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	05/23/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936 Based on record review and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of the resident's transfer and discharge to the hospital for 1of 2 residents reviewed for hospitalization (Resident #150). The findings included: Resident was admitted to the facility on [DATE]. A nursing note dated 4/13/2025 at 6:51 PM stated Resident #150 was transferred to the hospital for further workup of lack of appetite and generalized weakness. A nursing note dated 4/18/2025 at 2:37 PM indicated Resident #150 was readmitted to the facility. A nursing note dated 4/28/2025 at 6:26 PM stated Resident #150 was transferred to the hospital due to urinary retention. A nursing note dated 5/15/2025 at 4:15 PM indicated Resident #150 was readmitted to the facility. An interview on 5/22/2025 at 11:38 AM with the Ombudsman revealed she did not receive a hospital transfer and discharge list for April 2025. An interview on 5/22/2025 at 9:36 AM with the Director of Nursing (DON) indicated that Resident #150 had been transferred to the hospital several times since her admission to the facility. She indicated social work was responsible for communicating information to the Ombudsman regarding hospital transfers and discharges. An interview on 5/22/2025 at 11:56 AM with Social Worker (SW) #1 revealed she was unaware that information regarding hospital transfers and discharges was to be provided to the Ombudsman. SW #1 indicated this requirement had never been mentioned to her during her training. She stated she had not sent any transfer or discharge lists to the Ombudsman since the start of her employment in February 2025. She stated no one at the facility was currently sending the transfer/discharge list to the Ombudsman. (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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview on 5/22/2025 at 1:11 PM with the Administrator revealed that the SW was responsible for notifying the Ombudsman of hospital transfers and discharges. He stated he had become aware today that social work had not been providing the hospital transfer and discharge list to the Ombudsman. He did not understand how this requirement had been missed as he had sent SW #1 to other nursing facilities to train with other social workers. The Administrator stated the hospital transfer and discharge list should be sent to the Ombudsman each month.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge status (Resident #98), Preadmission Screening and Resident Review (PASRR) (Resident #76), falls (Resident #54), and physical restraints (Resident #73). This deficient practice occurred for 4 of 19 residents reviewed for accuracy of assessments. The findings included: 1. Resident #98 was admitted to the facility 6/15/23 and discharged from the facility 4/10/25. The facility discharge summary dated 4/10/25 revealed Resident #98 was discharged to an Assisted Living Facility (ALF). The discharge MDS assessment dated [DATE] indicated Resident #98's discharge was unplanned, initiated by the facility and return was not anticipated. Resident #98's discharge location was coded short-term hospital. During an interview with MDS Coordinator #1 on 5/21/25 at 3:46 PM he revealed when a resident was discharged from the facility, he reviewed the electronic medical record and/or communicated with staff to determine the resident's discharge location prior to completing the MDS. He stated Resident #98 was discharged to an ALF on 4/10/25. MDS Coordinator #1 indicated Resident #98's discharge location coded short term hospital was inaccurate and an oversight on his part. An interview with the Director of Nursing on 5/22/25 at 3:59 PM indicated Resident #98 was discharged to an ALF and the MDS assessment should have been coded with an accurate discharge location. An interview conducted with the Administrator on 5/22/25 at 4:24 PM revealed resident MDS assessments should be coded accurately. 40476 2. Resident #76 was admitted to the facility on [DATE] with diagnoses which included schizophrenia. A Pre-Admission Screening and Resident Review (PASRR) dated 05/24/24 revealed Resident #76 was determined to be a level II PASRR (a person having or suspected of having a PASRR condition such as serious mental illness, intellectual disability or developmental disability). Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #76 revealed she was moderately cognitively impaired. Under the section for PASRR Resident #76 was coded as not being a level II. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025 and was not at the facility when the annual MDS was completed. MDS Coordinator #1 stated the resident was a level II PASRR and should have been coded for it on the MDS assessment. MDS Coordinator #1 further stated he would modify the assessment and resubmit. An interview on 05/22/25 at 12:25 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions. 3. Resident #54 was admitted to the facility on [DATE] with diagnoses which included orthostatic hypotension. An incident report dated 12/29/24 at 10:31 PM revealed Resident #54 had experienced an unwitnessed fall and was found sitting on the floor in her room yelling for help. No injuries were noted at the time of the fall. An incident report dated 03/18/25 at 12:30 AM revealed Resident #54 had experienced a witnessed fall in her room by nursing staff. No injuries were noted at the time of the fall. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #54 revealed she was severely cognitively impaired. Under the section for fall history since admission, entry or reentry Resident #54 was coded as having experienced no falls since admission into the facility. An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025. MDS Coordinator #1 stated looking back at Resident #54's nursing progress notes she had experienced several falls and should have been coded for it on the MDS assessment. MDS Coordinator #1 further stated he would modify the assessment and resubmit. An interview on 05/22/25 at 12:25 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions. 4. Resident #73 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (CVA). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #73 revealed he was unable to complete the cognition portion of the assessment. Under the section for physical restraints, Resident #73 was coded for use of bed rails. Resident #73 was observed on 05/19/25 at 11:13 AM lying in bed. No bed rails were observed on Resident #73's bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. No bed rails were observed on Resident #73's bed. An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025 and was not responsible for completing the MDS assessment. MDS Coordinator #1 stated the facility was restraint free, and that no residents currently residing in the facility used bed rails. He stated the MDS was coded inaccurately. MDS Coordinator #1 further stated he would modify the assessment and resubmit. An interview on 05/22/25 at 12:25 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the area of colostomy care for 1 of 1 resident reviewed for colostomy care (Resident #35). The findings included: Resident #35 was admitted to the facility 4/13/22 with diagnoses that included colostomy status. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #35 was coded for having a colostomy. Resident #35's comprehensive care plan dated 2/18/25 revealed no problem areas or interventions related to colostomy care. During an interview with MDS Coordinator #2 on 5/21/25 at 4:00 PM she stated there were no interventions related to colostomy care in Resident #35's care plan which was an oversight on her part. An interview conducted with the Director of Nursing (DON) on 5/22/25 at 3:59 PM revealed Resident #35's colostomy status was a significant part of her care and should have been included in the comprehensive care plan. An interview with the Administrator on 5/22/25 at 4:24 PM indicated that goals and interventions related to colostomy care should be included in the resident's comprehensive care plan.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observation, record review, resident, and staff interviews, the facility failed to apply a right-hand splint for 1 of 3 sampled residents reviewed for limited range of motion (Resident #73). Findings included: Resident #73 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident (CVA). An active physician order originally dated 11/16/23 revealed a right resting hand splint, on after AM care and off after PM care daily. A review of Resident #73's medical record revealed an Occupational Therapy (OT) discharge summary dated 12/20/2024 indicated Resident #73 had a diagnosis of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis) following a cerebral infarction affecting the right dominant side. A splint program was established. Resident #73 had been agreeable to donning splint and self-doffs the splint 1-2 hours later. The summary stated Resident #73 should be wearing the right resting hand splint for up to 8 hours/day. OT completed staff/caregiver education for splinting program with appropriate staff/caregivers and would then transition into the splinting program due to no further need for OT to address. Resident #73's quarterly Minimum Data Set Assessment (MDS) dated [DATE] coded the resident as unable to complete the cognition portion of the assessment. He was coded as needing limited assistance of one staff member for toileting and transfers. His functional limitation in range of motion indicated he had no impairment to his upper extremity and lower extremity. A review of the May 2025 Medication Administration Record revealed documentation of Resident #73's right hand splint being on every AM from 5/1/25 through 5/21/25. Further review revealed the right-hand splint was documented as being on every AM shift on 05/19, 05/20 and 05/21 by Nurse #1. Resident #73 was observed on 05/19/25 at 11:13 AM without a splint to the right hand and the right hand was noted to be flaccid (limp and lacking voluntary movement). During the observation and interview, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. Resident #73 was observed to be pointing to his right hand to alert the surveyor that there was an issue. Resident #73 was unable to communicate verbally with the surveyor however was able to answer by giving a thumbs up for yes and a thumbs down for no. When asked the question, do the staff apply the hand splint, Resident #73 gave a thumbs down for no. The surveyor then asked if Resident #73 could apply the hand splint himself and he gave a thumbs down for no. The right-hand splint was not observed to be in Resident #73's room. Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. During the observation, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #73 was observed on 05/21/25 at 2:25 PM sitting in his wheelchair in the resident common area. The right-hand splint was not observed on Resident #73's hand. An interview conducted on 05/21/25 at 2:25 PM with Nurse Aide #1 revealed she hadn't seen Resident #73s right hand splint for several weeks. NA #1 stated she hadn't seen it placed on his right hand for over a month. She stated she thought therapy staff applied the residents splint and not nursing staff. The interview revealed she had not received education on applying the splint to Resident #73's right hand nor was told to. An interview conducted on 05/21/25 at 2:35 PM with Nurse #1 revealed she thought Resident #73 had a right-hand splint but that he removed it himself. She stated she would sometimes observe it when she went into the room to administer his medication, and that Therapy staff were good about applying it in the mornings after AM care. She stated in particular on 05/21/25 that she did not apply Resident #73's right hand splint because she thought therapy services were applying it. An interview conducted on 05/21/25 at 10:50 AM with the Therapy Director revealed Resident #73 was discharged from therapy services on 03/22/25. She stated the last time Resident #73 was evaluated for his right-hand splint was 12/20/24 in which they recommended the right-hand splint with a goal of 6-8 hours wearing the splint. She stated Resident #73 could remove the splint himself after it was applied. She stated the nursing staff were responsible for putting the right-hand splint on the resident and would have been provided education in December based on the Physical Therapy discharge summary. The Therapy Director indicated she had just evaluated Resident #73 prior to the interview and Resident #73's right hand mobility had not gotten worse since the last evaluation on 12/20/24 and he had not developed any skin breakdown or new injury to the right-hand. An interview was conducted on 05/22/25 at 12:25 PM with the Director of Nursing (DON). The DON stated Resident #73's splint should have been applied as indicated in the physician's orders. The DON stated it was her expectation for nursing assistants to apply the splint and if they had any difficulties then they should have informed their supervising nurse. An interview conducted on 05/22/25 at 1:54 PM with the Administrator revealed the nursing staff should have applied the splint as indicated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record review and staff interviews, the facility failed to ensure a medical record was accurate regarding the Medication Administration Record (MAR). This was for 1 of 1 resident in the area of right-hand splint application (Resident #73) and 1 of 1 resident in the area of medication administration (Resident #69) who were reviewed for medical record accuracy. Findings included: A review of the May 2025 Medication Administration Record revealed documentation of Resident #73's right hand splint being on every AM from 5/1/25 through 5/21/25. Further review revealed the right-hand splint was documented as being on every AM shift on 05/19, 05/20 and 05/21 by Nurse #1. Resident #73 was observed on 05/19/25 at 11:13 AM without a splint to the right hand and the right hand was noted to be flaccid (limp and lacking voluntary movement). During the observation and interview, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. Resident #73 was observed to be pointing to his right hand to alert the surveyor that there was an issue. Resident #73 was unable to communicate verbally with the surveyor, however, was able to answer by giving a thumbs up for yes and a thumbs down for no. When asked the question, do the staff apply the hand splint, Resident #73 gave a thumbs down for no. The surveyor then asked if Resident #73 could apply the hand splint himself and he gave a thumbs down for no. The right-hand splint was not observed to be in Resident #73's room. Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. During the observation, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. The right-hand splint was not observed on Resident #73's hand. Resident #73 was observed on 05/21/25 at 2:25 PM sitting in his wheelchair in the resident common area. The right-hand splint was not observed on Resident #73's hand. An interview conducted on 05/21/25 at 2:25 PM with Nurse Aide #1 revealed she worked with Resident #73 on a regular basis. She stated she hadn't seen Resident #73s right hand splint for several weeks. NA #1 stated she hadn't seen it placed on his right hand for over a month. An interview conducted on 05/21/25 at 2:35 PM with Nurse #1 revealed she thought Resident #73 had a right-hand splint but that he removed it himself. She stated she would sometimes observe it when she went into the room to administer his medication, and that Therapy staff were good about applying it in the mornings after AM care. She stated in particular on 05/21/25 that she did not apply Resident #73's right hand splint because she thought therapy services were applying it. She stated that was why she documented the right hand splint was on. An interview was conducted on 05/22/25 at 12:25 PM with the Director of Nursing (DON). The DON stated Resident #73's splint should have been applied as indicated in the physician's orders. The DON stated it was her expectation for nursing staff to be accurately document on the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 05/22/25 at 1:54 PM with the Administrator revealed the nursing staff should have accurately documented in the medical record. 51667 2. Resident #69 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 was cognitively intact. A review of current physician order for Resident #69 dated 6/28/2024 revealed to administer Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP. Give 17 grams orally as needed for constipation, mixed with 4 to 8 ounces liquid of choice. Daily as needed. Record review revealed progress note dated 5/2/2025 entered by Nurse #3. According to the note, Resident #69 had not had a bowel movement in 3 days and was given constipation medication on 5/2/25. A review of Resident #69's Medication Administration Record (MAR) for May 2025 revealed Nurse #3 did not document the administration of Polyethylene Glycol 3350 oral power in the month of May 2025. The phone interview on 05/22/25 at 3:43 PM with Nurse #3 revealed she was assigned to review bowel records and report negative findings to providers. Nurse #3 stated she did not remember progress note dated 5/2/25 for Resident #69. Nurse #3 reported that she remembered that Resident #69 had gone 3 days without bowel movement according to bowel records and gave Resident #69 whatever the provider ordered for constipation. Nurse #3 stated that she would document bowel interventions in the bowel record that was then linked to progress notes. Nurse #3 stated she would have documented any medication given to Resident #3 on his MAR. Nurse #3 stated she had forgotten to chart the medication for the bowel intervention. The Director of Nursing (DON) was interviewed on 05/22/25 at 04:06 PM. The DON reported Nurse #3 was assigned to review bowel records and work with the providers for bowel interventions for the residents. The DON stated that Nurse #3 should document bowel medications given to the residents in their MAR. The Administrator was interviewed on 05/22/25 at 01:55 PM. The Administrator reported the nurses were expected to document any medication provided to the residents in the residents' MAR. The Administrated stated, If it was not documented it was not done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40476 Based on observations, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy when the Unit Manager did not perform hand hygiene before each donning of clean gloves while providing wound care to Resident #7. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (Unit Manager). The findings included: Review of the facility's policy and procedure entitled Hand Hygiene read in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: a. Immediately before touching a resident. b. Before performing an aseptic task c. After contact with blood, body fluids, or contaminated surfaces. d. After touching a resident e. After touching the resident's environment f. Before moving from working on a soiled body site to a clean body site on the same resident; and g. Immediately after glove removal. A wound care observation was made on 05/22/25 at 9:13 AM on Resident #7 with the Unit Manager. The Unit Manager was observed cleaning the bedside table with disinfectant wipe and placed her wound supplies on the table after it dried. Unit Manager #1 donned a clean gown and clean gloves. She then removed the old dressing from the resident's sacrum and placed the soiled dressing onto the clean bedside table. She then proceeded to clean the area around the wound with a wound care solution and dry the area with gauze. The Unit Manager doffed her gloves and without sanitizing her hands, donned clean gloves and applied a collagen sheet with a dry dressing to Resident #7's wound. Using the same gloves the Unit Manager was observed assisting Resident #7's brief back on and lower the residents bed to a downward position. She then doffed her gown, washed her hands with soap and water, collected her supplies, wiped down the table and left the resident's room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 05/22/25 at 2:10 PM with the Unit Manager revealed she was aware that she had not sanitized her hands each time she had doffed her gloves. She stated she typically did not complete the dressing changes in the facility. However, the Wound Nurse had quit a couple of days before, so she was asked to perform wound care for the day. The Unit Manager stated she immediately realized she had not performed hand hygiene after the observation was made and knew she should have sanitized her hands in between or went into the resident's bathroom to wash her hands with soap and water. The Unit Manager also stated she should have placed the soiled dressing into the trash can instead of placing it onto the clean bedside table with the wound care supplies. An interview conducted on 05/22/25 at 10:57 AM with the Infection Preventionist (IP) revealed she was not aware of the errors made by the Unit Manager during wound care. She stated her expectation was that she would sanitize her hands every time that she removed her gloves and before putting on clean gloves during wound care. The IP further stated staff received education on infection control annually and multiple times during the year. An interview on 05/22/25 at 12:25 PM with the Director of Nursing (DON) revealed she was aware of the Unit Manager's errors during wound care and said she had been provided with additional education regarding doffing and donning and sanitizing in between glove changes. The DON stated it was her expectation that the Unit Manager followed infection control best practices to avoid introducing microorganisms into the wounds. She further stated the facility typically had a Wound Care Nurse however, she had left that same week, and the Unit Manager was asked to perform the dressing change for the day. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he would expect the Unit Manager to follow the Hand Hygiene policy for wound care.