

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

PRINTED: 03/06/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER ROCKWELL 1 & 2			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 152 EAST 6330 ROCKWELL, NC 28138		
(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the governing body failed to exercise general policy, budget, and operating direction over the facility relative to maintenance and repair. The findings are: A. The facility failed to address multiple areas of maintenance and repair at Rockwell 2. For example: Observation throughout the 3/3-4/26 survey revealed three couches present in the living room with numerous areas of wear and missing fabric. Continued observation in the living room revealed the ceiling to be damaged and crumbling. Further observation throughout the home revealed numerous areas of drywall patch and drywall exposure. Additional observations revealed damage to the floor in the kitchen and medication room. Subsequent observations revealed a missing mirror in the hallway bathroom, a broken closest doorknob with exposed screws in client #8's bedroom, and damaged bedroom furniture stacked on the front porch. Review of facility records on 3/4/26 revealed two work orders dated 12/6/25 which indicated "baseboards and walls need painting; and floors need replacing in kitchen." Continued review of facility records revealed two work orders dated 10/10/25 which indicated "ceiling in living room needs repaired (water spots); chairs/sofa needs replacing." Further review of facility records revealed another work order dated 10/8/25 which	W 104	A. The business manager will in-service maintenance coordinator on completing work orders in a timely manner. The clinical team will monitor through environmental assessments 2x/week for a period of 30-days and then continue on a routine basis to ensure all work orders are completed. Will ensure that the maintenance coordinator will ensure all work orders are completed in a timely manner based on the level of need. B. The business manager will in-service the maintenance coordinator on completing work orders in a timely manner as based on need. The clinical team will monitor through the environmental assessments 2x/week for a period of 30-days and then on a routine basis to ensure all work orders are completed in a timely manner. Couches for the living room will be ordered, delivered and replaced. Work orders have been placed on the spreadsheet. Business Manager is in the process of obtaining quotes from potential vendors to complete the drywall, and damages to the floor in the kitchen and medication room. Work orders have been placed for the exposed doorknobs and mirror replacement. WA work order will be placed for furniture removal from the front porch. Updated work orders will be placed to address exposed screws. Follow up emails, and phone calls with the Business Manager will occur on a weekly basis for status checks Maintenance Coordinator, Business Manager and Executive Director will complete weekly status reviews on work orders. Business Manager will obtain three vendor quotes as required prior to choosing appropriate vendor for the job. QP will place an order for replacement couches and is expected to arrive to the home no later than April 10, 2026.		

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

Anais Winton

TITLE

Executive Director

(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.

APR 06 2026

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W 104	Continued From page 1 Indicated "kitchen floors need repairing, baseboards need painting." Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/26 revealed they were aware of the maintenance and repair needs at Rockwell 2. Continued interview confirmed the facility has taken no action to address the maintenance and repair needs at Rockwell 2. B. The facility failed to address areas of maintenance and repair at Rockwell 1. For example: Observations in the Rockwell 1 home throughout the 3/3/26 - 3/4/26 survey revealed a couch present in the living room and further revealed the couch to smell strongly of urine. Further observation revealed no functioning lights in the bedroom/bathroom hallway used by all clients. Continued observation revealed a bathroom which is under construction and in need of completion as it presents an unsafe situation for all clients. Review of facility records on 3/4/26 revealed work orders dated 3/18/25 and 10/13/25, each stating, "Sofa in living room needs to be replaced, smells of urine." Further record review revealed a spreadsheet of requested repairs and maintenance for the Rockwell 1 home containing notations regarding the hallway lights and the unfinished bathroom. According to the spreadsheet, the hallway light replacement was requested on 12/17/25 and the bathroom repair was requested on 11/3/25. The spreadsheet also reveals that no work has begun with respect to these issues.	W 104	QP will in-service staff on the importance of maintaining the cleanliness of yhe home. DSS or Mentor will complete monthly environmental assessments. Business Manager will obtain three potential vendor quotes for kitchen floor repairs Business Manager will update via email vendor outcomes and update in-person during weekly briefings Maintenance Coordinator will some aspects of the work orders that are in his purview and provide statis updates during weekly meetings with the Executive Director Maintenance Coordinator and Executive Director will meet on a weekly basis to review statis on work orders QP will order a new couch and coordinate with Mainetance Coordinator, the disposal of present couch QP will complete a subsequent work order for the repair of the lights in the bedroom and hallway Business Manager will obtain the required three potential vendor quote for bathroom construction. Business Manager will provide weekly status updates regarding the ouctome of quotes and any potential vendors and start dates for bathroom completion. Business Manager will provide weekly status updates during brefing meetings. Business Manager will provide a start date once the vendor quote is approved. Executive Director and Maintenance Coordinator wil meet weekly to discuss the status of outstanding repairs that are in his purview to complete.		

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W 104	Continued From page 2 Interview with the QIDP on 3/4/26 confirmed that they are aware of the repairs and maintenance needs in Rockwell 1. Further interview confirmed that the facility has taken no action to address the repair and maintenance issues.	W 104	QP and/or DSS will continue to submit work orders for the home. Executive Director and Maintenance Coordinator will meet on weekly basis to review status of work orders. Business Manager will update weekly the status of work orders and quotes for larger repairs		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 2 of 6 clients in the Rockwell 1 home (#3 and #5) during care and treatment. The findings are: A. Observations in the group home on 3/4/26 at 8:00 AM, revealed staff to escort client #3 to the restroom. Further observation revealed staff to leave client #3 on the toilet with the restroom door open, where client could be seen from the hallway, until 8:30 AM. Continued observation revealed the door to remain open and the client to remain visible from the hallway during the entire 30 minute period. B. Observations in the group home on 3/4/26 at 7:00 AM revealed staff to direct client #5 to walk from their bedroom to the bathroom at the end of a common hallway for a shower and client #5 to comply with this direction. Further observation revealed client #5 to be dressed in a shirt and an adult disposable brief, but no pants. Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/26 confirmed that all clients should be given privacy during care and	W 130	A. The QP will facilitate in-service with staff as it relates to residents' privacy rights and how to appropriately exercise those rights for the individuals we support. The clinical team will monitor through interaction assessments 2x/week for a period of 30-days. Bi-weekly meetings will begin after the 30-day period ends. QP will ensure staff are trained properly and direct staff will be monitored by the QP, DSS, and the Mentor. B. QP will inform via the in-service that clients have the right to privacy when they are in their bedrooms and the bathroom. Bathroom doors are to be closed while the residents are toileting, showering, and completing any other intimate activities. Staff are to close the residents' bedroom doors when they are changing clothes, sleeping, grooming, etc. QP will complete an in-service with staff to inform/remind them that residents are expected to be fully dressed when they are not in the privacy of their rooms or in the bathroom. Staff are responsible for ensuring residents are dressed appropriately in all shared areas of the home. If/when staff fail to follow the privacy protocol, they will face corrective action.		

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W 130 W 247	Continued From page 3 treatment. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure that 3 of 6 clients in the Rockwell 1 home (#3, #4 and #5) were given opportunities for choice and self-management with respect to food selection. The findings are: Observations in the group home during the dinner meal on 3/3/26 revealed the menu to call for pizza, salad and yogurt. Further observation revealed that, although the pizza was available and served to the other three clients in the home, clients #3, #4 and #5 were served canned pasta instead of the pizza. Continued observation revealed client #5 to request pizza and the staff to tell client #5 to just eat their spaghetti. Record review on 3/4/26 revealed that clients #3, #4, and #5 are prescribed a ground consistency diet, while the remaining clients are prescribed diets which are either pureed or cut into 1/2" pieces. Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/26 revealed that there is no reason that the pizza could not have been modified to a ground consistency and offered to the three clients who require a ground diet. Further interview with the QIDP confirmed that clients should be offered opportunities to choose	W 130 W 247	The QP will facilitate an in-service on the subject of self-management of choice for the residents. Staff are to ensure that they offer the residents a minimum of two food choices. The clinical team will monitor through meal assessments 2x/week for a period of 30-days. After the 30-day period, monitoring will continue to occur during all meal times. DSS and the Mentor are to ensure that staff continue to provide food choices to the residents. Client #3; #4; #5: Staff will provide a minimum of two food choices to residents during meal time. If/When residents are unable to receive their food choice, staff are required to provide an explanation to the resident(s) as to why they are unable to receive their preferred choice. DSS will ensure that there is adequate amounts of food choices in the home for the residents. Clients #3; #4; #5: QP will facilitate in-service with staff to inform/remind them of the capability of processing foods to the documented modified diet textures in order for all residents to consume and enjoy the same foods. QP will review with staff how to utilize the blender and/or food processor to safely change the textures whenever applicable. DSS and/or the Mentor will monitor the food textures for all meals. DSS will ensure that direct care staff are continuously providing the residents with food choices.		

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W 247	Continued From page 4	W 247			
W 249	which foods they prefer to eat. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan (PCP) for 6 of 6 clients in the Rockwell 1 home (#1, #2, #3, #4, #5 and #6) relative to implementing training objectives and providing adaptive equipment. The findings are: A. The facility failed to provide adaptive equipment for client #6 during mealtimes. For example: Observations in the home on 3/3/26 during the dinner meal and 3/4/26 during the breakfast meal revealed a place setting laid on the dining room table for client #6 which included a high-sided divided dish, a maroon spoon, a non-skid mat and 2 regular cups. Further observation revealed client #6 to drink from the regular cups during the dinner, but not during breakfast.	W 249	QP will provide an in-service to staff regarding the continuation of appropriate and meaningful active treatment services as needed to promote successful completion. QP and DSS will review documentation in Therap to ensure that program goals are being documented. QP & Executive Director will meet on a weekly basis to review the residents' active treatment programs. Clients #1 - #6; QP will provide an in-service to staff regarding documented adaptive equipment to assist with residents with self-management. QP will ensure that staff are aware of the equipment needs for the identified resident well as proper use of the equipment. QP and DSS will ensure the house has the identified adaptive equipment in the home. DSS and Mentor will monitor staff during to confirm the equipment is being correctly used for g resident DSS, Mentor, and QP (when available) will review the equipment to ensure they are in good condition.		

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W 249	Continued From page 5 Record review revealed a PCP dated 10/21/25 for client #6. Continued review revealed that among client #6's dining and diet supports, occupational therapy "(OT) has recommended a high sided divided dish, flow troll cup, and maroon spoon to help keep client #6 safe during mealtime." Interview with the Qualified Intellectual Disability Professional (QIDP) on 3/4/26 confirmed that client #6's PCP, including dining recommendations, is current and that client #6 should have been provided with a controlled flow cup for their safety during mealtimes. B. The facility failed to implement training objectives and provide an adequate active treatment program for clients #1, #2, #3, #4, #5 and #6 during large amounts of unstructured leisure time. For example: Afternoon observations on 3/3/26 revealed the six clients who reside in Rockwell 1, #1, #2, #3, #4, #5 and #6 to sit in the living room of the home with the television on and without staff interacting with or prompting the clients to engage in any activities other than eating, removing dishes to the sink and personal hygiene for 105 minutes. During this time, staff performed tasks such as preparing dinner, setting the dining room table, preparing lunches for the next day, sweeping the dining room floor and wiping the dining room table without requesting any assistance from clients. Morning observations on 3/4/26 revealed clients #1, #2, #3, #4, #5 and #6 to sit in the living room of the home with the television on and without staff interacting with or prompting the clients to	W 249	QP will provide an inservice during house meeting too review/remind staff of the adaptive equipment recommended and introduced via occupational therapy. DSS and Mentor will monitor staff during mealtimes to confirm the inclusion of the controlled flow cup for the identified client(s). QP and Executive Director will review residents' adaptive equipment on a weekly basis. DSS and QP will review adapative equipment in the home on a monthly basis, or more often as needed. Clients #1 - #6; QP will facilitate an in-service to review/remind staff of their responsibility to actively engage with the residents to promote social interaction. Staff are responsibe for including the residents with activities which aid in self-management and independence. At no time are staff to utilize the TV or any other electronic device in lieu of personal engagement or social interaction. DSS, Mentor and QP are to ensure staff are appropriately interacting with the residents.		

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W 249	Continued From page 6 engage in any activities other than eating, removing dishes to the sink and personal hygiene for 120 minutes. Record review revealed a PCP for client #1 dated 5/7/25 which includes goals such as matching colors, stacking blocks and assisting with laundry. Record review revealed a PCP for client #2 dated 3/21/25 which includes goals such as cleaning their glasses, matching shapes and using sign language. Record review revealed a PCP for client #3 dated 4/14/25 which includes goals such as using a sensory board or other sensory activity, imitating clothing words, placing mealtime items in a bin, participating in oral hygiene care and assisting with punching their medications. Record review revealed a PCP for client #4 dated 2/16/26 which includes goals such as attending to a puzzle, tolerating oral hygiene, and selecting a shirt and pants. Record review revealed a PCP for client #5 dated 10/9/25 which includes goals such as sorting silverware, matching coins, making their bed and cleaning their walker. Record review revealed a PCP for client #6 dated 10/21/25 which includes goals such as matching tokens to cards, matching colors, placing clothes in the washing machine and using appropriate table manners. Interview with the QIDP on 3/4/26 confirmed that all clients' goals are current. Continued interview with the QIDP confirmed that staff should have	W 249	QP will facilitate an in-service to remind/ inform staff of the responsibility of promoting active treatment and program goals with the residents as it relates to their established items, duration, intensity, and frequency. Staff are expected to become familiar with the residents' PCP. QP, DSS, and Mentor will need to continue daily monitoring of active treatment and/or established program goals. QP & DSS will monitor documentation in Therap to ensure staff are completing goals with the residents.\ QP and DSS need to ensure that all items needed for atctive treatment are available to the residents and staff. DSS and Mentor will monitor all staff with resident goals during all shifts Executive Director and QP wil have weekly meetings to discuss resident active treatment and documentation in Therap. Staff will receive corrective action if it has been determined goal and/or program documentation has not been completed.		

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W 249	Continued From page 7 provided choices of activities and/or preferred items to all clients during leisure time.	W 249			
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 observation, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 12 clients (client #6) observed during medication administration. The finding is: During observations in the Rockwell 1 home on 3/4/26 at 7:35 AM, client #6 was observed to enter the medication room with staff and to be administered the following medications: divalproex, levothyroxine, naltrexone, senna, benztropine, cyproheptad, glycopyrrol, clonazepam, and olanzapine. Continued observations revealed client #6 to swallow all medications with applesauce at 7:44 AM. Review on 3/4/26 of client #6's physician's orders dated 3/4/26 revealed that the levothyroxine prescription indicates this medication is to be administered at 6:00 AM. Interview with the facility nurse on 3/4/26 confirmed that the prescription order is current and that the levothyroxine should have been administered between 5:00 AM and 7:00 AM.	W 369	Nursing staff will complete an in-service with staff during the subsequent house meeting to review correct medication administration. Client #6: Nursing staff will review the established times for medications and the windows of time to administer medications to avoid medication errors. Nursing staff will review the correct food items that the medication(s) can be given with safely. Nursing staff will continue to complete medication errors in Therap as needed. Nursing staff will conduct impromptu suervisions or monitoring of staff as needed as it reoates to medication administration. Nursing staff will meet with Executive Director on a weekly basis to discuss medication concerns as if staff will need to be removed from the medication administration list in order to be retrained. DSS and/or Mentor will observe staff during medication administration if there is concern over accuracy. If staff obtain two medication errors within the same year, staff will be subject to separation of employment.		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv)	W 420			

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W 420	Continued From page 8 The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide functional furniture, appropriate to the client's needs for 4 of 6 audited clients at Rockwell 2 (#7, #9, #10, #11). The finding is: Observation throughout the 3/3-4/26 survey revealed client #7's room to be missing blinds and curtains and no treatments on the bedroom windows. Continued observation revealed several large holes in the top of client #9's dresser. Further observations revealed broken blinds in client #10's bedroom. Additional observations revealed client #11's bed to have a broken headboard. Review of facility records on 3/4/26 revealed a work order dated 12/6/25 which indicated "client #10's blinds need replacing." Continued review of facility records revealed a work order dated 10/10/25 which indicated "client #9's dresser needs replaced." Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/26 revealed they were aware of the needs for client's #7, #9, and #10, and were unaware of client #11's damaged headboard. Continued interview confirmed the facility has taken no action to address the furniture needs for the clients at Rockwell 2.	W 420	QP will order appropriate furniture via the Business Office Manager. QP will obtain weekly status updates on the furniture order and anticipated delivery. QP and Executive Director will meet weekly to discuss the status of furniture orders and/or repairs. Executive Director and Maintenance Coordinator will meet weekly to review maintenance orders and the status. Business Manager will meet weekly with Executive Director and the Clinical Team to update status of work orders and furniture orders.		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair,	W 436			

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NAME OF PROVIDER OR SUPPLIER ROCKWELL 1 & 2			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 162 EAST 6330 ROCKWELL, NC 28138		
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W 436	Continued From page 9 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: Based on observations, record review and interviews, the facility failed to ensure that 1 of 12 clients (#3) was taught to wear his gait vest and helmet and make informed choices about their use. The finding is: During observations in the Rockwell 1 group home on 3/3/26 and 3/4/26, client #3 was observed doing various activities, including ambulating around the home. At no time during observations was client #3 observed to wear a gait vest or a helmet, nor were staff observed to prompt client #3 to wear such items. Review of client #3's record on 3/4/26 revealed an Person-Centered Plan (PCP) for client #3 dated 4/14/25. The PCP contains an Adaptive Equipment Summary including a gait vest to be used to assist with ambulation when client #3 is walking as well as a helmet to be used for safety due to the risk of falling, also to be used whenever client #3 is ambulating. Interview with the qualified intellectual disabilities professional (QIDP) on 3/4/26 revealed that client #3 should be provided with the gait belt and safety helmet whenever they are out of bed and walking around in their home.	W 436	QP will conduct an inservice with staff during the subsequent house meeting to review client #3 equipment and to remind them of the importance of wearing the adaptive equipment as prescribed. QP will review client #3 PCP with staff during house meeting to ensure understanding and compliance as it relates to client #3, especially during ambulation. DSS and Mentor will monitor staff during all hours where client #3 is ambulating to ensure the required gait vest and helmet are being worn. Executive Director and QP will review all clients on a weekly basis. QP and DSS will ensure that client #3 adaptive equipment is not damaged. Staff who fail to follow established protocols and procedures for client #3 will be subject to corrective action.		