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	01/07/2026

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Medical Director interviews, the facility failed to provide safe transport for a resident in a wheelchair when Nurse #1 transported Resident #1 in a wheelchair to the medication cart while Resident #1 held her legs up because she was unable to bend them and place them on the wheelchair footrests. Resident #1's left leg dropped down between the wheelchair footrests and got caught underneath the wheelchair. Resident #1 was complaining of severe pain to her left leg with swelling noted to her left shin and was transferred to the emergency department (ED) for further evaluation. X-rays obtained in the ED revealed Resident #1 sustained a left proximal (upper) tibia (shinbone) fracture and her left leg was placed in a splint and she returned to the facility with orders for hydrocodone/acetaminophen 5-325 milligrams two tablets administered every 6 hours as needed to manage her pain. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), osteoporosis, muscle weakness, and vascular dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was moderately cognitively impaired, was dependent on staff for transfers and mobility, used a manual wheelchair and had lower extremity range of motion impairment on both sides. The care plan dated 10/03/25 indicated Resident #1 was dependent on staff for assistance with all activities of daily living due to a diagnosis of cerebral infarction and often refused to get out of bed.An incident report dated 11/22/25 at 2:30 PM completed by Nurse #1 revealed several visitors arrived at the facility to celebrate Resident #1's birthday and her room was too small to accommodate them, so they requested a larger place to meet and for Resident #1 to be transferred out of bed into a wheelchair. Resident #1 initially refused to get out of bed but finally agreed after continued encouragement from the visitors and staff. Nurse #1 and Nurse #2 used the mechanical lift to transfer Resident #1 from the bed into a wheelchair, but she was unable to bend her legs to place them on the wheelchair footrests due to stiffness and pain. Nurse #1 asked Resident #1 to hold her legs up so she could transport her in the wheelchair to the medication cart to administer pain medication. Resident #1 agreed and Nurse #1 transported her approximately 30 feet when she heard her yell out my leg. Nurse #1 stopped the wheelchair and observed that Resident #1's left leg had fallen between the wheelchair footrests and got caught underneath the wheelchair. Nurse #1 slowly rolled the wheelchair backwards to remove Resident #1's left leg from underneath the chair and noted Resident #1 was complaining of pain and had swelling to her left shin. Nurse #1 called 911, notified the on-call provider and obtained an order to transport Resident #1 to the ED for further evaluation. Resident #1 remained in the wheelchair and was administered acetaminophen 650 milligrams (mg) for pain and when emergency medical services (EMS) arrived at the facility, she was transported to the emergency department (ED) for further evaluation. The incident report further noted the contributing factor to Resident #1's injury was due to (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	positioning in the wheelchair.An interview conducted with Nurse #1 on 1/06/26 at 11:35AM revealed she was assigned to Resident #1 on 11/22/25 7:00 AM to 3:00 PM. She stated several of Resident #1's family members arrived at the facility after lunch to celebrate her birthday and her room was too small to accommodate them, so they requested a larger place to meet, and she recommended the facility's library. She indicated the family agreed to gather in the facility's library and requested for Resident #1 to be transferred out of bed into a wheelchair. She stated Resident #1 usually refused to get out of bed but after continued encouragement from family and staff she agreed. Nurse #1 indicated Nurse #2 assisted her and they transferred Resident #1 from her bed to the wheelchair using the mechanical lift. She stated Resident #1's legs were stiff, she was complaining of leg pain and was unable to bend her legs to place them on the wheelchair footrests. Nurse #1 revealed she was rushing because the family was waiting, and asked Resident #1 to just hold her legs up so she could take her to the medication cart to administer pain medication and then bring her to the library. Nurse #1 revealed she transported Resident #1 in the wheelchair approximately 30 feet and was approaching the medication cart when Resident #1 yelled out my leg. Nurse #1 revealed she stopped the wheelchair and observed that Resident #1's left leg had fallen between the footrests and was caught underneath the wheelchair. She revealed she slowly rolled the wheelchair backwards to remove Resident #1's leg from under the chair and assessed her for injury. Nurse #1 stated Resident #1 was complaining of left leg pain, and her left shin was swollen. Nurse #1 revealed she was concerned Resident #1's leg was broken so she immediately called 911 and then called the on-call provider and obtained an order to transport Resident #1 to the ED for further evaluation. Nurse #1 indicated she administered acetaminophen to Resident #1 for pain and did not move or reposition her until EMS arrived. Nurse #1 revealed Resident #1 was diagnosed with a left tibia fracture in the ED and returned to the facility the same day, but it was after her shift ended. She stated Resident #1 had a soft splint in place on her left leg, was at her baseline and her pain was well managed. Nurse #1 indicated she was not aware of any previous episodes of Resident #1 not being able to bend her legs when she was transferred into the wheelchair and she thought her legs were stiff due to not getting out of bed for long periods of time. Nurse #1 revealed she should have given Resident #1's legs time to relax or used a different chair that could support her legs, but her family was waiting and she felt rushed.A review of the ED records dated 11/22/25 revealed Resident #1 was evaluated for an injury due to her left leg getting caught under a wheelchair. X-rays obtained in the ED revealed Resident #1 had an acute fracture of the left proximal tibia and also noted diffuse osteopenia (weakening of the bones). Due to Resident #1's non-ambulatory status prior to the injury surgery was not indicated and her left leg was placed in a splint for comfort. Resident #1 was discharged back to the facility with orders for hydrocodone/acetaminophen 5-325 mg every 6 hours as needed for pain and to schedule a follow up appointment with orthopedic. A nurse's note dated 11/22/25 at 9:53 PM written by the Director of Nursing (DON) revealed Resident #1 returned to the facility with a left lower leg splint and orders for hydrocodone/ acetaminophen 5-325 mg every 6 hours as needed for pain and to schedule a follow up with orthopedic.The Medical Director's note dated 11/24/25 indicated Resident #1 was transferred to the ED 11/22/25 due to a leg injury and diagnosed with an acute left proximal tibia fracture. Resident #1 was observed lying in bed comfortably with a left leg splint in place and had no complaints of pain. New orders were given to administer hydrocodone/ acetaminophen 5-325 mg two tablets every 6 hours for pain for 14 days and to follow up with orthopedic as needed.A review of Resident #1's physician orders and medication administration record (MAR) revealed the following:1/13/25 acetaminophen 325 milligrams (mg) give 2 tablets by mouth every 6 hours as needed for pain or fever. The MAR indicated it was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	administered on 11/22/25 at 3:01 PM, 11/25/25 at 4:00 PM and 11/26/25 at 3:20 AM.11/22/25 hydrocodone/acetaminophen 5-325 mg give 1 tablet by mouth every 6 hours as needed for pain. The MAR indicated it was administered on 11/22/25 at 11:50 PM and 11/23/25 at 10:05 AM.11/24/25 hydrocodone/acetaminophen 5-325 mg give 2 tablets by mouth every 6 hours for pain for 14 days.An orthopedic visit note dated 11/26/25 revealed Resident #1 was evaluated due to left proximal tibia fracture. Resident #1's left leg was placed in a long leg splint and was to remain in place until follow up appointment in 4 weeks for repeat x-raysAn orthopedic visit note dated 12/23/25 indicated x-rays obtained of Resident #1's left leg revealed no significant changes to the fracture and orders were given for long leg splint to remain in place until next follow up appointment in 4 weeks.An interview was conducted with the DON on 1/06/26 at 3:01 PM. She stated she was notified of the incident that occurred with Resident #1 on 11/22/25 and was at the facility when she returned from the ED. She revealed Resident #1 was diagnosed with a left tibia fracture and was placed in a soft splint. The DON indicated Resident #1 was at her baseline and her pain was well managed. She stated prior to the incident the wheelchair was appropriate to use for Resident #1 when she was out of bed, and she was not aware of any concerns related to her not being able to bend her legs. She indicated Resident #1 last used the wheelchair on 10/29/25 for an appointment outside of facility and was transported in the chair without incident. The DON revealed Nurse #1 transporting Resident #1 in the wheelchair when she was unable to bend her legs to place them on the footrests was unsafe.During a phone interview with the Medical Director on 1/06/26 at 3:40 PM he revealed he was notified on 11/22/25 that Resident #1 was evaluated in the ED and diagnosed with a left tibia fracture. He stated during a follow-up visit on 11/24/25 he assessed Resident #1 to be at her baseline, her pain was well managed, and she was exhibiting no signs of discomfort. The Medical Director revealed Resident #1 was immobile and had a diagnosis of osteoporosis which significantly increased her risk of fractures.A phone interview conducted with the Former Administrator on 1/06/26 at 4:00 PM indicated the DON notified him on 11/22/25 of the incident that occurred involving Resident #1. The Former Administrator revealed Resident #1 was not transported in the wheelchair safely and should not have been transported in the chair without her legs being placed on the footrests.The facility provided the following corrective action plan:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:On 11/22/2025 at approximately 2:00 pm 15-20 family members of Resident #1 arrived at the facility. Family demanded resident get up out of bed. Resident #1 refused but later agreed to get up in the wheelchair due to so many family members present to celebrate her birthday. At approximately 2:45 pm Nurse #1 and Nurse #2 assisted Resident #1 out of bed to Resident #1's personal wheelchair, using a mechanical lift. Resident #1 was complaining of pain while sitting in the wheelchair. Nurse #1 placed leg rest on wheelchair and positioned Resident #1 in the wheelchair, however Resident #1 could not bend her knees to place her feet on the leg rest. Resident #1 was positioned with her legs sticking straight out. Nurse # 1 assisted Resident #1 out of her room in the wheelchair, approximately 30 feet to the medication cart to administer ordered pain medication, at which time Resident #1 dropped her left leg, causing her leg to go slightly beneath the wheelchair and between the attached leg rest. On 11/22/2025 Nurse #1 immediately assessed Resident #1, which included a pain assessment and vital signs.On 11/22/2025 Nurse #1 immediately notified the family for Resident #1 who was in the facility.On 11/22/2025 Nurse #1 contacted the on-call physician and received orders to transport Resident #1 to the emergency room. On 11/22/2025 at approximately 3:30 pm Resident #1 was transported to the emergency room via Emergency Medical Services (EMS). On 11/22/2025 at approximately 9:45 pm Resident #1 returned to the facility with a diagnosis of a tibial fracture of the left leg. On (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11/22/2025 the Director of Nursing assessed Resident #1 upon return from the hospital without pain medication orders.On 11/22/2025 at approximately 9:50 pm the Director of Nursing contacted the emergency room for pain medication orders for Resident #1. On 11/22/2025 at approximately 10:00 pm the Director of Nursing obtained Resident #1s pain medication from the local pharmacy.On 11/22/2025 the Regional Clinical Director reviewed the care plan for Resident #1 to ensure the care plan reflected accurate transfer status. No concerns were identified.On 11/23/2025 at approximately 2:00 pm the facility in house Nurse Practitioner assessed Resident #1, orders were received to schedule pain medication every 6 hours.On 11/23/2025 the Director of Maintenance verified the wheelchair for Resident #1 was in proper working order. This included the wheelchair wheels, brakes and footrest. No concerns were identified.On 11/23/2025 the facility Occupational Therapist evaluated Resident #1 for proper seating and positioning when out of bed and recommended the use of a geri-chair. The Director of Nursing communicated the change to Resident #1's assigned nurse and NA and updated the kardex and care plan so all nursing staff were aware, and a geri-chair was placed in Resident #1's room.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:All residents that utilize wheelchairs have the potential to be affected.On 11/22/2025, the Regional Clinical Director and the Director of Nursing reviewed the facility Wheelchair Positioning and Transport Policy and Procedure. No revisions were required.On 11/23/2025 the Minimum Data Set (MDS) Coordinator reviewed the residents' most recent MDS assessment to ensure appropriate mode of transport was addressed in the care plan. Any concerns were immediately addressed. On 11/23/2025 the Director of Nursing completed competencies and return demonstration for Nurse #1 and Nurse #2 related to proper positioning and safe transport of a resident in a wheelchair. The competencies reviewed included wheelchair positioning/transportation, brakes locked before transfer, footrest in place before transport, feet properly placed on footrest before/during transport, ensure feet do not slip during transport, ensure resident is comfortable, position resident with hips back, pelvis neutral (pelvis is balanced, not tilting forward or backwards), trunk supported, feet on footplates and transport at a safe/controlled speed.On 11/23/2025 the Director of Maintenance completed a 100% audit of all resident wheelchairs to ensure proper functioning, including wheels, brakes and footrest. Any concerns were immediately addressed.On 11/23/2025 the Director of Rehabilitation completed a review of all facility wheelchairs to ensure wheelchairs were functional and footrest were available as indicated per resident needs.On 11/22/2025 and 11/23/2025 the Director of Nursing/Designee completed wheelchair competencies which included wheelchair positioning/transportation, brakes locked before transfer, footrest in place before transport, feet properly placed on footrest before/during transport, ensure feet do not slip during transport, ensure resident is comfortable, position resident with hips back, pelvis neutral (pelvis is balanced, not tilting forward or backwards), trunk supported, feet on footplates transport at a safe/controlled speed for all Licensed Nurses and Nursing Aides (NAs), Activities, Therapy, Transportation, Receptionist, and department managers, including Nursing Home Administrator, Medical Records, Maintenance Director, Rehab Manager, Activities Director, Admissions Director, Human Resource Director and Business Office Manager. All staff that were not available will have competencies completed prior to the start of their next shift and this will be the responsibility of the Director of Nursing. This was completed on 11/23/2025.On 11/23/2025 the Director of Nursing/Designee informed all residents' responsible parties per letter delivered by the United States Postal Service Mail to notify the facility as soon as possible, preferably within 24 hours, if a group of 5 or more visitors are visiting at the same time, to ensure the resident is ready and provisions can be made for a safe and comfortable visit. On 11/24/2025 & 11/25/2025 the facility Occupational (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Therapist completed seating and positioning screens for all current residents in wheelchairs. The Director of Nursing/designee communicated any changes to the residents' assigned nurse and updated the care plan and kardex accordingly. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:On 11/22/2025, the Director of Nursing began immediate education with all staff, including all Licensed Nurses and Nursing Aides (NAs), Activities, Therapy, Transportation, Receptionist, and department managers, including Nursing Home Administrator, Medical Records, Maintenance Director, Rehab Manager, Activities Director, Admissions Director , Human Resource Director and Business Office Manager using the facility Wheelchair Transport Policy and Procedure and Wheelchair Positioning Policy and Procedure. This education included:Before moving a resident:- Ensure both brakes are locked: if brakes do not lock, do not use wheelchair.- Verify the resident is properly positioned.- Confirm footrest are even and the appropriate length (as indicated)- Confirm footrests are down and residents' feet will not slip off of footrest.General Transport Rules:- Unlock brakes before transport.- Inform the resident before movement.- Keep both hands on wheelchair handles.- Move at a safe, controlled speed.- Ensure extremities remain inside the wheelchair.- Avoid sharp turns or sudden stops.Wheelchair positioning:-Verify wheelchair setup (brakes, footrests, cushion placement).-Position resident with hips back, pelvis neutral (pelvis is balanced, not tilting forward or backwards), trunk supported, feet on footplates.-Apply positioning devices as ordered.On 11/22/2025 the Director of Nursing educated all Nurse Aides (NAs) on reviewing the kardex for all their assigned residents prior to each shift for any updates or changes. The kardex, located in the electronic medical record, is updated by the DON/Designee as indicated with any changes.On 11/22/2025 the Director of Nursing educated all Licensed Nurses and Nursing Aides (NA's) to not transfer or transport residents in a wheelchair if there were any of the following concerns and to notify the Director of Nursing/Therapy so the resident's seating/mode of transportation can be evaluated for appropriateness and safety: -Resident is not comfortable during transfer or in the wheelchair-Resident is unable to place feet on the footrest correctly or comfortably, due to confusion, pain, contractures, wounds, etc.-Resident is unable to be positioned safely with hips back, pelvis is balanced, not tilting forward or backwards, trunk is supported, feet are placed on the footrest without sliding or falling off.-Footrests are not even and/or are not the appropriate length-Resident complains of pain or discomfort when placed in wheelchair and pain or discomfort is unrelieved by repositioning.-Resident cannot wear proper footwear, such as non-slip shoes, gripper socks, etc. -Wheelchair is in disrepair: has broken or sharp edges, brakes do not lock (do not place resident in wheelchair if brakes do not lock), pushing the wheelchair is difficult due to wheels not functioning properly.All education was completed on 11/23/2025. Any employee that was not educated will receive the education prior to their next shift and the Director of Nursing/Designee will be responsible for providing the education. The education will also be added to the facility orientation program for all new hires. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 11/24/2025 to discuss, review and approve the plan that had been initiated and implemented by the Regional Clinical Director and the Director of Nursing on 11/22/2025. The Quality Assurance Performance Improvement Committee also reviewed the policy and procedure for Wheelchair Transport and Wheelchair Positioning. The decision to monitor the plan was also decided upon during the Quality Assurance Performance Improvement Committee meeting on 11/24/2025. Root Cause Analysis was completed and determined that Nurse pushed resident in wheelchair while her legs were extended straight out and not on footrests. Resident should have been placed in an alternative chair relating to stiffness and inability to bend legs accordingly on this day.Indicate how the facility plans to monitor its performance to make (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sure that solutions are sustained include dates when corrective action will be completed:The Director of Nursing/Designee starting on 12/01/25 will observe 3 residents during transfers to the wheelchair weekly for 12 weeks to ensure proper positioning per policy, preference and comfort.The Director of Nursing/Designee starting on 12/01/25 will observe 3 wheelchair transports by staff weekly for 12 weeks to ensure proper transportation per policy.The Director of Rehab/Designee starting on 12/01/25 will audit 3 wheelchairs weekly for 12 weeks to ensure proper function and footrest are available as indicated per resident needs.The Director of Nursing/Designee starting on 12/01/25 will review competencies for wheelchair positioning and transfers for all newly hired staff weekly for 12 weeks to ensure competency completion.The Director of Nursing/Designee and the Director of Rehabilitation/Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.The facility alleged compliance as of 11/26/2025.The facility's corrective action plan was validated on 1/06/26. An interview conducted with the Director of Maintenance revealed he completed an audit of all the facility's wheelchairs on 11/23/25 to ensure they were working properly including Resident #1's wheelchair and no concerns were identified. During an interview with the Director of Rehabilitation she stated on 11/23/25 the occupational therapist assessed Resident #1 for proper seating when out of bed and recommended the use of a geri-chair which was placed in Resident #1's room. The Director of Rehabilitation indicated she also completed an audit of all the facility's wheelchairs to ensure they were functional and had compatible footrests, and the occupational therapist evaluated Resident #1 and determined a ger The Director of Rehabilitation further stated on 11/24/25 and 11/25/25 seating and positioning screens were completed by occupational therapy for all residents in wheelchairs and the DON was notified of any changes or recommendations, so the resident care plans were updated. Interviews were conducted with nursing, housekeeping and dining staff revealed they received education on the facility's Wheelchair Transport Policy and Procedure and Wheelchair Positioning Policy and Procedure which included proper wheelchair positioning, general rules for transporting a resident safely in a wheelchair and ensuring footrests were used. Observations conducted of staff transporting residents in wheelchairs revealed no concerns related to positioning or safety and footrests were observed being used. The facility's alleged compliance date of 11/26/25 was validated.