

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER The Rosewood Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8710 Cypress Club Drive Raleigh, NC 27615	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a comprehensive care plan that included interventions for high-risk medications for 1 of 5 residents (Resident # 25) reviewed for unnecessary medications.</p> <p>The findings included:</p> <p>1. Resident #25 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included hypertension and paroxysmal atrial fibrillation and nonrheumatic aortic (valve) stenosis.</p> <p>Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was moderately cognitively intact, was prescribed an anticoagulant (blood thinning medication) and had a diagnosis of hypertension (HTN) and paroxysmal atrial fibrillation.</p> <p>a. Physician order dated 2/4/25 revealed Resident #25 was prescribed Eliquis (anticoagulant) oral tablet 5 milligrams (mg) two times a day for atrial fibrillation.</p> <p>Medical record review revealed Resident # 25 had no care plan with interventions for the use of Eliquis.</p> <p>Review of Resident #25 medication administration record (MAR) for the months of March 2025, April 2025 and May 2025 revealed Resident #25 was administered Eliquis 5 mg 2 times a day.</p> <p>b. The Physician order dated 2/4/25 revealed administer Resident #25 Hydralazine HCl oral tablet 50 mg 3 times a day for hypertension. Further review of the physician orders revealed hydralazine HCl oral tablet 50 mg. Give 50 mg by mouth every 8 hours as needed (PRN) for HTN give for systolic blood pressure (SBP) greater (>) than 160.</p> <p>Review of the MAR for the months of March 2025, April 2025 and May 2025 revealed Resident #25 was administered Hydralazine HCl tablet 50 mg three times a day for hypertension.</p> <p>Review of the medical record revealed there was no care plan for hypertension with the use of Hydralazine HCl oral tablet 50 mg 3 times a day or the use of Hydralazine HCL PRN if SBP > 160.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The interview with the MDS Coordinator on 6/4/25 at 9:31 am revealed he would develop an individualized care plan for high-risk medications to include Resident #25's use of an anticoagulant. He further indicated the facility had a change in electronic medical records provider in February 2025. Resident #25 did not have a care plan for the use of an anticoagulant, and he must have missed creating the goals and interventions when transferring care plans to the new electronic medical record.</p> <p>An interview with the Director of Nursing on 6/4/25 at 10:11 am revealed Resident #25's use of an anticoagulant should have been care planned. The care plan should include monitoring for high-risk medications and interventions.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and physician interviews, the facility failed to administer medications as prescribed by the physician for resulting in significant medication error for 1 of 5 residents reviewed for unnecessary medications (Resident #25).</p> <p>The findings included:</p> <p>1. Resident #25 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included hypertension (HTN), history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, paroxysmal atrial fibrillation and nonrheumatic aortic (valve) stenosis, atherosclerotic heart disease of native coronary artery without angina pectoris, and peripheral vascular disease.</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was moderately cognitively impaired and had a diagnosis of hypertension. The annual MDS 5/29/25 was still in progress.</p> <p>Physician order dated 2/4/25 revealed administer Resident #25, Hydralazine HCl oral tablet 50 milligrams (mg). Give 50 mg by mouth every 8 hours as needed (PRN) for HTN give for systolic blood pressure (SBP) greater (>) than 160. Hydralazine is a medication used to treat high blood pressure and heart failure.</p> <p>Review of physician order dated 2/4/25 dated hydralazine HCl oral tablet 50 mg by mouth three times a day.</p> <p>a. Resident #25's blood pressure (BP) was reviewed in the electronic medical record which revealed a SBP of 169 on 3/22/25. Resident #25's blood pressure was taken by Nurse #3.</p> <p>Review of the Medication Administration Record (MAR) for the Month of March 2025 revealed the MAR was left blank on 3/22/25.</p> <p>Nursing progress notes for the month of March 2025 did not indicate if Resident#25 was administered the PRN hydralazine or not on 3/22/25. The nursing notes did not reveal Resident #25's blood pressure was rechecked for a SBP > or < 160.</p> <p>Interview with Nurse #3 on 6/4/25 at 1:26 pm revealed Resident #25 had heart medication that was PRN if his SBP was more than 160. She indicated if his blood pressure was 169 on 3/22/25 she should have provided the PRN medication. If there was no nursing note, it could have been because she rechecked the BP and it was lower. She further stated she could have also gotten busy and not completed a nursing note to state it had lowered. Nurse #3 revealed she would have also notified the oncoming nurse to monitor Resident #25 and recheck his BP due to fluctuations.</p> <p>b. Resident #25's blood pressure for 4/10/25 was reviewed in the electronic medical record. The blood pressure log revealed a SBP of 164 taken by Nurse #8.</p> <p>Review of the MAR for the month of April 2025 was left blank for 4/10/25.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing progress notes for the month of April 2025 did not indicate if Resident#25 was administered the PRN hydralazine or not on 4/10/25. The notes did not indicate Resident #25's BP was rechecked for a SBP > or < 160.</p> <p>Nurse #8 was out of the country and unavailable for interview.</p> <p>c. Resident #25's blood pressure was reviewed in the electronic medical record. The BP log revealed a SBP of 163 on 5/2/25 BP taken by Nurse #4, SBP of 162 on 5/8/25 taken by Nurse #5, SBP of 190 on 5/22/25 taken by Nurse #6 and SBP of 175 on 5/23/25 BP taken by Nurse #7.</p> <p>Review of the MAR for the month of May 2025 revealed it was left blank on 5/2/25, 5/8/25, 5/22/25 and 5/23/25.</p> <p>Nursing progress notes for the month of May 2025 did not indicate if Resident #25 was administered the PRN hydralazine on 5/2/25, 5/8/25, 5/22/25 and 5/23/25. The nursing progress notes did not indicate if Resident #25's BP was rechecked for a SBP > or < 160.</p> <p>Interview and observation of the MAR with Nurse #4 on 6/4/25 at 9:45 am revealed she passed medications to Resident #25 on 5/2/25. Nurse #4 stated there was nothing in the electronic system that would prompt the nurse to look at BP if it was higher than 160. Resident #25's BP would fluctuate easily so she would typically recheck the blood pressure herself. Resident #25 was on a standard dose of hydralazine 50 mg that he took three times a day which worked with Resident #25's BP. She further indicated if she had rechecked Resident #25's blood pressure she would have included it in a progress note. Nurse #4 indicated it would depend on the time she took the resident's blood pressure if she would have provided the PRN medication.</p> <p>Interview with Nurse #5 on 6/4/25 at 1:16 pm revealed she recalled working with Resident #25 on a couple of occasions. She stated when a nurse gave a resident a PRN medication, it should automatically generate a nurse's note. If she had not given the PRN there wouldn't be a nursing note. Nurse #5 stated she gave the medication, but she may have forgotten to sign the MAR.</p> <p>Interview with Nurse #6 on 6/4/25 at 7:55 pm revealed she was currently on shift and reviewing the MAR for Resident #25 for 5/22/25. She stated Resident #25's SPB was higher than 160 and she should have followed the physician order and administered Resident #25's PRN Hydralazine HCl. She stated she should have rechecked it to be sure and then given the PRN if the BP was still running high, and also report the high blood pressure to the resident's physician. She did not recall Resident #25 having any complications due to his SBP reading 195.</p> <p>An interview was attempted with Nurse #7. She was unavailable for an interview.</p> <p>Interview with the Director of Nursing (DON) on 6/4/25 at 10:11 am revealed she expected the nursing staff to follow physician orders as written. Upon observation of the MAR for the months of March 2025, April 2025 and May 2025, the DON stated the order for Hydralazine HCL PRN was not discontinued and should have been given when Resident #25's SBP was higher than 160.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident #25's Physician on 6/4/25 at 11:50 am revealed he would expect the facility to administer medications as he prescribed. If the medication was not administered as written he would further expect the nursing staff to document the reason why the medication was not provided. He further stated a systolic blood pressure of 195 could lead to a stroke or possible heart attack. Had he been contacted regarding Resident #25 a systolic blood pressure that was greater than 160 he would have advised the nurse to administer the PRN hydralazine he prescribed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on record review, observations, and staff interviews, the facility failed to discard the expired medications stored for use in 1 of 5 medication carts (300 Hall Medication Cart) reviewed for medication storage.</p> <p>The findings included:</p> <p>An observation of the 300- hall medication cart with Nurse #2 on 6/5/25 at 9:48 AM revealed three 16-ounce Children's Acetaminophen Oral Solution with an expiration date of 9/24/2024 on the pharmacy label and one, one-pint bottle of Chlorhexidine Gluconate 0.12% Oral Rinse was opened with no expiration date on the bottle or label. Nurse #2 was interviewed at the time of the observation and revealed she was not aware of the expired bottles of medication and the medication bottle with no expiration date. Nurse #2 stated expired medications or medications without an expiration date should not be in the medication cart. She further stated the expired medications and medication without an expiration date would be discarded.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/5/25 at 11:38 AM. The DON stated a pharmacy technician would perform medication cart audits monthly for expired medications. She also stated the night nurses were expected to check the medication cart for expired medications weekly. The DON revealed there was not a designated day of the week when nurses were expected to check the medication cart for expired medication. She further revealed expired medications were discarded in a drug buster (a product that facilitates the safe and eco-friendly disposal of unused or expired medications). The DON indicated there should be no expired medications in the medication carts and was not sure how the expired medications were missed and left in the cart. Lastly, she stated everyone was accountable for ensuring no expired medications were left in the medication cart.</p> <p>The Administrator was interviewed on 6/5/2025 at 11:45 AM. He stated medication carts were checked for expired medications weekly on night shift. He stated there was no designated day of the week for medication carts to be checked. The Administrator noted the pharmacy representative would audit the medication carts monthly for expired medications. He revealed expired medications were returned to the pharmacy or were disposed of in a secure medication disposal device. The Administrator further stated no expired medication should be in the medication carts. He noted there was a night shift audit failure since the pharmacy had not yet done the monthly audit.</p>		