

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER The Stewart Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for 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, On-Call Nurse Practitioner, Medical Director interviews, the facility failed to provide care in a safe manner when staff assisted a resident with dementia and contractures (permanent tightening of muscles resulting in loss of range in motion) of both lower extremities. The resident was assisted off the side of the bed onto the mat in the floor and laid on her back. While staff left room to get assistance, the resident rolled into fetal position and hit right eye on bed wheel. Resident #63 suffered a skin tear/abrasion to her right eyelid and received treatment at the facility. The deficient practice occurred for 1 of 3 residents for the prevention of accidents (Resident #63). Findings included: Resident #63 was admitted to the facility on [DATE] and discharged on 5/20/26. Diagnosis included Alzheimer's disease, dementia, pain, and contractures of both lower extremities. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 was severely cognitively impaired, had been assessed as being dependent on staff for all activities of daily living (ADL), transfers, mobility, and was always incontinent of bladder and bowel. Review of revised care plan dated 2/07/26 revealed Resident #63 required assistance with all activities of daily living related to history of dementia, impaired balance, and limited mobility. Interventions included Resident #63 required moderate to maximum assistance with care to include one person staff assistance for bed mobility. A telephone interview with Nurse Aide (NA) #1 on 7/09/26 at 1:09 PM revealed she had worked 3rd shift (7:00 PM to 7:00 AM) at the facility, was scheduled for the evening of 4/15/26 through the morning of 4/16/26 and had been assigned to work with Resident #63. NA #1 stated on the morning of 4/16/26 around 6:15 AM she had rolled Resident #63 towards her in bed while providing care. NA #1 revealed that as she was reaching for a wipe, Resident #63 moved or rolled forward toward the edge of the bed, and she thought Resident #63 might continue and fall off the side of the bed, so NA #1 cradled her in her arms and lowered her down onto the mat located in the floor. NA #1 stated that she had placed Resident #63 on her back and believed that she did use the call light, but when no one came NA #1 left Resident #63's room and went out into the hallway to get Nurse #1 for assistance. NA #1 revealed when she and Nurse #1 entered the room Resident #63 had moved from lying on her back into a fetal position and appeared to have hit her eye on the bed wheel. NA #1 stated Nurse #1 immediately began assessing Resident #63's eyelid and applied treatment, assessed for any further injuries and none were noted. NA #1 stated Resident #63 was able to talk, open and close both eyes and she did not complain of any pain at that time. NA #1 revealed that she and Nurse #1 provided Resident #63's personal care and assisted her back into her bed and that she stayed with Resident #63 while Nurse #1 contacted the on-call physician. NA #1 revealed that when she left Resident #63 was resting comfortably in bed. NA #1 stated the incident that occurred was an accident, and she knew that she should have stayed with Resident #63 instead (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 - Minimal harm or potential for actual harm Residents Affected - Few	of leaving her to find Nurse #1. NA #1 revealed that night was her first time ever working with Resident #63 and she panicked and wanted to find Nurse #1 as quickly as she could instead of yelling for help or waiting for Nurse #1 to answer the call light. Review of nursing progress note dated 4/16/26 written by Nurse #1 revealed NA #1 was changing Resident #63 in bed and as she reached for a wipe, Resident #63 rolled towards the edge of the bed. NA #1 was able to slowly assist Resident #63 to the floor onto mat. Resident #63 rolled into fetal position while on the mat, hit the right side of face on bed wheel, and had a slight skin tear/ abrasion to right eye lid. Assessed Resident #63 for injuries and no other injuries were noted, no complaints of pain, vitals were within normal limits and was able to talk and to open eyes. Resident #63 right eye lid was cleaned with normal saline and 4x4 gauze applied. NA #1 and Nurse #1 were able to provide Resident #63 personal care and placed back into bed. Called on-call Nurse Practitioner (NP) who advised continued monitoring and leave communication for facility physician for further evaluation. Nurse #1 also asked if neurological checks were needed and the on-call NP advised they were not needed at this time, due to Resident #63 not suffering a fall and not hitting her head. Responsible Person (RP) also notified. Resident #63 resting in bed and will continue to monitor. A telephone interview with Nurse #1 on 7/09/26 at 10:17 AM revealed she worked at the facility on 3rd shift (7:00 PM to 7:00 AM), was scheduled to work the evening of 4/15/26 through the morning of 4/16/26, NA #1 came down hallway asking for help. She stated NA #1 reported that while she was assisting Resident #63 with her care, she started to roll off the side of the bed, so NA #1 had assisted Resident #63 to floor onto her bedside mat. She revealed NA #1 had stated that she had laid Resident #63 onto her back, but when she and NA #1 had entered the room, Resident #63 had moved into the fetal position and appeared to have hit her eye on the wheel of the bed. Nurse #1 stated she immediately assessed Resident #63 and found a skin tear/abrasion to the right eye lid with a small amount of blood which she cleaned with normal saline and applied a gauze bandage. She revealed she also assessed Resident #63 for any other injuries and found that she was able to move her extremities, was able to talk and move her eyes, and there were no further injuries noted at that time. She stated she assisted NA #1 with providing Resident #63 with her personal care and placing her back into her bed. Nurse #1 revealed she contacted the on-call NP who advised continued monitoring of Resident #63 for any changes, contact facility physician for follow-up evaluation, and did not recommend neurological checks due to Resident #63 not suffering from an actual fall and not striking her head. She stated she left a voicemail for the facility physician, notified the Director of Nursing and Resident #63's RP, and also placed an incident note in the facility physician folder. Nurse #1 stated she felt the incident was an accident but their facility protocol does stated that anytime a resident has a fall or found lying in the floor staff should stay with the resident and use the call light for assistance, yell for help, and never move resident until assessed by a nurse. Review of on-call NP progress note dated 4/16/26 revealed received call from Nurse #1 who reported around 6:15 AM, NA #1 was providing Resident #63 with bed care when she rolled toward the edge of the bed. NA #1 was able to catch Resident #63 and assist her to the floor. While on the floor Resident #63 was initially lying on her back and then curled into a fetal position; during this movement Resident #63's head moved and her left eye struck the bottom of the bed near the wheel. Resident #63 had a slight skin tear described as more of an abrasion near the left eye with minimal bleeding (small amount on gauze). The abrasion was cleaned with normal saline and 4x4 gauze applied. Resident #63 was talking, stated she was hungry, and asked why she was on the floor. Resident #63 did not complain of pain, was able to move all of her extremities; no other injuries were noted. Nurse #1 stated Resident #63 did not fall and did not hit her head. Recommended treatment was to continue to monitor Resident #63 and the abrasion to her eye and to notify facility physician for follow-up (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was assessed by Nurse #1 and was able to move her extremities, had no complaints of pain, and no further injuries were noted at the time. She revealed Nurse #1 had cleaned and treated Resident #63's eyelid and assisted NA #1 with completing Resident #63's personal care and placing Resident #63 back into her bed. She stated Nurse #1 also notified the on-call physician, Resident #63's RP, and left a message for the facility NP and placed a note in the physician folder for the Medical Director for follow-up evaluation. The DON stated she agreed with the Administrator and also felt this incident was an accident, but that staff do need to make sure they are following all fall procedures whether the fall was an assisted fall or not. She revealed staff should never leave a resident alone after a fall or while lying on the floor and that NA #1 should not have left Resident #63 alone to get help from Nurse #1, but instead should have turned on the call light, yelled for help, or called on her cell phone.		