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	11/20/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 5 residents reviewed for unnecessary medications (Resident #62).The findings included:Resident # 62 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, and anxiety disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] 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 antianxiety medications.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.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.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.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 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. 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.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.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.The findings included: 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.a. Resident #42 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #42 was moderately cognitively impaired, was able to understand and be understood by others and was coded for current use of tobacco. 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. The safe smoking evaluation dated 11/11/25 revealed Resident #42 required supervision while smoking. 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. b. Resident #23 was admitted to the facility on [DATE]. The annual MDS dated [DATE] revealed Resident #23 was moderately cognitively impaired, was able to understand and be understood by others and was not coded for current tobacco use. 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. The safe smoking evaluation dated 11/11/25 revealed Resident #23 required supervision when smoking. 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. c. Resident #18 was admitted to the facility on [DATE]. The annual MDS dated [DATE] revealed Resident #18 was cognitively intact and was coded for current tobacco use. The care plan dated 9/26/25 indicated Resident #18 had a focus area related to tobacco use and the interventions included supervision when smoking and utilizing a smoking apron for safety. The safe smoking evaluation dated 11/11/25 revealed Resident #18 required supervision when smoking. 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.d. Resident #78 was admitted to the facility on [DATE]. The admission MDS dated [DATE] revealed Resident #78 was cognitively intact and coded for current tobacco use. 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. The safe smoking evaluation dated 11/11/25 revealed Resident #78 required supervision when smoking. 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. 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 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).The findings included:Resident #9 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease (COPD), and type 2 diabetes mellitus.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.A review of Resident #9's electronic medical record (EMR) revealed a smoking assessment dated [DATE] 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.A review of the annual Minimum Data Set (MDS) dated [DATE] indicated Resident #9 was cognitively intact and was not coded for tobacco use.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.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.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.The findings included:Resident #62 was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis (condition where there is breakdown of cartilage in multiple sites throughout the body) and constipation.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.A review of Resident #32's Physician's Orders did not include Polyethylene Glycol and Acetaminophen to be given at 9:00 AM.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.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 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.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.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.