

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/16/2026
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to provide a dignified dining experience when 1.) Nurse #3 stood up while providing assistance with eating to a resident (Resident #27), and 2.) staff did not ensure all residents seated at that table were served their meals at the same time when Resident #25 was served her meal more than 10 minutes after the remaining residents seated at the same table for 2 of 3 residents reviewed for dignity. A reasonable person expects to be treated with dignity while dining. Findings included:1. Resident #27 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was severely cognitively impaired and the resident required set up, clean up and needs supervision (oversight, encouragement, or cueing) assistance with eating. A continuous observation occurred on 7/14/26 from 12:17 pm through 12:39 pm of the lunch meal in the resident's dining room. Nurse #3 was observed providing assistance with eating to Resident #27 while standing next to the resident. Observation revealed a chair was available behind Nurse #3 at a table to her left. On 7/15/26 at 3:46 pm, interview with Nurse #3 revealed the facility's process was to sit down when providing feeding assistance to a resident. Nurse #3 indicated the facility provided education on feeding assistance during the yearly skills fair, on-line education modules, and as needed. Nurse #3 stated she was aware she must provide the residents with dignity and respect by sitting down when assisting with feeding. Nurse #3 indicated Resident #27 would sometimes try to feed himself if he's having a good day and Nurse #3 was trying to get him to feed himself by offering food to him. An attempt was made to interview Resident #27 but due to her cognitive status this could not be completed. Interview with the Director of Nursing (DON) on 07/15/26 at 4:01 pm revealed any staff providing feeding assistance to a resident were educated on the facility's policy and requirements to sit down while feeding to ensure all residents are treated with dignity and respect per regulation. The DON stated she was uncertain why Nurse #3 did not sit down when assisting Resident # 27. 2. Resident #25 was admitted to the facility on [DATE] with a diagnosis of dementia. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was severely cognitively impaired and required set up and clean up assistance with eating. A continuous observation occurred on 7/15/26 from 12:08 pm through 12:25 pm. The observation revealed Resident #25 was seated at a table with three other residents. The Dietary Assistant #1 was observed delivering the lunch meal to the three other residents at the table starting at 12:08 pm through 12:11 pm. The other three residents were observed eating their meal while Resident #25 waited to be served. Resident #25's lunch meal was not served until 12:25 pm. An attempt was made to interview Resident #25 but due to her cognitive status this could not be completed. Interview with the Dietary Manager on 07/15/26 at 1:02 pm revealed the usual practice should be to deliver their meal trays at the same time to provide (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with dignity and respect. The Dietary Manager also stated meal delivery was different from the facility's normal practice on the day of observation because the residents were served their meal trays one at a time to ensure the correct tray had been given to the resident. The Dietary Manager stated the process was to serve one table at a time, so all residents were eating at the same time. The Dietary Manager could not give a reason as to why meal delivery was different from the facility's normal process. The dietary staff were provided education via education modules on dignity and respect including sitting while assisting the resident eat. Dietary Assistant #1 who served Resident #25 completed education regarding aiding a resident with eating via an in-service during the annual skills fair on 12/10/25. Interview with the Director of Nursing (DON) on 07/15/26 at 4:04 pm revealed that any staff delivering meal trays to the residents must ensure meals are delivered to the entire table to maintain dignity and respect.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review, observation, and staff interviews, the facility failed to protect Residents private healthcare information (PHI) by leaving confidential medical information unattended, visible, and accessible to others on top of medication carts for 2 of 3 medication carts observed (100 hall medication cart and 400 hall medication cart). The findings included: a. On 07/16/2026 a continuous observation occurred from 8:12 AM to 8:25 AM of the medication cart on the 100-hall. The medication cart was left unattended with an empty medication blister packet face up exposing a resident's name, date of birth , medication name, medication dose, and medication frequency, an empty laxative bottle with a resident's label which exposed the resident's name and date of birth , and the facility's 24 hour report that was face up with many residents' PHI visible. During the time the medication cart was left unattended there were two residents sitting within 2 feet of the medication cart, and a Nurse Aide (NA) walked by the medication cart. During an interview on 7/16/2026 at 8:27 AM with Nurse #1, she explained when walking away from her medication cart, the top of the medication cart should not contain any visible resident information. Nurse #1 confirmed she had left a medication blister pack, a laxative bottle and the 24-hour report sheet all with resident information visible on top of her medication cart when she was not present at her medication cart. Nurse #1 acknowledged she did not ensure resident information was not visible to others. b. On 07/16/2026 a continuous observation occurred from 8:33 AM to 8:40 AM of the medication cart on the 400-hall. The medication cart was left unattended with a label from medication blister packet exposing a resident's name, date of birth , medication name, medication dose, and medication frequency, on top of the medication cart. During this time a housekeeper and dietary staff walked by. During an interview on 7/16/2026 at 8:40 AM with Nurse #2, she confirmed there was a label from the medication blister pack with resident information visible left on top of her medication cart. The nurse stated she would usually take the labels off the empty medication blister packets and shred them. Nurse #2 acknowledged she did not ensure resident information was not visible to others. An interview on 7/16/2026 at 10:42 AM with the Director of Nursing (DON) revealed the Nurses should not have walked away and left resident information visible for anyone walking by to see it. She indicated all resident PHI should be put away to protect resident's privacy whenever the medication cart was left unattended.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on record review, observation and staff interviews, the facility failed to secure medications and lock the medication cart for 1 of 3 medication carts observed for medication administration (100 Hall medication cart).The findings included:On 07/16/2026 at 8:25 AM, Nurse #1 placed the medication cart against the wall to the side of a resident's doorway. Nurse #1 then prepared medications to be administered to a resident. Nurse #1 removed 8 medication blister packets from the medication cart drawer, placed them on the top of the medication cart, and dispensed the medications into a medication cup for the resident. Nurse #1 then walked away from the medication cart and entered the resident room without securing the 8 medication blister packets that were on top of the medication cart and left the medication cart unlocked. The medication cart was out of sight from inside the resident's room. The medication cart lock system was electronic with a keypad that revealed a green flashing light when the medication cart was unlocked. When Nurse #1 walked away from the medication cart the flashing green light indicated it was not locked. The medications that were left unattended were as follows: allopurinol (blocks uric acid), aspirin, carvedilol (high blood pressure), docusate sodium, lisinopril (high blood pressure), memantine (Dementia), multivitamin, and pantoprazole sodium (acid reflux). During the time that Nurse #1 was not present at the medication cart, a housekeeper and an Occupational Therapist walked past the unlocked medication cart and the medications that were left on top of the cart. There were no residents in the area. During an interview on 7/16/2026 at 8:27 AM with Nurse #1, she explained that before leaving the medication cart, nurses were to make sure all medications were in the cart and that the medication cart was locked. Nurse #1 stated she usually placed the medications back in the cart and locked the medication cart before leaving it. The Nurse acknowledged she did not ensure the 8 medication blister packets were secured and the medication cart was locked when she went to administer the medications. Nurse #1 stated she didn't follow the process because she was being observed during the survey.An interview with the Director of Nursing (DON) took place on 7/16/2026 at 3:32 PM. The DON stated all nurses were to ensure medication carts were locked when unattended. The DON stated when doing a medication pass, nurses should bring the cart into the resident doorway, so the medication cart was in line of sight. The DON stated the Nurse was to place the medication blister packs back in the medication cart drawer once the medications were prepared and lock the medication cart. The DON stated she felt Nurse #1 was nervous and that was why the process was not followed.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to ensure the daily nurse staffing posting had the correct census for 15 of 23 days reviewed for (6/1/26 through 6/8/26) and (7/1/26 through 7/15/26). The findings included: A review of the facility's Daily Nurse staff posting from 6/1/26 through 6/8/26 and 7/1/26 through 7/15/26 revealed the following: Daily Nurse Staffing Information dated 6/1/26 revealed a resident census of 45. Review of the facilities detailed census report dated 6/1/26 revealed a resident census of 43. Daily Nurse Staffing Information dated 6/4/26 revealed a resident census of 46. Review of the facilities detailed census report dated 6/4/26 revealed a resident census of 45. Daily Nurse Staffing Information dated 6/5/26 revealed a resident census of 46. Review of the facilities detailed census report dated 6/5/26 revealed a resident census of 45. Daily Nurse Staffing Information dated 6/6/26 revealed a resident census of 46. Review of the facilities detailed census report dated 6/6/26 revealed a resident census of 48. Daily Nurse Staffing Information dated 6/7/26 revealed a resident census of 46. Review of the facilities detailed census report dated 6/7/26 revealed a resident census of 48. Daily Nurse Staffing Information dated 6/8/26 revealed a resident census of 48. Review of the facilities detailed census report dated 6/8/26 revealed a resident census of 47. Daily Nurse Staffing Information dated 7/1/26 revealed a resident census of 44. Review of the facilities detailed census report dated 7/1/26 revealed a resident census of 43. Daily Nurse Staffing Information dated 7/2/26 revealed a resident census of 44. Review of the facilities detailed census report dated 7/2/26 revealed a resident census of 43. Daily Nurse Staffing Information dated 7/3/26 revealed a resident census of 43. Review of the facilities detailed census report dated 7/3/26 revealed a resident census of 42. Daily Nurse Staffing Information dated 7/4/26 revealed a resident census of 44. Review of the facilities detailed census report dated 7/4/26 revealed a resident census of 42. Daily Nurse Staffing Information dated 7/6/26 revealed a resident census of 44. Review of the facilities detailed census report dated 7/6/26 revealed a resident census of 45. Daily Nurse Staffing Information dated 7/9/26 revealed a resident census of 45. Review of the facilities detailed census report dated 7/9/26 revealed a resident census of 44. Daily Nurse Staffing Information dated 7/12/26 revealed a resident census of 45. Review of the facilities detailed census report dated 7/12/26 revealed a resident census of 46. Daily Nurse Staffing Information dated 7/13/26 revealed a resident census of 45. Review of the facilities detailed census report dated 7/13/26 revealed a resident census of 46. Daily Nurse Staffing Information dated 7/15/26 revealed a resident census of 46. Review of the facilities detailed census report dated 7/15/26 revealed a resident census of 45. An interview was conducted with the Director of Nursing (DON) on 7/16/26 at 11:27 a.m. The DON explained that the Social Worker (SW) would send the resident census that was created the previous day at midnight to a member of the leadership team. The DON also explained that a bed hold could sometimes cause a discrepancy in the resident census on the Daily Nurse Staffing Information. The overnight nurse was responsible for posting the Daily Nurse Staffing Information including the resident census. Any changes that needed to be made to the Daily Nurse Staffing Information were to be completed by the Medical Records Coordinator. An interview with the Social Worker on 7/16/26 at 1:27 p.m. revealed she was responsible for completing a daily report which included resident bed hold information. She was unsure if the report she sent to the Administrator and DON was included in the resident census on the Daily Nurse Staffing Information. An interview with the Medical Records Coordinator on 7/16/26 at 12:08 p.m. revealed the night shift nurse was responsible for posting the Daily Nurse Staffing Information. The Medical Records Coordinator further revealed if the night shift nurse did not post the Daily Nurse Staffing Information, she would post it. She explained she would (continued on next page)		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	make any changes to the resident census but rarely ever had to. During a follow-up interview with the Medical Records Coordinator on 7/16/26 at 3:39 p.m. she revealed before today's date she had not been updating the daily resident census on the Daily Nurse Staffing Information. An interview with Administrator on 07/16/2026 1:37 p.m. revealed he was not sure of the process of updating the resident census on the Daily Nurse Staffing Information when there were admissions or discharges. During interview with night shift Nurse #4 on 7/16/2026 at 2:46 p.m., she revealed she completed and posted the Daily Nurse Staffing Information according to the midnight census. She stated she obtained the resident census by counting all residents in each hallway.		