STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEWOOD HEALTH CENTER	8710 CYPRESS CLUB DRIVE , RALEIGH, North Carolina, 27615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0001 SS = F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	E0001	[No data entered]	06/30/2025

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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E0001 SS = F	Continued from page 1 This CONDITION is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan for the facility, which is required to be reviewed annually. The facility also failed to include collaboration with local, regional, state, and federal EP officials. In addition, the failed to update contact information for the staff, physician, federal, state, and local emergency personnel, and failed to provide education to facility staff to be aware of where the EP plan was located within the facility. The findings included: A review of the facility's Emergency Preparedness plan on 6/5/25 revealed: a.The EP plan had not been reviewed and updated in its entirety since August 2023. b.The EP plan did not include updated contact information for the current facility staff and Medical Director. c.The EP plan did not include EP collaboration with local, regional, state, and federal EP officials to maintain an integrated response in the event of an emergency. d.The EP plan did not include emergency officials contact information for the federal, state, regional, or local emergency preparedness staff. The Minimum Data Set (MDS) Nurse was interviewed on 6/5/25 at 10:42 am and stated the emergency plan and contact information was in the chart room. He then showed a book labeled Emergency Plan, that contained only the current residents' names and room numbers with their respective identifiers. There were no emergency contacts information, such as federal, state, and regional emergency officials in the manual. During an interview with Nurse Aide (NA) #1 on 6/5/25 at 10:31 am she stated she could not find the EP plan	E0001		

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E0001 SS = F	Continued from page 2 at the first-floor nursing station and was not aware where the EP plan was kept. NA #2 was interviewed on 6/5/25 at 10:33 am and she revealed she didn't know where the EP plan was located. An interview with the Director of Facilities (oversees the functioning and maintenance of the buildings and grounds of the campus) on 6/5/25 at 10:00 am revealed that there were no logs to show when the EP plan was updated. An interview with the Assistant Director of Facilities and the Maintenance Supervisor on 6/5/25 at 10:05 am revealed the last update in the EP plan was in August 2023. The Maintenance Supervisor stated some sections of the EP plan had been reviewed, but he was unsure of the dates and the sections. The Maintenance Supervisor explained that some of the EP plan had been recently updated because the facility had recently conducted a fire drill. The Administrator was interviewed on 6/5/25 at 10:15 am and he stated the EP plan needed to be updated, and they would be updating the EP plan for completion and timely review.	E0001		
F0000	INITIAL COMMENTS An unannounced onsite recertification survey and complaint investigation were conducted from 06/02/2025 through 06/05/2025. Additional informtion was obtained off-site on 06/06/2025; therefore the exit date was changed to 06/06/2025. The following intakes were investigated: NC00230971, NC00222077, and NC00215507. 4 of the 4 complaint allegations did not result in deficiency. Event ID #JFV011.	F0000		
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F0640		06/30/2025

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F0640 SS = A	Continued from page 3 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State	F0640		

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F0640 SS = A	Continued from page 4 which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit to the Centers for Medicare and Medicaid Services (CMS) database a discharge Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for resident assessment (Resident #44). The findings included: Resident #44 was admitted to the facility on 01/03/2025. Facility documentation indicated Resident #44 had been discharged home on 01/24/2025. On 06/03/2025, Resident #44's MDS assessments were reviewed. There was no discharge assessment for Resident #44 initiated, completed or transmitted as required to the CMS database. An interview and review with the MDS Coordinator on 06/04/2025 at 9:37 AM was completed of Resident #44's MDS assessments in the electronic health record. The review revealed that Resident #44 had an entry assessment dated 01/03/2025 and an admission MDS assessment dated 01/13/2025 completed. The MDS Coordinator stated he should have opened a discharge assessment when Resident #44 returned home. He explained the facility was in the process of switching systems (February 2025) and the resident was not imported into the new system and therefore the missed assessment did not flag as not completed or overdue. The MDS Coordinator verbalized when he ran his missing assessment report this month (June 2025), the assessment would flag for being over 120 days. The MDS Coordinator stated he would open a discharge assessment for completion. An interview with the Director of Nursing (DON) was completed on 06/04/2025 at 11:23 AM who stated the MDS Coordinator should follow the Resident Assessment Instrument (RAI) Manual and its process for completing required assessments within the designated timeframes	F0640		

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F0640 SS = A	Continued from page 5 which includes the discharge assessment. The DON stated the assessment was missed when they transitioned to a new system.	F0640		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F0656	[No data entered]	06/30/2025

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F0656 SS = D	Continued from page 6 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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. The findings included: 1. Resident #25 was admitted to the facility on 10/18/21 and readmitted on 5/23/24 with a diagnosis that included hypertension and paroxysmal atrial fibrillation and nonrheumatic aortic (valve) stenosis. Minimum Data Set (MDS) assessment dated 2/26/25 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. 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. Medical record review revealed Resident # 25 had no care plan with interventions for the use of Eliquis. 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. 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.	F0656		

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F0656 SS = D	Continued from page 7 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. 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. 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. 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.	F0656		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: 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). The findings included:	F0760	[No data entered]	06/30/2025

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F0760 SS = E	Continued from page 8 1. Resident #25 was originally admitted to the facility on 10/18/21 and readmitted on 5/23/24 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. The Minimum Data Set (MDS) assessment dated 2/26/25 revealed Resident #25 was moderately cognitively impaired and had a diagnosis of hypertension. The annual MDS 5/29/25 was still in progress. 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. Review of physician order dated 2/4/25 dated hydralazine HCl oral tablet 50 mg by mouth three times a day. 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. Review of the Medication Administration Record (MAR) for the Month of March 2025 revealed the MAR was left blank on 3/22/25. 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. 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	F0760		

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F0760 SS = E	Continued from page 9 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. 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. Review of the MAR for the month of April 2025 was left blank for 4/10/25. 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. Nurse #8 was out of the country and unavailable for interview. 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. 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. 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. 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	F0760		

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F0760 SS = E	Continued from page 10 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. 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. 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. An interview was attempted with Nurse #7. She was unavailable for an interview. 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. 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.	F0760		

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F0760 SS = E F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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. The findings included: 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	F0760 F0761	[No data entered]	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEWOOD HEALTH CENTER	8710 CYPRESS CLUB DRIVE , RALEIGH, North Carolina, 27615

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F0761 SS = D	Continued from page 12 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. 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. 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.	F0761		