STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G292	A. BUILDING _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWOOD	4409 ROCKWOOD DRIVE RALEIGH, NC 27612

(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
W 000	INITIAL COMMENTS A complaint survey was completed on 10/10/24 for intake #NC00221904. The complaint was substantiated with deficiencies cited.	W 000		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific information regarding the use of his tablet. This affected 1 of 2 audit clients. The finding is: During morning observations in the home on 10/10/24 from 6:30am - 9:15am, client #4 was nonverbal and used gestures and body movements to communicate his wants and needs. The client was not prompted or assisted to use a tablet. Interview on 10/10/24 with Staff B revealed client #4 has two tablets for his use. Additional interview indicated one tablet was mainly used to communicate with his mom using an app while the other was to assist him with playing video games. Review on 10/10/24 of client #4's IPP dated 9/19/24 revealed no information regarding the client's tablets or how he should be assisted to utilize them. Interview on 10/10/24 with the Qualified Intellectual Disabilities Professional (QIDP)	W 240		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 240	Continued From page 1 confirmed client #4's tablets are not identified in his IPP and there was no information regarding their use.	W 240		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were effectively trained to ensure client #4 received necessary vital sign readings, his prescribed medications and staff documented on the MAR (Medication Administration Record) as appropriate. This affected 1 of 2 audit clients. The findings are: A. During observations of medication administration in the home on 10/10/24 at 8:55am, the Medication Technician (MT) dispensed Revia, Pepcid, Buspar, Centrum and Linzess medications a presented them to client #4 for ingestion. The client refused to take the medications and pushed the MT's hand away. The MT also attempted to place an O2 saturation device on the client's finger; however, he pushed the MT's hand away again. The MT attempted to give the client his medications and to take his O2 saturation twice more during the med pass. Client #4 continued to refuse. Immediate interview with the MT revealed they attempt to give him his medications and take his	W 340		

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W 340	Continued From page 2 O2 saturation three times and if he refuses, they call the triage nurse to report it. When asked how often client #4 refuses his medications, the staff stated, "Every other day...it's hit or miss." Review of client #4's MAR for September '24 and October '24 (through 10/10/24) revealed he refused prescribed medications and/or his blood pressure/pulse/O2 saturation/weight nine times in September '24 and seven times so far in October '24. Interview on 10/10/24 with the Home Supervisor confirmed client #4 will often refuse medications and treatments. Additional interview indicated they have tried taking his vitals when he's asleep but he's a light sleeper and will wake up when they enter his room. Interview on 10/10/24 with the Qualified Intellectual Disabilities Professional (QIDP) indicated MT's have not been given any specific guidance on how to obtain client #4's vitals or addressing his medication refusals. B. During morning observations in the home on 10/10/24 at 7:20am, Staff C placed a large vest over client #4's chest which remained in place for approximately 20 minutes before being removed by the staff. Immediate interview with Staff C revealed client #4 wears the vest before meals to assist him with eating without vomiting. Review on 10/10/24 of client #4's MAR dated September '24 and October '24 revealed an order, "Vest...apply vest twice a day and leave on for 20 minutes on an empty stomach...7:00am,	W 340		

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W 340	Continued From page 3 9:00pm." Additional review of both MARs revealed no documentation of the vest's use. Interview on 10/10/24 with the facility nurse and the QIDP confirmed client #4's vest should be utilized and documented on the MAR by the MT on the shift as indicated.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 2 clients (#2) observed to receive medications. The finding is: During observations of medication administration in the home on 10/10/24 at 8:50am, client #2 ingested Norethodron .35mg, Centrum, Keppra 500mg, Lamictal 200mg, Vitamin D3 1000IU, and Vimpat 50mg. Review on 10/10/24 of client #2's physician's orders and the Medication Administration Record (MAR) dated 9/12/24 revealed all medications ingested during the med pass at 8:50am on 10/10/24 were ordered for 7:00am. Immediate interview with the Medication Technician (MT) indicated they are trained to give medications 1 hour before or 1 hour after the prescribed time.	W 368		

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W 368	Continued From page 4 Interview on 10/10/24 with the facility nurse confirmed all medications ordered for 7:00am should be administered between 6:00am - 8:00am. The nurse indicated any amount of time after 8:00am would need to be reported to the triage nurse.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 clients (#2) observed to receive medications. The finding is: During observations of medication administration in the home on 10/10/24 at 8:50am, client #2 ingested Norethindrone .35mg, Centrum, Keppra 500mg, Lamictal 200mg, Vitamin D3 1000IU, and Vimpat 50mg. No other medications were ingested during this time. Review on 10/10/24 of client #2's physician's orders dated 9/12/24 revealed an order for Lactulose solution 10gm/15ml, take 60ml by mouth twice daily for elevated ammonia level and constipation, 7a, 7p. Interview on 10/10/24 with the facility nurse confirmed client #2 should have received Lactulose during the morning med pass as indicated.	W 369		