

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER ROCKWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 125	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client (#6) had the right to a court appointed legal guardian. This affected 1 of 3 newly admitted audit clients. The finding is:</p> <p>Review on 12/29/25 of client #6's record revealed there is no documentation of guardianship. Further review of client #6's Individual Program Plan (IPP) dated 2/7/25 revealed a family member is her guardian.</p> <p>During an interview on 12/30/25, the Program Director confirmed there is no documentation in client #6's record indicating who her legally appointed guardian is.</p>	W 125			
W 263	<p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 5 audit clients (#3 and #6). The findings are:</p> <p>A. Review on 12/29/25 of client #3's Behavior</p>	W 263			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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W 263	Continued From page 1 Support Plan (BSP) dated 12/5/25, revealed she did not have a current BSP consent in her chart. Further review revealed client #3 has behavior medications. B. Review on 12/29/25 of client #6's BSP dated 12/5/25, revealed she did not have a current BSP consent in her chart. Further review revealed client #6 has behavior medications. During an interview on 12/30/25, the Program Director confirmed clients #3 and #6 did not have current BSP consents signed by their legal guardians.	W 263			
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications remained locked except when being prepared for administration. The finding is: During medication administration in the home on 12/30/25 at 6:07am, Staff A exited the medication room following after client #4 because she did not take her medication. Further observations revealed the medication box was sitting on the table, while the surveyor was in the room alone. During an interview on 12/30/25, Staff A stated he is aware not to leave medications unattended. During an interview on 12/30/25, the facility's nurse confirmed medications are not to be left	W 382			

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W 382	Continued From page 2 unattended.	W 382			
W 388	DRUG LABELING CFR(s): 483.460(m)(1)(i) Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were labeled appropriately. This effected client 1 of 5 audit clients (#2). The finding is: During medication administration in the home on 12/30/25 client #2's Dorzolamide eye drops did not have a label on either the box or the eye drop bottle. During an interview on 12/30/25, Staff A confirmed client #2's Dorzolamide eye drops were not labeled. During an interview on 12/30/25, the facility's nurse confirmed medications are to have a label on them.	W 388			
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible	W 455			

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W 455	<p>Continued From page 3</p> <p>cross-contamination. This potentially affected 2 of 5 clients (#1 and #4) living in the home. The finding is:</p> <p>During dinner observations in the home on 12/29/25 at 6:04pm, client #4 was observed using her fingers to scoop food off her plate and onto her fork and then eat. Client #4 then reached for the pitcher that contained orange juice and poured some into her cup. At 6:05pm, client #1 then reached for the pitcher and poured herself some of the orange juice. Further observations revealed at 6:09pm, client #4 touched inside of a bowl of rice to pull it towards her. At 6:10pm, client #4 then had physical assistance with her right hand to scoop some of the rice onto her plate; at the same time she used her left hand to reach where the serving spoon of rice was still over the bowl of rice. Client #4 then left go the rice and some fell into the serving bowl and then client #1 independently scooped some of th rice onto her plate. At no time where client #4's hands sanitized during thr process.</p> <p>During an interview on 12/30/25, the Site Supervisor stated the pitcher handle should have been wiped off prior to client #1 touched it. Further interview revealed the bowl of rice should have ben discarded after client #4 put her hand in it.</p>	W 455			