

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345489</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Rockwell Park Rehabilitation and Healthcare Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1930 West Sugar Creek Road , Charlotte, North Carolina, 28262</b>	
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E0000	Initial Comments  An unannounced onsite recertification survey was conducted on 11/17/25 through 11/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1DB61D-H1.	E0000		12/08/2025
F0000	INITIAL COMMENTS  An unannounced onsite recertification survey was conducted on 11/17/25 through 11/20/25. Event ID# 1DB61D-H1.	F0000		12/08/2025
F0552 SS = D	Right to be Informed/Make Treatment Decisions  CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care.  The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review, and Responsible Party and staff interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to increasing the frequency for 1 of	F0552	On 12/1/2025 the  Director of Nursing and  the Assistant Director of Nursing  obtained consent from  the responsible party of resident #62  for ABH gel, which included  explaining risk and benefits. On  11/20/2025 Unit Manager #1  was re-educated on  obtaining consent, which included  explaining the risk and benefits of psychotropic medications.  All residents have the potential to  be affected. On 12/9/2025 the  Director of Nursing/Designee  reviewed all new psychotropic  medication orders for current	12/13/2025

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 reverse for further 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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F0552 SS = D	<p>Continued from page 1 5 residents reviewed for unnecessary medications (Resident #62).</p> <p>The findings included:</p> <p>Resident # 62 was admitted to the facility on 7/1/20 with diagnoses that included dementia with behavioral disturbance, and anxiety disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated 6/23/25 indicated Resident #62 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #62 had physical behavioral symptoms directed towards others and other behavioral symptoms not directed towards others which occurred 4 to 6 days during the assessment period. Resident #62 also had verbal behavioral symptoms directed towards others and rejection of evaluation or care behaviors which occurred 1 to 3 days during the assessment period. The MDS further indicated that Resident #62's current behavior status was worse compared to the prior assessment. Resident #62 received antipsychotics and anti-anxiety medications.</p> <p>A review of Resident #62's Physician Orders indicated an active order dated 6/23/25 for ABH gel (Lorazepam 0.5 milligrams/Diphenhydramine 12.5 milligrams/Haloperidol 1 milligram) which changed from twice daily to three times a day for anxiety. The order read to "apply 1 milliliter topically to inner aspect of wrist."</p> <p>A review of Resident #62's medical record indicated an electronic psychotropic medication informed consent form completed by Unit Manager #1 on 10/2/25 about the use of ABH gel three times a day. The form indicated that Resident #62's Responsible Party (RP) gave a verbal consent to the use of ABH gel for Resident #62.</p> <p>A phone interview with Resident #62's RP on 11/18/25 at 2:18 PM revealed she was not aware what an ABH gel was. The RP stated the nurses had not discussed with her about Resident #62 receiving this medication and they had not talked to her about its risks and benefits. Resident #62's RP stated that she wished they would discuss with her any changes in Resident #62's medications, and that she was not aware that they had increased the frequency of the medication.</p> <p>An interview with Unit Manager #1 on 11/19/25 at 11:57 AM revealed she completed the psychotropic medication consent form on 10/2/25 after a care conference meeting with Resident #62's RP over the phone. Unit Manager #1</p>	F0552	<p>Continued from page 1 residents, including ABH gel for the last 30 days, to ensure responsible party notification, which included obtaining consents, explaining the risk and benefits of medication. Any concerns were immediately corrected. This audit was completed on 12/10/22025</p> <p>On 11/21/2025 the Director of Nursing/Designee re-educated all license nurses on obtaining consents for all new psychotropic medications, to include explaining risk and benefits of medications to residents or resident's responsible party. This Education was completed on 12/10/2025. This education will be added to the facility orientation process and will be the responsibility of the Director of Nursing/Designee. The Director of Nursing/Designee will audit new orders for psychotropic medications, including ABH gel 5 times a week for 12 weeks to ensure psychotropic medication consents have been obtained, including risk and benefits of medication use.</p>	

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F0552 SS = D	<p>Continued from page 2 stated that all she could remember telling Resident #62's RP was that Resident #62 was still receiving the ABH gel and the RP asked her if it was working, and she told her that it was as long as it was given in a timely manner. Unit Manager #1 stated that Resident #62' RP knew about Resident #62 receiving the ABH gel, but she did not discuss with the RP about the risks and benefits of using the ABH gel, and she could not remember if she told her that they had increased the frequency in June 2025.</p> <p>A follow-up interview with Unit Manager #1 on 11/20/25 at 9:46 AM revealed she entered the order change for Resident #62's ABH gel on 6/23/25 but she could not remember if she obtained a consent from Resident #62's RP prior to entering the order. Unit Manager #1 stated she should have obtained the consent, but she couldn't remember whether they had started obtaining psychotropic medication consents at that time.</p> <p>An interview with the Director of Nursing (DON) on 11/20/25 at 10:19 AM revealed the process that they followed regarding psychotropic medication consents was when the nurses get the order for psychotropic medications or changes, they need to call the RP or guardian and obtain a consent prior to starting the medication or implementing the change. The DON stated they had noticed as they were looking at different processes at the facility around August 2025 that a number of psychotropic medication consents were not obtained or in place prior to starting therapy. The DON stated that she knew a care plan meeting was completed on 10/2/25 where the ABH gel was discussed with Resident #62's RP, but she agreed that the consent should have been obtained prior to increasing the dose in June 2025.</p>	F0552	<p>Continued from page 2</p> <p>The Director of Nursing or 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.</p> <p>Compliance Date: 12/13/2025</p>	
F0561 SS = E	<p>Self-Determination</p> <p>CFR(s): 483.10(f)(1)-(3)(8)</p> <p>§483.10(f) Self-determination.</p> <p>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,</p>	F0561	<p>On 11/19/2025 residents # 42, #23, #18 and #78 were offered the choice to utilize tobacco cigarettes. On 11/19/2025 the Regional Clinical Director educated the Director of Nursing and the Administrator on the facility Smoking policy, including</p>	12/13/2025

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F0561 SS = E	<p>Continued from page 3 assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and staff and resident interviews, the facility failed to honor a resident's choice to smoke a tobacco cigarette by making residents use vaping devices for 4 of 4 residents reviewed for choices (Resident #42, Resident #23, Resident #18 and Resident #78). This deficient practice had the potential to affect all residents that smoked cigarettes.</p> <p>The findings included:</p> <p>The facility's smoking policy revised on 9/19/25 read in part: This facility is a safe smoking facility, and the use of tobacco products is limited to e-cigarettes and vaping devices and permitted only in designated areas.</p> <p>a. Resident #42 was admitted to the facility on 3/01/21.</p> <p>The annual Minimum Data Set (MDS) dated 9/19/25 revealed Resident #42 was moderately cognitively impaired, was able to understand and be understood by others and was coded for current use of tobacco.</p> <p>The care plan dated 9/19/25 indicated Resident #42 had a focus area related to tobacco use and the interventions included supervision when smoking and utilizing a smoking apron for safety.</p>	F0561	<p>Continued from page 3</p> <p>residents' rights to self-determination/residents choice to smoke tobacco cigarettes.</p> <p>All residents who smoke have the potential to be affected. On 11/19/2025 the Director of Nursing reviewed the facility Smoking Policy with all residents who smoke, offering smoking materials of choice per facility policy. This was completed 11/22/2025.</p> <p>On 11/19/2025 the Director of Nursing/Designee began re-education with all staff on the facility smoking policy, including residents' rights to self-determination/residents choice to smoke tobacco cigarettes. This education was completed on 12/10/2025.</p> <p>This education will be added to the facility orientation program and will be the responsibility of</p>	

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F0561 SS = E	<p>Continued from page 4</p> <p>The safe smoking evaluation dated 11/11/25 revealed Resident #42 required supervision while smoking.</p> <p>During an observation and interview with Resident #42 on 11/18/25 at 2:15 PM he was observed vaping in the facility's designated smoking area. Resident #42 stated approximately a month ago the facility smoking policy changed and only vaping was allowed. He revealed he was not given the option to continue smoking tobacco cigarettes, which was his preference, and he did not like vaping.</p> <p>b. Resident #23 was admitted to the facility on 3/02/23.</p> <p>The annual MDS dated 1/21/25 revealed Resident #23 was moderately cognitively impaired, was able to understand and be understood by others and was not coded for current tobacco use.</p> <p>The care plan dated 10/21/25 indicated Resident #23 had a focus area related to tobacco use and the interventions included supervision when smoking and utilizing a smoking apron for safety.</p> <p>The safe smoking evaluation dated 11/11/25 revealed Resident #23 required supervision when smoking.</p> <p>An interview conducted with Resident #23 on 11/19/25 at 12:25 PM revealed the facility recently changed their smoking policy and residents were only allowed to vape. Resident #23 revealed she wanted to smoke tobacco cigarettes and was not able to vape because it made her sick.</p> <p>c. Resident #18 was admitted to the facility on 11/08/24.</p> <p>The annual MDS dated 5/05/25 revealed Resident #18 was cognitively intact and was coded for current tobacco use.</p> <p>The care plan dated 9/26/25 indicated Resident #18 had</p>	F0561	<p>Continued from page 4</p> <p>the Director of Nursing/Designee.</p> <p>Beginning 12/8/2025 the Director of Nursing/Designee will interview 3 residents weekly for 12 weeks to ensure residents are utilizing smoking materials of choice per facility policy.</p> <p>The Director of Nursing or 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.</p> <p>Compliance Date: 12/13/2025</p>	

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F0561 SS = E	<p>Continued from page 5 a focus area related to tobacco use and the interventions included supervision when smoking and utilizing a smoking apron for safety.</p> <p>The safe smoking evaluation dated 11/11/25 revealed Resident #18 required supervision when smoking.</p> <p>During an observation and interview on 11/19/25 9:29 AM Resident #18 was observed vaping in the facility's designated smoking area. He stated the facility recently changed the smoking policy to only allow vaping and he was not given the choice to continue smoking tobacco cigarettes. Resident #18 revealed he did not like vaping and wanted to smoke cigarettes.</p> <p>d. Resident #78 was admitted to the facility on 4/11/25.</p> <p>The admission MDS dated 5/08/25 revealed Resident #78 was cognitively intact and coded for current tobacco use.</p> <p>The care plan dated 5/15/25 indicated Resident #78 had a focus area related to tobacco use and the interventions included supervision when smoking and utilizing a smoking apron for safety.</p> <p>The safe smoking evaluation dated 11/11/25 revealed Resident #78 required supervision when smoking.</p> <p>An interview was conducted with Resident #78 on 11/19/25 at 11:20 AM. Resident #78 stated the facility recently changed their smoking policy to only allow vaping and if she wanted to continue smoking tobacco cigarettes she would have to move to another facility. Resident #78 revealed she did not like vaping and if she had a choice she would smoke cigarettes.</p> <p>During an interview with the Administrator on 11/19/25 at 1:17 PM he revealed the facility implemented a new smoking policy on 10/20/25 due to concerns related to residents not holding lit cigarettes safely and increased difficulty for staff supervising residents during the scheduled smoking times. He indicated the new policy allowed residents to vape or use e-cigarettes, but smoking tobacco cigarettes was no</p>	F0561		

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F0561 SS = E	Continued from page 6 longer permitted. The Administrator stated residents were initially informed of the new smoking policy in the Resident Council Meeting on 9/19/25 and then weekly meetings were held to remind them of the upcoming change. The Administrator indicated residents that did not want to vape or use e-cigarettes were offered smoking cessation options or to move to a facility that permitted the use of tobacco cigarettes and was accepting new residents.	F0561		
F0657 SS = D	Care Plan Timing and Revision  CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans  §483.21(b)(2) A comprehensive care plan must be-  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to--  (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff.  (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.  (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  This REQUIREMENT is NOT MET as evidenced by:  Based on record review and staff interviews, the facility failed to revise a resident's care plan when her smoking status changed for 1 of 18 residents reviewed for comprehensive care plans (Resident #9).	F0657	On 11/20/2025 the MDS Nurse updated the care plan for Resident #9 to reflect current smoking status.  All residents that no longer smoke have the potential to be affected.  On 12/1/2025 the Director of Nursing/Designee reviewed care plans for all residents to ensure care plans for smoking were accurate and reflected current smoking status.  No other concerns were identified. This audit was completed on 12/2/2025.  On 11/20/2025 the MDS Nurse was re-educated on care plan timing and revision to include resolving care plans of resident who no longer smoke. This education will be added to the facility	12/13/2025

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F0657 SS = D	<p>Continued from page 7</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on 8/2/24 with diagnoses of hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus.</p> <p>A review of Resident #9's most up-to-date care plan revealed a focus area indicating tobacco use- and Resident #9 was assessed to be an unsafe and supervised smoker with a revision date of 8/19/24. Interventions included conducting smoking safety evaluation on admission and as needed and utilizing a smoking apron.</p> <p>A review of Resident #9's electronic medical record (EMR) revealed a smoking assessment dated 6/30/25 which indicated Resident #9 as a non-smoker who did not use smokeless tobacco products or electronic cigarettes. The assessment also revealed Resident #9 quit smoking in the previous month and wished to remain non-smoking.</p> <p>A review of the annual Minimum Data Set (MDS) dated 8/14/25 indicated Resident #9 was cognitively intact and was not coded for tobacco use.</p> <p>An interview with Resident #9 on 11/19/2025 at 2:50 PM revealed she made the decision to quit smoking by herself last summer because she knew smoking was bad for her.</p> <p>An interview with MDS Nurse 11/20/2025 at 2:22 PM revealed any changes in a resident's smoking status would be discussed in the clinical portion of the management's morning meeting. The MDS Nurse indicated he would update the care plan and MDS if a status changed.</p>	F0657	<p>Continued from page 7 orientation program for all newly hired MDS Nurses. The Director of Nursing/Designee will be responsible for this education.</p> <p>The Regional Director of Clinical Reimbursement will audit 10 care plans weekly for 12 weeks to ensure smoking is accurate.</p> <p>The Regional Director of Clinical Reimbursement or 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.</p> <p>Compliance Date: 12/13/2025</p>	
F0759 SS = D	<p>Free of Medication Error Rts 5 Prcnt or More</p> <p>CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors.</p> <p>The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0759	<p>On 11/19/2025 resident #32 did not any adverse effects, resident #32 did not receive incorrect medications. On 11/20/2025 License Nurse #1 was re-educated on the 7 rights of medication administration, including identification</p>	12/13/2025

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F0759 SS = D	<p>Continued from page 8</p> <p>Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of medications to the wrong resident (2 medication errors out of 26 opportunities), resulting in a medication error rate of 7.69% for 1 of 5 residents (Resident #62) observed during medication pass.</p> <p>The findings included:</p> <p>Resident #62 was admitted to the facility on 7/1/20 with diagnoses that included polyosteoarthritis (condition where there is breakdown of cartilage in multiple sites throughout the body) and constipation.</p> <p>The Physician's Orders in Resident #62's electronic medical record indicated an active order dated 11/17/23 for Polyethylene Glycol oral powder give 17 grams orally one time a day for constipation – mix with 4 to 8 ounces of fluid and an active order dated 6/26/25 for Acetaminophen liquid 160 milligrams (mg)/5 milliliters – give 650 mg by mouth three times a day for osteoarthritis.</p> <p>A review of Resident #32's Physician's Orders did not include Polyethylene Glycol and Acetaminophen to be given at 9:00 AM.</p> <p>On 11/19/25 at 10:30 AM, Nurse #1 was observed as she prepared to administer Resident #62's medications. Nurse #1 entered Resident #62's room but walked over directly to Resident #32. As she attempted to give Resident #62's Acetaminophen liquid to Resident #32, Resident #32 pushed the cup away but did not say anything. The surveyor asked Nurse #1 if she was sure she was giving the medication to the right resident and Nurse #1 stated that she was sure Resident #32 was Resident #62. Nurse #1 then attempted to give Resident #62's Acetaminophen liquid to Resident #32 who pushed the cup away again. Nurse #1 then stepped outside the room and looked at the resident names by the door. She went to Resident #62's bedside and asked for her name. Resident #62 stated her first name. Nurse #1 then proceeded to administer Resident #62's medications.</p> <p>An interview with Nurse #1 on 11/19/25 at 10:38 AM revealed this was her first time working with Resident #62 and was not familiar with her. Nurse #1 stated that she would look at the names at the door and look at the picture in the Medication Administration Record (MAR) to identify the correct resident, but she did not know what to say about why she identified the wrong</p>	F0759	<p>Continued from page 8 of residents before administrating medication.</p> <p>On 11/20/2025 the Staff Development Coordinator immediately observed medication administration for Licensed Nurse #1 to ensure no further issues were identified.</p> <p>All residents have the potential to be affected. On 11/20/2025 the Director of Nursing/Designee interviewed residents on Nurse #1s assignment with Brief Interview for Mental Status (BIMs) of 13 or higher to ensure no concerns with medication administration. No concerns were identified.</p> <p>On 11/20/2025 the Director of Nursing/Designee assessed all residents on Nurse #1s assignment with Brief Interview for Mental Status (BIMs) of 12 or less to ensure vital signs were at baseline. No concerns were identified.</p> <p>On 11/21/2025 the Staff Development Coordinator re-educated all Licensed Nurses and Medication Aides on the 7 Rights of Medication Administration,</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345489</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>Rockwell Park Rehabilitation and Healthcare Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1930 West Sugar Creek Road , Charlotte, North Carolina, 28262</b>	
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F0759 SS = D	<p>Continued from page 9 resident. Nurse #1 stated that she would have given Resident #62's medications to the wrong resident if Resident #32 did not push the cup away.</p> <p>An interview with Unit Manager #1 on 11/19/25 at 11:57 AM revealed Nurse #1 was probably nervous because she was being observed administering medications. Unit Manager #1 stated Nurse #1 normally worked on the other medication cart and was not familiar with the residents where she was assigned today. Unit Manager #1 stated they had pictures on the MAR and names on the door where the first name was always the resident on the first bed. Unit Manager #1 stated that these should have helped Nurse #1 identify the right resident as well as she should have asked the resident their names before administering medications to them.</p> <p>An interview with the Director of Nursing (DON) on 11/20/25 at 10:19 AM revealed Nurse #1 should have checked the resident identifiers like the picture on the MAR and the names on the door, and asked the resident to state their name before giving their medications. The DON stated the nurses should be checking and verifying that they give medications to the right resident.</p>	F0759	<p>Continued from page 9 including the right medication, the right route, the right dose, the right resident, the right time, the right documentation and the right reason. This education was completed on 12/10/2025 and will be added to the facility orientation program and will be the responsibility of the Director of Nursing/Designee.</p> <p>The Director of Nursing/Designee will observe 3 medication administrations weekly for 12 weeks to ensure Licensed Nurses and/or Medication Aides are administering medications properly, ensuring the correct resident is receiving correct medication.</p> <p>The Director of Nursing or 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.</p> <p>Compliance Date: 12/13/2025</p>	