9/24 one on one competency assessments were completed for the two nurse aides involved in the incident by Licensed Charge Nurse with emphasis on safety procedures including how to inspect lift slings for rips, tears, and frays, and to immediately remove any slings that are defective. The two nurse aides demonstrated correct usage of the mechanical lift. On 3/9/24 in-person education was provided to all nurse aides and licensed nurses on duty by the Maintenance Director on proper lift usage and safety procedures including how to inspect lift slings for rips, tears, and frays before each use, as well as to immediately remove any slings from use if they are defective and take them to the immediate supervisor. The training was continued after 3/9/24 for all direct care staff for rest of the month for those not on duty the day of the incident. All agency staff were	

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F 689	Continued From page 19 #43 had a problem area related to activities of daily living self-care performance deficit and the intervention was to use a mechanical lift and two-person assistance for transfers. A review of the facility incident report dated 3/09/24 at 3:34 PM written by Nurse #3 revealed Resident #43 was being transferred with the mechanical lift when one of the left side straps on the lift pad snapped in half and Resident #43 flipped out of the lift pad and landed on the floor. Resident #43 was observed lying on the floor at the base of the mechanical lift, had a blank stare and was only responding to painful stimuli for approximately 1 minute. Resident #43 reported hitting her head and was complaining of pain to her whole right side. Resident #43 was assessed for injury and noted to have a "huge" hematoma to the back right side of her head. Nurse #1 called Emergency Medical Services (EMS), notified the Nurse Practitioner (NP) and Resident Representative (RR), and Resident #43 was transferred to the ED for further evaluation. A review of NA #1's statement dated 3/11/24 indicated on 3/09/24 NA #2 assisted her with transferring Resident #43 to a shower chair. The 4 straps on the lift sling were secured to the hooks on the mechanical lift. During the transfer one of the sling straps broke and Resident #43 fell to the floor hitting her head and landing on her right side. Several attempts were made to call NA #1 were unsuccessful. A review of NA #2's statement dated 3/11/24 revealed on 3/09/24 she was assisting NA #1 to transfer Resident #43 to a shower chair using the	F 689	in-serviced during facility orientation. The Director of Nursing was responsible for providing education and responsible for tracking the staff that required education. Staff were not allowed to work until education was completed. New hires are required to complete education during orientation. Alleged date of IJ removal 03/10/24 Example #2 F689 1.Corrective Action for Affected Residents Immediate corrective actions were taken for Resident #76 to ensure no harm resulted from the incident. Training was provided to the nurse aides involved, focusing on the proper use of mechanical lifts, including the critical step of securing wheel brakes. This training was completed on 01/31/2025. Education was also provided to all direct care staff on 01/31/2025. 2.Identification of Other Potentially Affected Residents The facility conducted a comprehensive review of all transfers involving mechanical lifts to identify any other residents who might have been similarly affected. This audit was completed 02/19/2025. All residents who require a mechanical lift for transfers have the potential to be affected by this alleged	

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F 689	Continued From page 20	F 689		

mechanical lift. When they began lifting Resident #43 one of the straps on the sling broke and she slipped out of the sling, fell to the floor and hit her head.

An interview with NA #2 on 1/29/25 at 8:21 AM revealed on 3/09/24 she assisted NA #1 with transferring Resident #43 to a shower chair using the mechanical lift sometime after lunch. She stated NA #1 placed the lift sling under Resident #43 and hooked the sling straps to the mechanical lift before she entered the room, so she was unsure if NA #1 inspected the sling to ensure it was in good condition. NA #2 indicated they were supposed to check the lift slings before every use to make sure the sling was in good condition and the straps were not frayed or torn. NA #2 revealed when they were lifting Resident #43 from the bed one of the straps on the lift sling snapped and Resident #43 slid out of the sling and fell approximately 3 feet to the floor hitting her head. She indicated they immediately called out for help, Nurse #3 responded and assessed Resident #43 for injury. NA #2 stated she did not recall which strap on the lift sling broke nor did she look at the sling following the incident.

A review of the Nurse Practitioner note dated 3/09/24 indicated Resident #43 fell to the floor from approximately 3 feet hitting her head and landing on her right side. Nurse #3 reported Resident #43 had a blank stare for one minute and was complaining of head pain and pain to her right side. EMS was called and Resident #43 was sent to the ED for further evaluation.

A review of the hospital records revealed Resident #43 was evaluated in the ED on 3/09/24 due to falling from a mechanical lift and was

non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents

3.Systemic Changes to Prevent Recurrence

Monthly training sessions will be conducted every month for 2 months and annual thereafter. to ensure all staff are proficient in the safe operation of mechanical lifts. These sessions will include direct demonstrations, review of the policy and mechanical lift skills checklist. The first monthly training was conducted 02/19/2025. All new direct care staff will be trained in new hire orientation. Direct care staff will undergo competency evaluations annually.

4.Monitoring Performance

To ensure the effectiveness of the corrective actions, the facility will monitor compliance of mechanical lift procedures. Staff will undergo competency evaluations to demonstrate their ability to use mechanical lifts safely and effectively according to the skills checklist. These evaluations will be conducted by the Director of nursing, or designee. In addition, quarterly audits will be conducted by the Director of Nursing, or designee. These audits will assess both adherence to the checklist and the overall safety of the transfer processes. The first audit was conducted 02/19/2025, then weekly for 4 weeks, then monthly for 2 months.

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 _____	C 02/03/2025

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F 689	Continued From page 21	F 689		

complaining of pain to her head, right leg and hip. Computed tomography (CT) scans of the head, chest and spine were obtained as well as x-rays of the pelvis, right leg and hip. The CT scan results showed no acute trauma, and the x-rays were negative for fractures. Resident #43 experienced acute respiratory insufficiency while in the ED, suspected to be related to rib pain and/or narcotic administration. Resident #43 was admitted to the hospital on 3/09/24 for observation and discharged back to the facility on 3/13/24 with no new orders.

An interview conducted with Resident #43 on 1/29/25 at 4:30 PM revealed she did not recall the date, but during a transfer with the mechanical lift from her bed to the shower chair a strap on the lift sling broke and she fell to the floor. She indicated she fell left out of the sling, flipped as she fell to the floor landing on her right side and hitting her head. Resident #43 indicated her head and whole right side hurt and the nurse responded and called EMS. She revealed she was transferred to the ED for further evaluation but did not have any injuries or fractures. Resident #43 stated she had to use the mechanical lift to be transferred to a shower chair and only received a few showers since the incident because she was scared to use the mechanical lift. She stated staff were giving her bed baths, but she really enjoyed taking a shower once or twice a week. Resident #43 indicated the few times she received a shower and was transferred with the mechanical lift she had a panic attack.

An interview conducted with Nurse #3 on 1/29/25 at 9:54 AM indicated she was assigned to Resident #43 on 3/09/24. She revealed she

Completion Dates for Corrective Actions
The facility alleges compliance on 2/20/25.

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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(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
F 689	Continued From page 22	F 689		

heard NA #1 and NA #2 yelling for help and responded to Resident #43's room and observed her lying on the floor. She stated NA #1 and NA #2 reported they were using the mechanical lift to transfer Resident #43 when one of the straps on the lift sling snapped and Resident #43 fell to the floor and hit her head. Nurse #3 revealed she assessed Resident #43 but did not recall if she had any visible injuries. She stated because Resident #43 hit her head she immediately called EMS, notified the NP and Resident #43 was transferred to the ED for further evaluation. Nurse #3 revealed she did not recall which of the 4 straps on the lift sling broke, but she observed the sling after the incident and the broken strap was frayed which caused it to rip in half.

An interview conducted with the NP on 1/30/25 at 12:47 PM revealed she was notified by Nurse #3 that Resident #43 had a fall to the floor from approximately 3 feet and hit her head. The NP stated Resident #43 was transferred to the ED for further evaluation. She indicated CT scans and x-rays obtained in the ED were negative for acute injury or fractures. The NP revealed she was not immediately aware that Resident #43 fell during a transfer with the mechanical lift, however that would not have changed the course of treatment. She revealed when a resident falls and hits their head they were at risk for suffering injuries including a concussion or brain bleeding and standard protocol was to transfer them to the ED for further evaluation. The NP stated she could not comment on the safety measures that staff should take when using a mechanical lift to transfer a resident.

An attempt was made to call the Former Director of Nursing, but the phone number was no longer

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 _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 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
F 689	Continued From page 23	F 689		

in service.

An interview with the Former Director of Maintenance on 1/31/25 at 3:45 PM revealed he inspected all the mechanical lifts and lift slings once a month to ensure they were in good repair. He stated the nursing staff were responsible for inspecting the lift slings before every use. He stated he was aware of the incident on 3/09/24 involving Resident #43 falling from the mechanical lift due to a strap on the lift sling breaking. The Director of Maintenance indicated he did not recall observing any lift slings during his monthly inspections prior to the incident on 3/09/24 that were damaged or had frayed or torn straps.

An interview was conducted with the Former Administrator on 1/29/25 at 12:58 PM. He stated on 3/09/24 he was notified that NA #1 and NA #2 were using a mechanical lift to transfer Resident #43 when one of the straps on the lift sling broke and Resident #43 fell to the floor. He revealed he initiated an investigation that day and determined the lift sling that NA #1 used to transfer Resident #43 was damaged and she did not inspect it prior to use. The Former Administrator indicated when staff were using the mechanical lift to transfer a resident, they should inspect the lift sling prior to every use for damage and ensure it was in good repair.

The Administrator was notified of immediate jeopardy on 1/29/25 at 6:00 PM.

The facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered or are

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 _____	C 02/03/2025

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 689	Continued From page 24	F 689		

likely to suffer a serious adverse outcome as a result of the noncompliance:

On 03/09/2024, Resident #43 experienced a fall during a transfer using a mechanical lift. The loop on the sling that connects to the mechanical lift tore resulting in the resident falling to the floor. The Licensed Nurse immediately assessed the resident, found unresponsive to vocal stimulation for about one minute, but responded to painful stimuli. The Licensed Nurse also observed a hematoma on the right side of the back of her head and the resident reported pain to her full right side but denied pain to her neck or back. The Nurse Practitioner was notified of the incident. Resident #43 was subsequently transferred to the hospital via EMS for further evaluation. The hospital evaluation resulted in no fractures reported from the performed imaging and the CT scan of chest, abdomen, pelvis, and spine did not show acute trauma. The resident returned to the facility on 03/13/24 with no new orders.

On 03/09/2024 the Nurse Aide initially removed the damaged sling from Resident #43's room after the incident occurred and was inspected by the Maintenance Director and Nurse Aide. The sling was immediately thrown in the trash after it was inspected.

Residents at risk of experiencing similar adverse outcomes would include those who rely on mechanical lifts for transfers. A facility-wide audit of all mechanical lift slings was conducted on 03/09/2024 by the facility Maintenance Director with the assistance of a nurse aide. The audit's purpose was to identify residents at risk. The lift slings were thoroughly inspected for rips, tears,

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 _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 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
F 689	Continued From page 25	F 689		

and frays. No other lift slings were found to have been defective.

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 completed:

On 3/9/24 one on one competency assessments were completed for the two nurse aides involved in the incident by Licensed Charge Nurse with emphasis on safety procedures including how to inspect lift slings for rips, tears, and frays, and to immediately remove any slings that are defective. The two nurse aides demonstrated correct usage of the mechanical lift.

On 3/9/24 in-person education was provided to all nurse aides and licensed nurses on duty by the Maintenance Director on proper lift usage and safety procedures including how to inspect lift slings for rips, tears, and frays before each use, as well as to immediately remove any slings from use if they are defective and take them to their immediate supervisor. The in-person training was continued after 3/9/24 for all direct care staff, including agency staff, for the rest of the month for those not on duty the day of the incident. All agency staff were in-serviced during facility orientation. The Director of Nursing was responsible for tracking the staff that required education and for providing the education. Staff were not allowed to work until education was completed. New hires, including agency staff, are required to complete education during orientation.

Alleged date of immediate jeopardy removal: 03/10/24

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 _____	C 02/03/2025

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 689	Continued From page 26	F 689		

The facility's credible allegation of immediate jeopardy removal was validated on 1/31/25. Observations conducted of the facility's lift slings revealed they were in good repair and there were no slings observed to have frayed straps or other damage. An observation conducted of a resident being transferred with a mechanical lift revealed the NA inspected the lift sling prior to use, it was observed to be in good condition and was used per the manufacturer's instructions. An interview conducted with NA #2 indicated she received education on how to inspect mechanical lifts and lift slings prior to every use for damage, removing damaged equipment immediately from service and then reporting equipment concerns to administration. NA #2 revealed she also received education on performing a safe resident transfer using the mechanical lift and then completed a return demonstration. Interviews conducted with nurses and nurse aides revealed they received education on how to properly inspect mechanical lifts and lift slings prior to every use, immediately removing equipment from service that was damaged, and reporting equipment concerns to administration. An interview conducted with the Former Director of Maintenance indicated he completed safety inspections of all the mechanical lifts and lift slings, and no concerns were identified. Additionally, it should be noted that the facility was unable to locate the initial audit completed on 03/09/24 of all of the facility's mechanical lifts nor was the facility able to locate the audit completed on 03/09/24 of all the lift slings that were inspected for rips, tears, and frays. The facility was also unable to provide any ongoing monitoring that had occurred since the 03/09/24 incident. The facility's immediate jeopardy removal date of 03/10/24 was validated on 1/31/25.

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 _____	C 02/03/2025

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 689	Continued From page 27	F 689		

2. A review of the mechanical lift manufacturer's instructions provided by the facility read in part: Operating instructions: Preparation before lifting - widen the base and engage the caster (wheel) brake.

Resident #76 was admitted to the facility 8/15/24 with diagnoses including: Right tibia fracture, muscle weakness and cognitive communication deficit.

The quarterly Minimum Data Set (MDS) dated 11/07/2024 indicated Resident #76 was severely cognitively impaired and required substantial to maximal assistance with transfers.

The care plan dated 11/26/24 revealed Resident #76 had a problem area related to activities of daily living self-care performance deficit. The intervention was to provide substantial to maximal assistance with transfers but did not include the use of a mechanical lift.

An observation was conducted on 1/29/25 at 11:50 AM of Nurse Aide (NA) #2 and NA #3 using the mechanical lift to transfer Resident #76 from her bed to the wheelchair. Nurse Aide (NA) #2 positioned the base of the mechanical lift under the bed while NA #3 locked the brake on the bed. NA #2 did not secure the wheel brake on the base of the mechanical lift. NA #2 was operating the mechanical lift and when she was raising Resident #76 from the bed the base of the lift moved and shifted to the right. After Resident #76 was raised from the bed NA #2 moved the mechanical lift from the bed to the wheelchair while NA #3 guided Resident #76 in the lift sling positioning her over the wheelchair. NA #3 made

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 _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 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
F 689	Continued From page 28	F 689		

sure the wheelchair brakes were locked and NA #2 lowered Resident #76 into the wheelchair. NA #2 did not secure the wheel brake on the mechanical lift before lowering Resident #76.

An interview was conducted with NA #3 on 1/29/25 at 3:30 PM. She stated she was assisting NA #2 to transfer Resident #76 with the mechanical lift. NA #3 indicated she was not operating the mechanical lift during the transfer, and it was the responsibility of the person operating the lift to ensure the wheel brake was secured prior to lifting the resident. NA #3 revealed she did not notice that the brake on the mechanical lift was not secured prior to Resident #76 being lifted from the bed and she was unsure as to why NA #2 did not secure the brake.

A phone interview with NA #2 on 1/30/25 at 1:18 PM revealed when using the mechanical lift to transfer a resident, the wheel brake on the mechanical lift should be secured prior to lifting or lowering the resident. NA #2 stated when she was using the mechanical lift to transfer Resident #76 on 1/29/25 she did not recall that the wheel brake on the mechanical lift was not secured when she was lifting and lowering Resident #76 and she thought she had secured the brake.

A phone interview was conducted with the Director of Nursing (DON) on 1/30/25 at 8:40 AM. She stated when staff were transferring a resident with the mechanical lift they should operate the lift per the manufacturer's guidelines. The DON further stated if the manufacturer's guidelines indicated the wheel brake on the mechanical lift should be secured prior to lifting or lowering the resident then staff should secure the wheel brake accordingly.

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 _____	C 02/03/2025

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 689	Continued From page 29 A phone interview was conducted with the Administrator on 1/31/25 at 9:30 AM. He stated nursing staff should operate the mechanical lifts per the manufacturer's guidelines including securing the wheel brake on the mechanical lift prior to lifting or lowering a resident to ensure the resident was transferred safely.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to obtain a physician's order for the use of supplemental oxygen for 1 of 3 residents reviewed for oxygen use (Resident #29). The findings included: Resident #29 was admitted to the facility on 12/02/2024 with diagnoses which included chronic obstructive pulmonary disease (COPD, a lung disease that makes it difficult to breathe) and respiratory failure. Review of a significant change Minimum Data Set (MDS) dated 12/07/2024 revealed Resident #29	F 695	F- 695 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 2/18/25, resident #29 received new oxygen orders and were obtained by the Director of Nursing; oxygen continuous at 2L/min via nasal cannula or Chronic Respiratory Failure. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:	2/21/25

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 _____	C 02/03/2025

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 695	Continued From page 30 was cognitively intact and received oxygen therapy. Review of Resident #29's physician's orders revealed there were no orders for supplemental oxygen. An observation and interview was conducted on 01/26/2025 at 12:05 PM with Resident #29. Resident #29 was observed lying in bed with oxygen on at 3.5 liters per minute via nasal canula. She stated 3.5 liters per minute was her normal setting and she had been on supplemental oxygen for over a year. An observation was conducted on 01/27/2025 at 3:27 PM of Resident #29. Resident #29 was observed lying in bed with oxygen on at 3.5 liters per minute via nasal canula. An observation was conducted on 01/28/2025 at 2:08 PM of Resident #29. Resident #29 was observed lying in bed with oxygen on at 3.5 liters per minute via nasal canula. An interview was conducted on 01/28/2025 at 1:23 PM with Nurse #2. Nurse #2 stated if a resident was on oxygen, there should be an order in the resident's medical record. Nurse #2 stated Resident #29 had been on oxygen since admission and stated she was unsure why she did not have an order. Nurse #2 stated Resident #29 should have had an order for oxygen. An interview was conducted on 01/28/2025 at 1:32 PM with Unit Manger #1. Unit Manager #1 stated if a resident was on oxygen there would be an order in the resident's medical record and would sign off that oxygen was in use on the	F 695	The Director of Nursing and Unit Manager conducted an audit on 2/19/25 of all residents that have oxygen to ensure that orders were obtained and that all residents are administered oxygen per physician orders including the rate. Audit revealed that there were no additional residents affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 2/19/25, the Director of Nursing, and the Unit Manager initiated re-educated to the licensed nurses regarding the need for obtaining an order for the use of oxygen and administering oxygen and rate as ordered. Education included agency staff, all shifts, and weekends. Education was completed on 2/21/25. New direct care staff will be educated in new hire orientation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitoring sheet will be completed by the Director of Nursing, or designee to ensure that any resident needing oxygen has proper orders and that the rate is administered per physician order, This monitoring process will consist of reviewing the orders of residents who require oxygen and take place weekly for	

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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 695	Continued From page 31 Medication Administration Record (MAR). Unit Manager #1 stated she was not aware Resident #29 did not have an order for oxygen and stated she should have. An interview was conducted on 01/28/2025 at 1:53 PM with the Director of Nursing (DON). The DON stated if a resident required oxygen there should be an order in the resident's chart. The DON stated she was not sure why Resident #29 did not have an order for oxygen and stated she should have.	F 695	4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 2/21/25.	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		2/21/25

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 _____	C 02/03/2025

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 727	Continued From page 32 Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours per day, 7 days a week for 29 of 389 days reviewed for sufficient staffing. The findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1 - March 31, 2024) revealed the facility had no RN coverage on 1/06/2024, 1/20/2024,1/21/2024, 2/03/2024, 2/04/2024, 2/10/2024, 2/11/2024, 2/17/2024, 2/18/2024, 3/02/2024, 3/10/2024, 3/16/2024 and 3/30/2024. Review of the PBJ Staffing Data Report Fiscal Year - Quarter 3, 2024 (April 1 - June 30, 2024) revealed the facility had no RN coverage on the following dates: 5/12/2024, 5/18/2024, 6/08/2024 and 6/15/2024. Review of the PBJ Staffing Data Report Fiscal Year - Quarter 4, 2024 (July 1 - September 31, 2024) revealed the facility had RN coverage for 8 consecutive hours per day, 7 days a week during the report period. The facility's daily assignment schedules from 10/01/2024 to 1/31/2024 revealed the facility failed to provide 8 hours of RN coverage on the following dates: 10/05/2024, 10/06/2024, 10/20/2024, 10/27/2024, 11/03/2024, 11/16/2024, 11/30/2024, 12/07/2024, 12/08/2024, 12/14/2024, 12/17/2024, and 12/20/2024. An interview with the Staff Scheduler on 1/31/25 at 3:30 PM indicated he scheduled an RN daily to work at least 8 consecutive hours. He stated if	F 727	F-727 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 2/19/25 the Administrator re-educated the Director of Nursing and the scheduler regarding the daily Registered Nurse staffing requirements that require at least 8 hours of RN coverage per day, 7 days a week. On 2/19/25, the corporate recruiter placed an ad for RN weekend staff. The new DON and new scheduler will be educated in the new hire orientation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that the required daily Registered Nurse staffing	

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 _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 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
F 727	Continued From page 33 the RN was scheduled to work on a weekday and called out the MDS Coordinator or Wound Care Nurse were able to fill in as the RN on duty. The Staff Scheduler further stated if the RN scheduled to work on a weekend day called out there was not usually another RN in the building to fill in and they had difficulty finding a replacement. He indicated they were actively working to hire nurses including RNs and currently used three different staffing agencies to fill vacant shifts. A phone interview was conducted with the Administrator on 1/31/25 at 9:30 AM. He stated the facility came under new ownership 12/16/2024 and they had a corporate recruiter that was working on hiring nursing staff including RNs. He indicated he was unable to provide records that an RN worked on the dates identified both on the PBJ Staffing Data Reports and the facility's daily assignment schedules that there was no RN coverage. The Administrator stated the facility should have an RN scheduled at least 8 consecutive hours per day, 7 days a week.	F 727	requirements are met. This monitoring process will be an audit starting on 2/19/25 and take place daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 2/21/25.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		2/21/25

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 _____	C 02/03/2025

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(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
F 732	Continued From page 34 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a record of the daily posted nurse staffing sheets for 472 of 519 days of the period reviewed from September 1, 2023 through January 31, 2025. The findings included: The daily nurse staffing sheets for September 2023 revealed no information was available for the days of 9/01/2023 through 9/30/2023. The daily nurse staffing sheets for October 2023	F 732	F-732 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance	

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	345201	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 732	Continued From page 35 revealed no information was available for the days of 10/01/2023 through 10/31/2023. The daily nurse staffing sheets for November 2023 revealed no information was available for the days of 11/01/2023 through 11/30/2023. The daily nurse staffing sheets for December 2023 revealed no information was available for the days of 12/01/2023 through 12/31/2023. The daily nurse staffing sheets for January 2024 revealed no information was available for the days of 1/01/2024 through 1/31/2024. The daily nurse staffing sheets for February 2024 revealed no information was available for the days of 2/01/2024 through 2/29/2024. The daily nurse staffing sheets for March 2024 revealed no information was available for the days of 3/01/2024 through 3/31/2024. The daily nurse staffing sheets for April 2024 revealed no information was available for the days of 4/01/2024 through 4/30/2024. The daily nurse staffing sheets for May 2024 revealed no information was available for the days of 5/01/2024 through 5/31/2024. The daily nurse staffing sheets for June 2024 revealed no information was available for the days of 6/01/2024 through 6/30/2024. The daily nurse staffing sheets for July 2024 revealed no information was available for the days of 7/01/2024 through 7/31/2024.	F 732	and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 2/19/25, the Administrator re-educated the Director of Nursing and the scheduler regarding the daily nurse staff posting information requirements that all required areas must be accurately filled out to only include direct care staff. The posting needs to be placed in an easily accessible location daily. The daily posting also needs to be updated daily with a change of staff. The scheduler or manager on duty will fill out the posted staffing based on staffing and policy. The scheduler or manager on duty will update the posted staff during the weekday and weekends. The new DON and new scheduler will be educated in new hire orientation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee starting on 2/19/25, to monitor and ensure that including weekends, all the required daily nurse staffing information is complete, accurate, and displayed in an easily accessible location. This audit process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.	

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F 732	Continued From page 36 The daily nurse staffing sheets for August 2024 revealed no information was available for the days of 8/01/2024 through 8/31/2024. The daily nurse staffing sheets for September 2024 revealed no information was available for the days of 9/01/2024 through 9/30/2024. The daily nurse staffing sheets for October 2024 revealed no information was available for the days of 10/01/2024 through 10/31/2024. The daily nurse staffing sheets for November 2024 revealed no information was available for the days of 11/01/2024 through 11/30/2024. The daily nurse staffing sheets for December 2024 revealed no information was available for the days of 12/01/2024 through 12/15/2024. A phone interview with the Scheduler on 1/30/2025 at 8:54 AM indicated he was responsible for completing the daily posted nurse staffing sheets and maintaining a record of the sheets for 18 months. He stated due to the facility's ownership changing on 12/16/2024 they did not have access to the posted nurse staffing sheet records prior to that date. A phone interview with the Administrator on 1/31/2025 at 9:30 AM indicated the facility's ownership changed on 12/16/2024 and there were no records of the daily posted nurse staffing sheets available prior to that date. He stated records of the daily posted nurse staffing should be maintained for 18 months.	F 732	The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 2/21/25.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/28/25

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F 880	Continued From page 37 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 38 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions during high-contact care and hand hygiene when Nurse #1 performed wound care for a resident with a full-thickness wound without wearing a gown and failed to perform hand hygiene after removing a soiled dressing, cleaning a wound, and before applying a new wound dressing for Resident #20. The deficient practice occurred for 1 of 1 staff	F 880	F-880 (1) How corrective action will be accomplished for resident(s) found to have been affected Root cause: Resident #20 was on Enhanced Barrier Precaution, (EBP), and PPE necessary for EBP was placed in the room. Staff education is needed to understand the criteria for Enhanced Barrier Precaution.	

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F 880	Continued From page 39 member (Nurse #1) observed during wound care. The findings included: The facility's Enhanced Barriers policy approved 03/28/24 revealed "it is the policy of this facility to use enhanced barrier precautions (EBP) based on guidance from the Center for Disease Control (CDC). Enhanced barrier precautions refer to the infection control intervention aimed at reducing transmission of multi-resistant organisms (MDROs) through the targeted use of gown and gloves during high-contact resident care activities. High-contact resident care activities requiring EBP include wound care (any skin opening requiring a dressing). The "Hand Hygiene" policy last revised July of 2024 revealed staff were to perform hand hygiene "before performing dressing care or touching wounds of any kind, after handling dressings, urinals, catheters, bedpans, contaminated tissues, linen, etc." The policy also stated hand hygiene should be performed after "removing gloves." The "Clean Dressing Change" policy effective July 2024 revealed staff were to complete the following: - Wash hands and put on clean gloves. - Place a barrier cloth or pad next to the resident, under the wound to protect the bed and body sites. - Loosen the tape and remove the existing dressing. - Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacles. - Wash hands and put on clean gloves. - Cleanse the wound as ordered. Pat dry with	F 880	This education would result in no further reoccurrence of this issue for Resident #20 or any other EBP resident. Nurse #1 was educated verbally on 1/29/2025. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 2/19/25 the Director of Nursing began to in-service all licensed and non-licensed staff on Enhanced Barrier Precautions; that EBP refers to the infection control intervention aimed at reducing transmission of multi-resistant organisms (MDROs) through targeted use of gowns and gloves during high-contact activities requiring EBP including wound care and using proper hand hygiene. On 2/19/25, the Director of Nursing and Unit Manager observed staff performing care for EBP residents to determine if any other residents were affected. This observation revealed that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 2/19/25, the Director of Nursing, and Unit Manager are including Enhanced Barrier Precautions education for the clinical staff upon hire and orientation. The Director of Nursing or designee will observe proper hand hygiene technique with the clinical staff. The nursing supervisors will be	

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F 880	Continued From page 40 gauze. - Wash hands and put on clean gloves. - Apply topical ointments or creams and dress the wound as ordered. - Secure dressing. Mark with initials and date. - Discard disposable items and gloves into appropriate trash receptable and wash hands. An observation was conducted on 1/29/2025 at 9:26 AM while Resident #20 received wound care. Nurse #1 was observed entering Resident #20's room without a gown, laying wound supplies on the bedside table and applied clean gloves without performing hand hygiene. Nurse #1 removed a soiled dressing from Resident #20's sacrum and changed gloves without performing hand hygiene. Nurse #1 cleaned the wound on Resident #20's sacrum and placed a clean dressing on the wound. Nurse #1 then removed her gloves and washed her hands prior to exiting Resident #20's room. An interview was conducted on 1/29/2025 at 9:36 AM with Nurse #1. Nurse #1 stated Resident #20 was not on Enhanced Barrier Precautions. Nurse #1 stated EBP were used when a resident had an indwelling medical device and was unsure if it was needed for wounds. Nurse #1 stated she did not sanitize or wash her hands between removing the old dressing, cleaning the wound, and placing the new dressing on Resident #20's wound because she had just forgotten and was doing the best that she could. Nurse #1 stated after the surveyor brought the EBP to her attention she then noticed the EBP sign located at the head of the resident's bed on the wall. Nurse #1 stated there should be gowns on the outside of the resident room so she would have known he was on EBP. The interview revealed Nurse #1 typically	F 880	responsible for ensuring there are PPE in the EBP rooms. New direct care staff will be educated in new hire orientation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Director of Nursing, or designee and started on 2/19/25, to monitor and ensure that the clinical staff are adhering to the EBP policy. The monitoring process consists of observation of care for the EBP residents as well as hand hygiene. Monitoring will take place 5 times per week for 4 weeks, weekly for 2 weeks, then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 2/28/25.	

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F 880	Continued From page 41	F 880		

did not complete wound care in the facility however, the Wound Care Nurse had called out on the date observed and she was asked to complete all dressing changes for the day.

An interview was conducted on 1/29/2025 at 10:25 AM with the Director of Nursing (DON). The DON stated she served as the Infection Control Nurse for the facility since January 2025. The DON stated staff received education about infection control during orientation and annually. The DON stated when staff performed wound care, they should wash their hands and change gloves before removing the old dressing and then perform hand hygiene and glove changes in between steps. The DON stated Nurse #1 should have changed gloves and performed hand hygiene after she removed the dirty dressing, after cleaning, and before applying a new dressing. The DON stated residents with a wound, required EBP. The DON stated she was not sure why Resident #20's EBP sign was not located on the resident's door or have gowns outside of the room for staff. The DON stated she was still new to the facility and would be keeping a closer eye on EBP.