| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| ROCKWOOD | 4409 ROCKWOOD DRIVE RALEIGH, NC 27612 |

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| W 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on 3/21/25 for intake #NC00226826. The allegation was unsubstantiated, however related deficiencies were cited. A revisit was conducted for deficiencies cited on 12/31/24. Some deficiencies were corrected, however W460 and W489 remain out of compliance; with one new area of non-compliance identified at W436. | W 000 | | |
| W 153 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(2)<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure law enforcement were notified for an allegation of physical abuse. This affected 1 of 3 audit clients (former client #4). The finding is:<br><br>Record review on 3/21/25 revealed an abuse investigation involving the former client #4 (FC #4) and former staff A occurred on 1/13/25 in the home. The facility filed a report with Incident Response Improvement System (IRIS) on 1/13/25 accused former staff A of twisting FC #4's arm and not permitting him to stand to walk away from meal; with a conclusion on 1/16/25 of substantiated physical abuse.<br><br>Record review on 3/21/25 with the Raleigh Police Department revealed they did not receive any reports of abuse from the facility. | W 153 | | |

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

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| W 153 | Continued From page 1<br>Record review on 3/21/25 of the facility's Abuse Policy, revised May 2012 revealed the procedure outline staff are to report any suspected or known incidents of abuse/neglect resulting in injury to the individual. "He/she may also report to Law Enforcement..."<br><br>Interview on 3/21/25 with the Program Director revealed she did not make a police report for the incident because she did not know it was a requirement. | W 153 | | |
| W 331 | NURSING SERVICES<br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure nursing services were provided after an allegation of abuse for 1 of 3 audit (former client #4) clients. The finding is:<br><br>Record review on 3/21/25 of texted photographs from 1/14/25 of the former client #4 (FC #4) revealed redness on his knee cap and a small circular fading bruise on the back of the right arm. An additional review on 3/21/25 revealed the FC #4 had a doctor's visit on 1/14/25 to be fitted for a DMO suit. The doctor noted the FC #4 had "some redness on his arms..."<br><br>Interview on 3/21/25 with Staff F revealed she worked on 1/13/25 and observed during breakfast the FC #4 was supervised at breakfast by former staff A. FC #4 did not want to eat his food and stood up to leave several times but was not permitted to leave the table by former staff A. Staff F saw former staff A twist the right arm of | W 331 | | |

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| W 331 | Continued From page 2<br>FC #4 behind his back, and worried the arm could get fractured. Staff F acknowledged she was aware that the FC #4's right arm had been previously repaired and wanted to prevent re-injuring the arm.<br><br>Interview on 3/21/25 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed he was aware the FC #4 had previous surgical repairs to the right arm that was twisted by former staff A. The QIDP did not seek evaluation and treatment for the FC #4's arm but accompanied him to a medical appointment on 1/14/25 that was already scheduled for his scoliosis.<br><br>Interview on 3/21/25 with the Program Director confirmed the facility did not arrange nursing services for the FC #4 on 1/13/25 after the physical abuse and that she was unaware the arm had been previously repaired. | W 331 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to furnish a replacement chest strap, to improve posture for 1 of 3 audit clients (#5). The finding is:<br><br>During lunch observation in the home on 3/21/25 at 12:50pm, client #5 sat in her wheelchair during the meal and was leaning toward the table as she | W 436 | | |

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| W 436 | Continued From page 3<br>was fed by Staff F. There was no presence of a chest strap.<br><br>Record review on 3/21/25 of client #5's Feeding Protocol report on 2/20/25 revealed she should be "sitting with chest strap on to assist with maintaining an optimal posture for feeding (15-45 degrees wheelchair backrest recline). Additional record review of an email from the Occupational Therapist to the Site Supervisor to the on 3/19/25 acknowledged a report that client #5's chest strap had broke again after a recent repair.<br><br>Interview on 3/21/25 with the Site Supervisor revealed she began her position this week and recognized that client #5 did not have an extra chest strap to improve her posture during meals. The Site Supervisor revealed the strap broke because of rocking movements while sitting in the chair, that cause the strap to break. | W 436 | | |
| {W 460} | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(1)<br><br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to ensure 2 of 5 audits clients (#4 and #6) received a modified and specially prescribed diet. The findings are:<br><br>A. Observations in the home on 12/30/24 during lunch, 1:12pm-1:30pm, the Home Manager (HM) prepared tater tots, chicken patty and bread in a blender for client #6. The food was prepared | {W 460} | | |

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| {W 460} | Continued From page 4 | {W 460} | | |

mechanically soft. The Area Supervisor #1 (AS #1) was present in the dining room, examined the plate and was heard telling the HM the food needed to be processed longer to a puree consistency. The HM returned to the kitchen and blended the food longer. The chicken did not achieve a smooth blended consistency, but the tater tots and bread did. Client #6 was fed lunch while sitting in her wheelchair, and her face was hunched over her knees. The HM was observed to randomly push client #6 in an upright position with her left hand and also moved her forehead back, to get her to sit closer to the headrest.

Additional observations on 12/30/24 at dinner, at 5:05 pm, Staff D stood next to client #6's wheelchair and began feeding her chopped green beans, ground chicken and smooth mashed potatoes. Client #6 ate the food without incident.

Interview on 12/30/24 with the HM, while Staff D fed client #6 revealed she processed client #6's dinner to a mechanical ground consistency because of the dietary orders from 9/18/24 by the Registered Dietician that hung inside the kitchen cabinet. The HM acknowledged that she only served client #6's lunch pureed earlier because she was directed to do so by AS #1.

Observations in the home on 12/31/24 at 6:45am during breakfast, the second Area Supervisor (AS #2) processed instant oatmeal, toast, jelly and a fresh banana in the blender until processed smooth and blended. Staff B sat in front of client #6 at the table and fed her dinner, while client #6 sat in a tailor position, with the chest strap, high on her upper torso and leaned forward with her chin near the table's edge and consumed her meal, without incident.

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| {W 460} | Continued From page 5<br><br>Review on 12/30/24 of client #6's Hospital Discharge Summary from 9/27/23 to 10/2/23 due to a seizure revealed she had a diagnosis of dysphagia and was prescribed the International Dysphagia Diet Level 4 and Dysphagia Liquid, Level 0. The facility's nurse signed the summary on 10/3/24 that she reviewed the hospital's recommendations. In addition, client #6's Incident Report from 12/17/23 revealed she had food come out of her mouth and nose, during dinner and was sent to the emergency room.<br><br>Review on 12/30/24 of client #6's Incident Reports revealed on 11/17/24 on 2nd shift, revealed client #6 "was spitting a lot, sounded like mucous in chest when she coughed. Staff F tried to feed her and she choked on food/spit and spit up all food. 911 was called. Triage was called and she was taken to the emergency room (ER)." Furthermore, on 12/3/24 during dinner, client #6 ate steak, dinner salad and oranges when she began to "choke and spit food back up. She began to turn red and coughing. Attempted to hold both arms over her head. She continued to spit up, 911 was called."<br><br>Interview on 12/31/24 with the Qualified Intellectual Disabilities Professional #3 (QIDP #3) revealed he had trained the staff several times throughout the year on dietary orders. The QIDP #3 acknowledged that client #6 used to be on a pureed diet over a year ago but was switched to a mechanical soft/ground diet. The QIDP #3 confirmed there have been two recent choking incidents with client #6 in the home. The QIDP #3 revealed there were staff from another home working with client #6 on 12/3/24. The staff prepared her meal, consisting of steak and salad, | {W 460} | | |

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| {W 460} | Continued From page 6 | {W 460} | | |

cut up the meat with utensils instead of processing it in the blender. The QIDP #3 confirmed this caused client #6 to choke on her dinner and she was sent to the emergency room for treatment. The QIDP #3 also acknowledged that he was not aware the physician changed the diet orders back to pureed after examining client #6 on 12/5/24.

Interview on 12/31/24 with the Nurse revealed previously client #6 was placed on a pureed diet but she had been getting a mechanical soft diet for over a year. The Nurse did not know the reason the diet had been upgraded back to a mechanical soft consistency. The Nurse acknowledged she was part of the CORE Team and has been notified in their monthly meetings of any medical incidents involving the clients. The Nurse recalled she had reviewed the new order on from 12/5/24 to prepare all of client #6's pureed, and contacted the Family Nurse Practioner #2 (FNP #2) about clarifying the order and questioned if client #6 should be on mechanical soft. The Nurse revealed the doctor's practice has different FNP who see client #6 and FNP #1 wrote an order in September, 2024 for client #6 to be on a pureed diet but the Registered Dietician recommended a mechanical soft diet with nectar thick liquids on 9/18/24. The nurse also acknowledged that client #6 not sitting in an upright sitting position during meals, could contribute to choking during her meal. The nurse revealed she requested a Speech Language Swallow Study for client #6 after the last choking incident, but it has not been completed yet.

Interview on 12/31/24 with the AS #1 revealed she was aware client #6 should be on a pureed diet and told staff yesterday at lunch and dinner,

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| {W 460} | Continued From page 7 | {W 460} | | |

to be sure client #6 received a puree consistency.
B. During lunch and dinner observations on 12/30/24, client #4's meat was not ground, it was chopped into 1/2 pieces and he was not prompted to sip between bites. The majority of his liquid consumption occurred after his meal.

Record review on 12/30/24 of client #3's Dietary Assessment recommends a regular calorie diet, 1/4 inch pieces except all meat ground. Guidelines for meal time for September 24 recommend "alternate small bites (quarter sized) and offer sips between bites. small sips."

Interview on 12/31/24 with the Home Manger revealed she thought client #4's diet consistency was bite size, and he should be drinking between bites because he is an aspiration risk.

Interview on 12/31/24 with the Program Director revealed that she did not know client #4's diet consistency, but she was aware that he has an alternate food texture and has to have a 1:1 staff at meals. She was unsure of the sipping between bites recommendations. She advised staff will place a small amount of food on the plate for client #4 to eat and continue the same until he has consumed all of his meal.

Interview 12/31/24 will the AS #1 revealed that she was aware of client #4 being required to sip between bites according to what she remember from his dietary plan.

A revisit was conducted at the home on 3/21/25.

Observation of client #5 on 3/21/25 at 12:50pm revealed Staff F feeding regular consistency ravioli. The Site Supervisor walked into the dining

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| {W 460} | Continued From page 8<br>room and told Staff F the meal had to be pureed and had her stop feeding client #5 and return to the kitchen to process the food in the blender, until it had a texture like pudding.<br><br>Record review on 3/21/25 of a dietary list from 2/26/25 revealed client #5 should receive a pureed consistency diet.<br><br>Interview on 3/21/25 with Staff F revealed she worked with client #5 weekdays and revealed she was on a mechanically soft diet. Staff F acknowledged the ravioli was regular consistency but revealed "it was soft and could be mashed with a fork."<br><br>Interview on 3/21/25 with the Site Supervisor revealed client #5 should have received a pureed consistency meal.<br><br>Interview on 3/21/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he had conducted training and meal observations of staff since the last survey and staff had used the right diet consistency. | {W 460} | | |
| {W 489} | DINING AREAS AND SERVICE<br>CFR(s): 483.480(d)(5)<br><br>The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure all clients were fed in an upright position. This affected 1 of 5 audit clients (#6). The finding is:<br><br>Observations in the home on 12/30/24 during | {W 489} | | |

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lunch, 1:12pm-1:30pm, the Home Manager (HM) fed client #6 from her wheelchair, while client #6 was hunched over her folded knees, with chin close to the dining room table. The HM was observed to randomly push client #6 in an upright position with her left hand and also moved her forehead back, to get her to sit closer to the headrest. Client #6 was not using any shoulder or chest device to support her upper trunk. Client #6 also sat in a Tailor sitting position, the entire meal.

An additional observation on 12/31/24 at 7:15am, Staff B sat in front of client #6, seated in her wheelchair and fed her breakfast. Client #6 did not sit up right and was hunched over in the wheelchair with her face close to the table's edge.

Record review on 12/31/24 of the Occupational Therapy In-service dated 11/12/24 for client #6's feeding protocol revealed the following terms: "Please make sure [client #6] is sitting upright chest strap on to assist with maintaining an optimal posture for feeding (15-45 degrees wheelchair backrest recline). In addition to the chest strap, staff may offer intermittent physical prompts to sit straight (as much as possible). Please maintain this position during and 30 minutes after feeding."

An Interview on 12/31/24 with Staff B revealed she was aware client #6 was not sitting upright when she fed her, but responded, "she still has to get fed."

An interview on 12/31/24 with the HM revealed client #6 used to have a chest harness like client #2 to help her sit upright but the Occupational Therapist (OT) discontinued it last month, allowing staff to just use a chest strap. When

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asked why would the OT write an order to discontinue the chest harness, the HM responded because it was felt client #6 was most comfortable sitting in with her knees (tailer sitting position) and she could not sit that way with the harness.

An interview on 12/31/24 with the nurse revealed she was part of the CORE TEAM and client #6's choking incidents had been reported at their monthly meetings. The Nurse acknowledged client #6 was supposed to sit upright during her meals. The Nurse also acknowledged client #6 not sitting upright could contribute to her choking on her foods during meals.

An interview on 12/31/24 with the Area Supervisor #1 (AS#1) revealed the OT had changed the order last month to discontinue the shoulder/chest harness, to help support client #6 sit upright. The AS #1 also acknowledged client #6 was unable to independently sit up right in her wheelchair.

A revisit on 3/21/25 was conducted.

During lunch observation in the home on 3/21/25 at 12:50pm, Staff F fed client #5 in her reclined wheelchair. Client #5 was leaning forward with her face inches away from the table. Staff F was able to get client #5 to hold her cup and drink in a more upright position by propping her elbows on the arms of her wheelchair.

Record review on 3/21/25 of client #5's Feeding Protocol report on 2/20/25 revealed she should be "sitting with chest strap on to assist with maintaining an optimal posture for feeding (15-45 degrees wheelchair backrest recline). Staff may

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| {W 489} | Continued From page 11<br>use intermittent physical prompts to sit her upright (as much as possible). The position should be maintained during and 30 minutes after feeding.<br><br>Interview on 3/21/25 with Staff F acknowledged client #5 did not sit up while eating lunch.<br><br>Interview on 3/21/25, the Site Supervisor anknowledged client #5 did not sit up during lunch because her chest strap was broken. | {W 489} | | |