STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwell Park Rehabilitation and Healthcare Center	1930 West Sugar Creek Road Charlotte, NC 28262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, resident, and Medical Director interviews, the facility failed to ensure the necessary supervision was provided to prevent a cognitively impaired resident who was care planned as having a history of attempting to leave the facility, who wandered aimlessly and had impaired safety awareness from exiting the building at night without staff knowledge. On 07/17/25, the resident was last seen at 9:00 PM. At approximately 9:30 PM Nurse Aide (NA) #1 was unable to locate Resident #1. Staff members searched the building before checking the back doorway employee entrance, which required a keycode for exit. Resident #1 was found outside lying on his left side with his wheelchair on top of his lower back area. Resident #1 had traveled approximately 30 feet out of a back employee entrance down a sidewalk that led to a dark dumpster area which was approximately 5 feet from where Resident #1 was found and that staff sometimes used as a parking area. The area of sidewalk where Resident #1 was found was noted to have a large crack in the pavement. The resident was brought back into the building at approximately 10:10 PM. This deficient practice had the high likelihood to cause serious harm or serious bodily injury to Resident #1 including serious head injury, fractures, or internal injuries. The deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses of heart failure, metabolic encephalopathy and non-Alzheimer's dementia. A current care plan initiated on 04/01/25 revealed a focus area for Resident #1 as an elopement risk/wanderer related to disorientation to place, history of attempts to leave the facility unattended, and impaired safety awareness. Resident #1 was noted to wander the facility aimlessly, significantly intruding on the privacy or activities of other residents. The goal was for Resident #1's safety to be maintained through the next review date. Interventions included distracting the resident from wandering, identifying the pattern of wandering, increased supervision and a wanderguard bracelet (bracelet that causes the door to alarm if a resident exits a door that was equipped with wanderguard alarm sensor) to the resident's ankle. Resident #1's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired and required moderate assistance of one staff member for sit to stand transfers and chair to bed transfers. Wandering behavior not exhibited during the assessment reference period. Resident #1 used a wheelchair as an assistive device and had no functional impairments with range of motion to the upper or lower extremities. He did not receive an anticoagulant during the assessment period. Resident #1 used a wander/elopement alarm daily. A physician order dated 04/27/25 revealed Resident #1 had a wanderguard. Nursing staff were to check placement of the bracelet to left ankle every shift and monitor the wanderguard each shift. Review of Resident #1's Medication Administration Record dated July 2025 revealed an order for staff to check placement of the bracelet to left ankle every shift and monitor the wanderguard each shift. The order was initialed as completed on each shift by the nursing staff.Review of Resident #1's medical record from June 2025 to July 2025 revealed no progress notes that mentioned Resident #1's wandering behaviors or tendencies. An incident report dated 07/17/25 revealed Resident #1 was found by Nurse #1 on the ground by the employee entrance. Resident #1 stated he was going to the kitchen. The resident was assessed by Nurse #1 and noted to have no injuries at the time of the fall. Resident #1 was assisted into his wheelchair by two staff members The note revealed Resident #1's vital signs were at baseline, range of motion was within normal limits and a head-to-toe skin assessment revealed his skin was intact. Neurological monitoring was initiated. The incident report was completed by Nurse #1. An elopement risk evaluation dated 07/17/25 completed by Nurse #1 revealed Resident #1 scored a level 6 and was labeled as a low risk for potential elopement. A nursing note dated 07/17/25 at 11:16 PM written by Nurse #1 revealed Resident #1's vital signs were the following: blood pressure 164/74 (normal range 120/80), pulse 65 (normal range 60-90), respirations 18 (normal range 12-20) and oxygen saturation level 97% (normal range greater than 92%). Resident #1 was noted to have had a fall from his wheelchair. He was placed back into his wheelchair by two-person assistance with neurological monitoring in place. The residents Responsible Party was notified as well as the on-call provider. On 09/04/25 at 10:04 AM an interview was conducted with Nurse #1. During the interview Nurse #1 stated she was responsible for Resident #1 on 07/17/25 during the 3:00 PM to 11:00 PM shift. Nurse #1 stated Resident #1 was alert but confused and would often wander around the facility in his wheelchair. She stated on 07/17/25 she had administered his nighttime medications at 9:00 PM. Nurse Aide (NA) #1 went to check on Resident #1 at 9:30 PM and noticed he was not in his room. NA #1 went to