STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion Health Center at Brightmore	10011 Providence Road West Charlotte, NC 28277

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
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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 record review, video footage, observations, and interviews with family members, staff, the Medical Director, Police Officer, and Fire Captain, the facility failed to supervise a severely cognitively impaired resident (Resident #1) from exiting the facility without staff knowledge on 11/22/25 (Saturday) at approximately 10:28 AM on foot for 1 of 3 residents reviewed for supervision to prevent accidents. Resident #1 who had a primary diagnosis of toxic encephalopathy (neurological disorder caused by exposure to toxic substances, leading to diffuse brain dysfunction) exited from the facility without staff's knowledge for over two hours on the morning of 11/22/25. Resident #1 walked on the sidewalk on Providence Road (Providence Road is a heavily trafficked road in the city of [NAME]), fell and was assisted by strangers who placed the resident into their private vehicle and drove across town where the strangers dropped Resident #1 off at a fire department 20 miles away from the facility. The fire department called medics who transported Resident #1 to the hospital. Resident #1 was noted to have an abrasion and mild swelling over the right maxilla (upper jawbone) and abrasions on posterior aspect of bilateral hands from a reported fall on Providence Road where the facility was located. This had the high likelihood of causing serious harm and/or injury.The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy, cardiac arrest, atherosclerotic heart disease (coronary artery disease caused by the buildup of fats, cholesterol and other substances in and on the walls of the heart arteries) and chronic kidney disease. A review of the Interdisciplinary Risk Assessment (this assessment is completed during admission to determine a resident's risk factors in the areas of pressure ulcer, wandering, falls, malnutrition and dehydration) for Resident #1 dated 11/8/25 and completed by the admitting nurse indicated Resident #1 did not have a history of wandering per family or other medical notes, did not have a history of elopement, had not been noted to wander, and did not have a diagnosis of dementia. The assessment also indicated Resident #1 had the following risk factors for fall: confusion/disorientation/impulsivity and altered elimination which meant he was frequently incontinent of both urine and bowel.Resident #1's care plan initiated on 11/10/25 indicated Resident #1 was at increased risk for falls due to confusion, poor balance and poor communication/comprehension and that he had impaired cognitive function or impaired thought processes. Interventions included to anticipate and meet needs as much as possible, to check on the resident frequently throughout the shift and to cue, reorient and supervise the resident as needed. Resident #1 did not have a care plan for wandering behaviors or risk for elopement.The admission Minimum Data Set assessment dated [DATE] indicated Resident #1 was severely cognitively impaired and did not exhibit wandering behaviors during the assessment period. Resident #1 did not have any range of motion impairments, used a wheelchair, and required partial/moderate assistance with most activities of daily living including walking 10 feet. Resident #1 did not have any falls since admission.A nursing progress note dated 11/21/25 at 6:36 AM documented by Nurse #2 indicated Resident #1 was resistive to personal care per staff. Nurse with nurse aide encouraged Resident #1 to allow staff to change soiled brief. Resident #1 showed confusion with understanding the need for changing and his ability to do it himself. The nurse explained to Resident #1 several times that they were there to help him due to his weakness displayed and unsteady gait. Resident #1 allowed staff to change him. Confusion noted throughout the personal care. Resident #1 placed legs into brief and attempted to ambulate alone. Nurse had to keep Resident #1 from falling while ambulating.A review of an Incident Report dated 11/22/25 prepared by the Director of Nursing indicated at approximately 11:30 AM, staff suspected that Resident #1 was missing from the building after they were unable to locate him when his (family member) came to visit. The Weekend Supervisor initiated the Code Pink protocol for missing residents. (Code Pink protocol meant a resident was missing and was used by the facility to alert staff to start searching for the missing resident.) Before the incident, staff interaction with the resident included a Nurse Aide who served him breakfast at approximately 8:15 AM, and his assigned Nurse Aide who picked up his tray at approximately 9:30 AM and observed him still lying in bed. Staff conducted an extensive search of the facility and surrounding areas, including neighboring buildings, the street, nearby bushes and drainage ditches but could not locate the resident. The Weekend Supervisor reported the incident to the Director of Nursing and Administrator and notified law enforcement. Upon arrival at the facility, staff provided the police with all relevant identifying information of the resident. The Weekend Supervisor notified the resident's listed family members of Resident #1 missing. At approximately 12:55 PM, law