STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stewart Health Center	6920 Marching Duck Drive Charlotte, NC 28210

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stewart Health Center	6920 Marching Duck Drive Charlotte, NC 28210

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, pictures captured of video footage, record review, and staff, family member, 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, had impaired safety awareness, and hearing loss and aphasia (a language disorder that affects a person's ability to communicate) from exiting the building without staff knowledge. On Saturday 09/06/25, Resident #1 entered a conference room area where the inside entrance doors had been propped open by the Dietary Manger. The Dietary Manger then went to the kitchen and the left the conference room area unattended. Resident #1 entered the conference room area and exited the facility through a wanderguard alarmed door at 1:45 PM. The wanderguard alarm system did not alarm or sound, which allowed Resident #1 to exit the facility without staff knowledge. Resident #1 walked down the main road to the facility and passed a security gate at 1:54 PM. He was found lying on the sidewalk near a very busy intersection of Park Road and Park South Drive that was a 4-lane highway with a posted speed limit of 35 miles per hour by a bystander at 2:02 PM who notified police. Resident #1 was transported to the hospital and assessed to have a contusion of the face and skin tear of the right hand. This deficient practice had a high likelihood of causing 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). Immediate jeopardy began on 09/06/25 when Resident #1 exited the facility unsupervised and without staff knowledge. Immediate jeopardy was removed on 09/12/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective and education is completed.Findings included: An interview was conducted with Family Member #1 on 09/22/25 at 1:10 PM. Family Member #1 stated that Resident #1 had memory issues and could not take care of himself. She stated when she visited Resident #1 in his independent living apartment prior to admission on [DATE], she would find burned pans and burned coffee machine, and he could not make food for himself. One time he went to the dining room and could not remember how to get back to his apartment. An interview with Family Member #1 on 09/10/25 at 3:01 PM revealed Resident #1 had previously lived on campus in an independent living setting; however the resident was becoming more forgetful such as leaving his coffee pot on during the day. Family Member #1 stated she did not feel comfortable with him living alone so the family decided to place him in a more assisted environment. Resident #1 was admitted to the facility on [DATE] from his independent living apartment on the same campus with diagnoses of aphasia, atrial fibrillation, hearing loss and mild cognitive impairment. Review of Clinical admission dated 07/21/25 at 12:50 PM revealed that Resident #1 wore hearing aids and indicated his level of cognitive impairment was mild impairment (some confusion) and was alert and oriented x 3 (fully aware of person, place and time), communicated verbally, speech is clear, is able to understand and be understood when speaking. The clinical admission was completed by Nurse #4. An Elopement Evaluation dated 07/21/25 at 1:07 PM revealed that Resident #1 had a history of elopement or attempted leaving the facility without informing staff, verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door, wandered, and had been recently admitted or readmitted . The evaluation gave him a score of 3 and any score 1 or higher indicated risk of elopement. The evaluation was completed by Nurse #4. Nurse #4 was interviewed via telephone on 09/23/25 at 10:10 AM and confirmed that she has completed the admission assessment and elopement evaluation risk assessment for Resident #1 on 07/21/25. Nurse #4 stated that Resident #1 used to live in the independent apartments on campus and would come daily to visit his spouse who lived on the skilled unit. Nurse #4 stated that she had seen a decline with Resident #1 during his visits with his spouse prior to his admission on [DATE]. Nurse #4 stated that Resident #1 even prior to admission on [DATE] while living in the independent living had a sitter and one day as the sitter was leaving she noted Resident #1 walking towards the health center where his spouse resided and called the family, the family then called the health center and asked the staff to make sure he got home safely because the family was worried he would wander off. Nurse #4 stated that during the admission process Resident #1 did not understand that he was going to be moving into the unit, but he was essentially non-verbal so knowing for sure what he understood and did not understand was very difficult. She explained