

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation during this survey, Event ID# WFNJ11.	F 000			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility identified a raised bathroom doorway threshold caused a fall and failed to adjust the doorway to prevent further falls for 1 of 2 sampled residents at risk for falls (Resident #57). The findings included: Resident #57 was admitted to the facility on 07/31/13 with diagnoses which included a history of falls and hemiplegia due to cerebral vascular disease. Review of a nursing note, written by Nurse #5, dated 01/06/14 revealed Resident #57 seated on the floor of the bathroom doorway. Resident #57 reported to Nurse #5 the fall occurred when he rolled into the bathroom and stood.	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 323 Free of Accidents Hazards/Supervision/Devices Corrective Action: Resident # 57 last fall was on 11/16/2014 with no injury. The bathroom threshold was adjusted by the Maintenance Director on 11/25/2014.	12/18/14	

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

TITLE

(X6) DATE

Electronically Signed

12/12/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 323	<p>Continued From page 1</p> <p>Review of Resident #57's annual Minimum Data Set (MDS) dated 08/02/14 revealed an assessment of intact cognition and no falls since the prior assessment of 05/04/14.</p> <p>Review of a physical therapy evaluation dated 09/04/14 revealed Resident #57 could use a rolling walker with contact guard assistance with independence in wheelchair use.</p> <p>Review of Resident #57's quarterly MDS dated 11/02/14 revealed an assessment of intact cognition with independence in locomotion.</p> <p>Review of Resident #57's care plan dated 11/05/14 revealed a risk for falls. Interventions included frequent safety reminders and record possible root causes.</p> <p>Review of a nursing note dated 11/16/14 written by Nurse #1 revealed Resident #57 fell in the bathroom doorway. Nurse #1 documented Resident #57 "in rolling w/c (wheelchair) attempting to get over hump on floor between BR (bathroom) and room pushed self onto floor." The fall did not injure Resident #57 and the physician, nursing supervisor and Resident #57's family member received notification.</p> <p>Review of a fall investigation report dated 11/16/14 revealed a predisposing environmental factor contributed to the fall. A revision to Resident #57's care plan dated 11/16/14 specified: "Staff will continue to remind me to call for staff assistance since I will not agree to use an alarm on me."</p> <p>Interview with Nurse # 2 on 11/18/14 at 10:55 AM revealed the raised threshold in the bathroom</p>	F 323	<p>The Interdisciplinary team (Nursing, SS, Dietary, Activities and Therapy as applicable) reviewed the fall care plan to ensure interventions in place were appropriate interventions.</p> <p>Identification of other residents who may be involved with this practice: All residents who utilize a w/c and who are capable of self-transferring and capable of using the bathroom have the potential to be affected. All residents were assessed on December 8, 2014 by the interdisciplinary team which includes DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed to identify residents who require an intervention to the bathroom threshold. This review revealed: 22 Rooms with bathroom thresholds needing priority adjustments. The completion date for these adjustments will be December 18, 2014. All other bathroom thresholds will have adjustments completed by February 28, 2015.</p> <p>All fall incidents for the last 30 days were reviewed at the Clinical QA Meeting on 12/4/2014 for any incidents that occurred in the bathroom that were related to the bathroom door threshold. This revealed no other incidents involving the bathroom threshold. The Daily Clinical Meeting includes DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 323	<p>Continued From page 2</p> <p>doorway caused Resident #57's fall on 11/16/14. Nurse #2 explained the "bump" in the doorway was difficult for residents using wheelchairs and walkers.</p> <p>Observation on 11/19/14 at 8:42 AM revealed the bathroom door threshold's height was approximately ½ inch and approximately 2 inches wide. The threshold strip separated the room floor and the tiled bathroom floor.</p> <p>Interview with Nurse #1 on 11/19/14 at 10:39 AM revealed she assessed Resident #57 immediately after the fall on 11/16/14. Nurse #1 explained Resident #57 sat close to the edge of the seat. Nurse #1 reported the "bump of the strip" caused the fall.</p> <p>Interview with Resident #57 on 11/19/14 at 10:42 AM revealed the raised threshold caused difficulty entering the bathroom safely. Resident #57 explained he fell over the threshold "about 8 months ago" and thought the facility was going to make it smooth. Resident #57 explained he could use the bathroom independently but needed the wheelchair. Resident #57 reported he did not want to rely on staff for assistance when he could toilet independently. Resident #57 explained the threshold caused the fall on 11/16/14 and he tried to be careful.</p> <p>Observation on 11/19/14 at 11:20 AM revealed Resident #57 seated in a wheelchair at the bathroom doorway entrance. Resident #57 propelled the wheelchair away from the doorway approximately 4 feet and propelled back and forth 3 times. Resident #57 explained he had to gather up speed and aim straight in order to get over the threshold.</p>	F 323	<p>Systemic Changes: The facility has implemented a schedule to install adjustments to all bathroom thresholds completion date of February 28, 2015. All nursing staff Nurse and Nurse Aide part time and full time were in-serviced by the DON on 12/11/2014. Housekeeping, maintenance and therapy staff were inserviced on 12/8/2014. Topics included fall interventions, observation of residents <input type="checkbox"/> mobility to utilize the bathroom without assistance and reporting need for threshold adjustment to the Administrator, DON, or Maintenance Director for installation.</p> <p>Monday through Friday the Daily Clinical QA meeting will review new falls related to the bathroom threshold for interventions implemented including threshold Adjustment. This falls review will include: Review of incident reports, Nurse Daily Report and Nurses notes to ensure an appropriate intervention is initiated to lessen risk of future falls with injury. At the Daily Meeting the Maintenance Director will report on rooms with threshold repair completed and those scheduled for the week. The Nursing Team will review falls and identify residents that would need their room scheduled in advance of current rooms on the schedule. The Daily Meeting includes Administrator, DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Maintenance Director, Dietary and other clinical staff as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 323	Continued From page 3 Telephone interview with Nurse #3, the weekend supervisor, on 11/19/14 at 3:31 PM revealed she received the report of Resident #57's fall when it occurred on 11/16/14. Nurse #3 reported she did not know the cause of Resident #57's fall. Interview with Nurse #4, the unit manager, on 11/19/14 at 3:41 PM revealed the bathroom door's threshold caused Resident #57's fall. Nurse #4 explained a request for a review of the threshold would not be expected since the thresholds of all residents' room had the straight edge raised threshold. Interview with the Maintenance Director on 11/19/14 at 3:46 PM revealed he estimated the straight edge height of the bathroom doorway threshold to be approximately 1/2 inch. The Maintenance Director reported he did not receive a request to look at the threshold. Interview with the Director of Nursing (DON) on 11/19/14 at 3:57 PM revealed she was on duty when Resident #57 fell on 11/16/14 and the root cause of the fall was identified as the doorway threshold. The DON explained all of the bathroom doorway thresholds are built with the straight edge raised area. The DON explained residents needed to ask for assistance getting over the threshold. The DON reported Resident #57's fall on 01/06 /14 occurred before her employment in March 2014. Interview with Nurse #5 on 11/19/14 at 4:50 PM revealed she remembered Resident #57's fall on 01/06/14. Nurse #5 explained Resident #57 fell in the doorway of the bathroom. Nurse #5 explained Resident #57 required several attempts	F 323	Monitoring: To ensure compliance the Supervisor/Unit Manager will conduct a review of fall incidents related to the bathroom to ensure interventions have been implemented appropriately. This will include verifying notification to Maintenance Director and threshold repair complete. This will be done five times a week for 8 weeks or until all thresholds are adjusted. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, HIM, Dietary Manager and the Administrator Date of Compliance: December 18, 2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 323	Continued From page 4 to "get over the bump rolling his wheelchair." Nurse #5 reported she asked Resident #57 to ask for staff assistance before going to the bathroom. Nurse #5 explained she did not request an adjustment to the threshold since all resident bathrooms had the raised threshold.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and review of medical and facility records, the facility failed to provide podiatry services to 1 of 3 sampled residents reviewed for podiatry services. (Resident #305) The findings included: Resident #305 was admitted to the facility 08/28/14. Diagnoses included peripheral vascular disease. An admission minimum data set dated 09/04/14, assessed Resident #305 with intact cognition.	F 328	F 328 Treatment and Care for Special needs Corrective Action: Resident #305 was seen by the podiatrist in the facility on 11/20/2014. The nurse was counseled on reporting podiatry needs to Social Service. Identification of other residents who may be involved with this practice: All residents with request to see the Podiatrist have the potential to be effected by this practice. All current residents were interviewed or assessed for the need to see the Podiatrist on 12/4/2014 by	12/11/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 328	Continued From page 5 Resident #305 stated in an interview on 11/18/14 at 10:24 AM that when she received the November 2014 activity calendar, she saw that podiatry services were provided and asked a staff member (unknown) if she could be seen, but did not get a response. The Resident further stated that on Friday, 11/14/14 she also informed NA #1 that she had an ingrown toenail to her right great toe and would like to see a podiatrist, but was told by NA #1 that because she was a short-term rehab resident, she did not meet the criteria to receive podiatry services. An interview on 11/20/14 at 8:30 AM with the social worker (SW) revealed the activity calendar recorded the podiatry clinic that occurred in the facility on 11/12/14, 11/13/14 and 11/14/14. She stated a podiatrist provided onsite podiatry services to qualifying residents during the clinic or the facility arranged for the service in the community for residents who needed the service. The SW stated that podiatry services was made available to all residents who met the criteria and either requested the service or was identified by nursing staff to need the service. The SW provided a list of residents seen by the podiatrist during the clinic; review of the list revealed Resident #305 was not included on the list. An interview with nurse aide #1(NA #1)/clinic coordinator on 11/20/14 at 9:10 AM revealed she coordinated podiatry services for residents. She stated the podiatry services were made available to all residents who met the criteria for the service. NA #1 described the criteria for podiatry services to include residents with ingrown toenails. NA #1 further stated that short-term residents were advised of the criteria to receive	F 328	RN supervisor. . The audit revealed 2 residents in need of Podiatry Services and 14 residents requesting the service. The podiatrist saw all of these residents in house on 12/5/2014. Systemic Changes: The Charge Nurse on the floor is responsible for notifying Social Service of resident's podiatry needs. The NA offers nail care weekly on shower day for all non-diabetic residents and performs care per policy and reports any additional nail care needs to the Nurse. If the resident is diabetic the nurse will offer nail care. Social Service is responsible notification of the family/RP of future appointment. For any nail condition that requires immediate attention the nurse will notify the MD and as needed an out of the facility appointment will be made for an office visit. The Daily Clinical Meeting includes DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed. Inservice for all Nurses and Nurse Aides part time and full time was be provided on 12/11/14 by the DON. The topics included: Nail Care procedure, podiatry services provided in the facility, scheduling of services, and reporting of residents needs for an appointment to the Social Service Department to secure an appointment. Housekeeping, maintenance, and therapy staff were inserviced on 12/8/2014 with how to report a podiatry need to nursing if a resident voices that need to them. Monitoring: To ensure compliance the Supervisor/Unit Manager will conduct a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 328	<p>Continued From page 6</p> <p>onsite podiatry services at no charge to the resident. NA #1 stated that a short-term resident was advised that podiatry services were available to residents at no charge if the resident had a qualifying need. NA #1 stated Resident #305 requested podiatry services on Friday, 11/14/14, but was declined when NA #1 observed the Resident's toenails not to be "overly grown". NA #1 stated she advised Resident #305 that she did not meet the criteria for onsite podiatry services at no charge. NA #1 also informed Resident #305 that the podiatry clinic had ended and that a nurse aide or a nurse could trim her toenails or the Resident could make an appointment with a podiatrist when she returned to the community. NA #1 stated that Resident #305 informed her that she did not have a podiatrist in the community and her right great toe felt as if an ingrown toenail was there. NA #1 stated she did not tell another staff member or the Resident's nurse that Resident #305 requested podiatry services due to an ingrown toenail, but rather advised the Resident to tell the nurse if she wanted to have her toenails trimmed.</p> <p>On 11/20/14 at 09:20 AM Resident #305's right great toe was observed by NA #1 and the Resident described what she stated felt like an ingrown toenail in the right corner. Her toenails were observed to extend approximately 1/4-1/2 inch beyond the tip of the toe. Resident #305 stated her right great toe was painful to touch and stated "It feels like an ingrown toenail is well on its way." Resident #305 further stated she did not have a podiatrist in the community, but would like to have podiatry services provided in the facility.</p> <p>An interview with the assistant director of nursing (ADON) on 11/20/14 at 9:45 AM revealed he had</p>	F 328	<p>review using the QA Survey Tool reviewing four residents per week for nail care provided and if applicable that the reporting of podiatry need to Social Service was completed. Ensuring appointment recorded for next Podiatry visit to the facility, or if needed an out of facility appointment made and transportation arranged. This will be done weekly for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, Dietary Manager and the Administrator.</p> <p>Date of Compliance: 12/11/2014</p>		

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 328	Continued From page 7 not been informed that Resident #305 requested podiatry services. The ADON stated he would expect a nurse aide to advise the nurse if a resident requested podiatry services so that a medical professional could assess the resident's needs. An interview with the director of nursing (DON) on 11/20/14 at 12:37 PM revealed Resident #305 did not advise a nurse that she wanted podiatry services and so her toenails were not assessed by a nurse to determine if there was a medical need for the service. The DON further stated that podiatry services was made available to all residents who had a medical need for the service.	F 328			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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	F 431		11/25/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 431	<p>Continued From page 8 have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to remove 6 of 7 doses of expired intravenous (IV) Levofloxacin from 1 of 1 IV medication dispensing machine. The facility failed to discard expired and discontinued topical medications from 1 of 3 treatment carts.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. On 11/20/14 at 11:10 AM, 4 doses of IV Levofloxacin with an expiration date of 09/14 and 2 doses of IV Levofloxacin with an expiration date of 10/14 was observed in the facility IV medication dispensing machine located in the 500 and 600 hallway medication storage room. <p>On 11/20/14 at 11:12 AM an interview was conducted with the Assistant Director of Nursing (ADON) who confirmed that 6 of 7 doses of IV Levofloxacin in the IV medication dispensing machine were expired. The ADON shared that monthly checks for medication expiration dates</p>	F 431	<p>F 431 Drug Records, Label/Store Drugs and Biologicals Corrective Action: All identified open, unlabeled or expired medications (IV Levofloxin, Lidocaine/Prilocaine cream, Nystatin powder and Aquaphor) were returned to pharmacy or destroyed. The treatment carts were cleaned and all creams, ointment etc. were checked for pharmacy label identifying resident, storage and expiration date. The medication dispense machine was checked to ensure all medication including Intravenous were entered with expiration dates in the computer system and no other drugs were expired. This was completed by Pharmacy and DON on 11/21/2014 and 11/25/2014. No additional expired meds were found. The Treatment Nurse was educated on checking treatment carts monthly for medication storage, labeling and expired medication procedure.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 431	<p>Continued From page 9</p> <p>were supposed to be conducted by pharmacy and it was an over site that the medication expiration dates were not checked for the IV medication dispensing machine.</p> <p>On 11/20/14 at 11:21 AM an interview was conducted with the pharmacy consultant for the facility who shared that she was not responsible for checking expired medication in the IV medication dispensing machine. The pharmacy consultant stated that when the facility opened that an agreement was made between pharmacy and nursing that nursing would be responsible for checking for expired medication in the IV medication dispensing machine.</p> <p>On 11/20/14 at 11:53 AM a telephone interview was conducted with the Director of the Pharmacy who shared that nursing was responsible for pulling up the monthly drug sheets and checking for expired medication in the IV medication dispensing machine. The Director of Pharmacy stated that when a replacement drug was returned to the facility, the Director of Nursing (DON) was to place the replacement drug in the IV medication dispensing machine and check for the next closet expiration date and notify the pharmacy of the upcoming expiration date.</p> <p>On 11/20/14 at 11:53 AM an interview was conducted with the DON and Administrator who shared that the facility had no system in place for checking for expired medication in the IV medication dispensing machine. The DON stated that it was her responsibility to check monthly for expired medication in the IV medication dispensing machine. The DON stated that because she did not receive a monthly sheet of expired medication dates from the pharmacy, she</p>	F 431	<p>Identification of other residents that may be involved in this practice: All residents have the potential to be affected by the alleged practice. On 11/24/2014 all medications in the med carts were inspected for opened unlabeled or expired medications by the nurses. No additional expired med or storage issues were identified.</p> <p>Systemic Changes: Pharmacy Consultant will check Treatment and Medication carts monthly for cleanliness and expired medications also to ensure open medications are dated, labeled and stored correctly. QA Nurse Consultant will inspect quarterly during site visit to ensure compliance. All RNs, LPNs were inservice on 12/11/2014 by the DON on medication storage, expired meds and the labeling and dating medication upon opening along with the cleaning responsibilities for the med cart. The DON was inserviced by the Pharmacy Technician on 11/25/2014 on the medication dispense machine computer and the process to create a report listing expiration dates for removal from the dispense machine to return to pharmacy monthly.</p> <p>This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>Monitoring: The Nurse Managers will inspect the Medication and Treatment carts for storage, open unlabeled or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 431	<p>Continued From page 10</p> <p>did not check the IV medication dispensing machine for expired IV medication. The DON stated that her expectation were for nurses to check for expired dates prior to administering a drug. The DON shared that she was going to put a system in place for checking for expired stock IV drugs in the IV medication dispensing machine.</p> <p>2. Review of Resident #65's hospital discharge summary dated 11/13/14 and admission orders dated 11/13/14 revealed no order for lidocaine 2.5 %/prilocaine 2.5% cream application.</p> <p>Observation on 11/20/14 at 12:35 PM revealed the 100 hall and 200 hall treatment cart contained one opened tube of lidocaine 2.5%/prilocaine 2.5% cream with an expiration date of 01/24/14 in a plastic bag. Resident #65's name was hand written on the bag and there was no pharmacy label.</p> <p>Interview with Nurse #1 on 11/20/14 at 12:36 PM revealed the lidocaine 2.5%/prilocaine 2.5% cream should not be in the treatment cart available for administration. Nurse #1 reported Resident #65 did not receive lidocaine/prilocaine application and could not provide a reason for the availability.</p> <p>Interview with the Director of Nursing (DON) on 11/20/14 at 12:47 PM revealed nurses should check the treatment cart weekly and discard expired medication. The DON explained all nurses shared the responsibility of discarding expired medication.</p> <p>3. Review of Resident #14's physician's orders dated 09/30/14 revealed direction to discontinue application of Nystatin powder to affected area</p>	F 431	<p>expired meds one day a week for four weeks then monthly for three months using the Survey QA Tool. The DON will check the medication Dispense machine monthly for any expired medication for removal and return to pharmacy. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life Meeting.</p> <p>Date of Compliance: 11/25/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 431	<p>Continued From page 11 two times daily.</p> <p>Observation on 11/20/14 at 12:37 PM revealed Nystatin powder without a cap on the container and approximately ¼ full in the 100 hall and 200 hall treatment cart. The pharmacy label indicated a fill date of 06/09/14 for Resident #14.</p> <p>Interview with Nurse #1 on 11/20/14 at 12:38 PM revealed the discontinued Nystatin powder should not be in the treatment. Nurse #1 explained all nurses shared the responsibility for discarding discontinued medications.</p> <p>Interview with the Director of Nursing (DON) on 11/20/14 at 12:47 PM revealed she expected nursing staff to discard discontinued topical medication. The DON explained all nurses shared to the responsibility to discard or return discontinued medications.</p> <p>4. Review of Resident #49's November 2014 monthly physician's orders revealed direction to apply Aquaphor twice daily to body.</p> <p>Observation on 11/20/14 at 12:39 PM on 11/20/14 revealed a container of Aquaphor with an expiration date of 04/2014.</p> <p>Interview with Nurse #1 on 11/20/14 at 12:40 PM revealed she did not notice the expiration date. Nurse #1 explained nurses check the cart regularly and the Aquaphor should be discarded.</p> <p>Interview with the Director of Nursing on 11/20/14 at 12:47 PM revealed she expected nursing staff to discard expired medications. The DON explained all nurses shared the responsibility of discarding expired medications.</p>	F 431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to identify and implement a plan of action to prevent falls over a raised bathroom door threshold.</p> <p>The findings included:</p>	F 520	<p>F520 QAA Committee Meets Quarterly Corrective Action: Resident # 57 last fall was on 11/16/2014 with no injury. The bathroom threshold was adjusted by the Maintenance Director on 11/25/2014. The Interdisciplinary team (Nursing, SS, Dietary, Activities and Therapy as applicable) reviewed the fall care plan to ensure interventions in place were</p>	12/18/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 520	<p>Continued From page 13</p> <p>This tag is cross referred to:</p> <p>F 323 Accidents. Based on observation, resident and staff interview, and record review, the facility identified a raised bathroom doorway threshold caused a fall and failed to adjust the doorway to prevent further falls for 1 of 2 sampled residents at risk for falls (Resident #57).</p> <p>Interview with Nurse # 2 on 11/18/14 at 10:55 AM revealed the "bump" in the doorway was difficult for residents using wheelchairs and walkers. Nurse #2 explained nursing administration was aware of the difficulty.</p> <p>Interview with Nurse #4, the unit manager, on 11/19/14 at 3:41 PM revealed a request for a review of the threshold would not be expected since the thresholds of all residents' rooms had the straight edge raised threshold. Nurse #4 explained residents asked for assistance over the threshold since it was difficult to go through the doorway.</p> <p>Interview with the Maintenance Director on 11/19/14 at 3:46 PM revealed the straight edge bathroom doorway could "possibly" be changed to a gradual incline from the resident room floor to the bathroom floor.</p> <p>Interview with the physical therapist (PT) on 11/20/14 at 9:25 AM revealed the bathroom door thresholds have been a concern for resident safety since the move into the new building last November 2013. The PT explained therapists informed residents of the hazard and asked residents to request assistance to go over the threshold when using wheelchairs and walkers.</p>	F 520	<p>appropriate interventions.</p> <p>Identification of other residents who may be involved with this practice: All residents who utilize a w/c and who are capable of self-transferring and capable of using the bathroom have the potential to be affected. All residents were assessed on December 8, 2014 by the interdisciplinary team which includes DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed to identify residents who require an intervention to the bathroom threshold. This review revealed: 22 Rooms with bathroom thresholds needing priority adjustments. The completion date for these adjustments will be December 18, 2014. All other bathroom thresholds will have adjustments completed by February 28, 2015.</p> <p>All fall incidents for the last 30 days were reviewed at the Clinical QA Meeting on 12/4/2014 for any incidents that occurred in the bathroom that were related to the bathroom door threshold. This revealed no other incidents involving the bathroom threshold. The Daily Clinical Meeting includes DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed.</p> <p>A Meeting of QA Committee was held on 12/5/2014 to review the findings concerning the raised bathroom door threshold with Resident # 57's fall. In an effort develop and implement an appropriate plan. The QA Committee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 520	Continued From page 14 Interview with the Director of Nursing (DON) on 11/19/14 at 3:57 PM revealed all of the bathroom doorway thresholds are built with the straight edge raised area. The DON explained residents needed to ask for assistance getting over the threshold. A second interview with the DON, chairperson of the QAA, on 11/20/14 at 4:22 PM revealed the QAA committee composition included physical therapy, maintenance and nursing disciplines. The DON explained resident falls were included in the meeting agenda in addition to fall reviews during a daily management meeting. The DON reported the raised thresholds were discussed informally by staff but not as part of the QAA meeting.	F 520	consists of Medical Director, Administrator, DON, Unit Managers, Rehab Director, Maintenance Director and any other staff member as needed. Plan was developed to adjust all bathroom thresholds and identify rooms of residents <input type="checkbox"/> independent with w/c mobility and independent toileting for priority adjustment by December 18, 2014, of bathroom threshold. All other bathrooms thresholds will be adjusted by February 28, 2015. Systemic Changes: The facility has implemented a schedule to install adjustments to all bathroom thresholds with completion date of February 28, 2015. All nursing staff Nurse and Nurse Aide part time and full time were in-serviced by the DON on 12/11/2014. Topics included fall interventions, observation of residents <input type="checkbox"/> mobility to utilize the bathroom without assistance and reporting need for threshold adjustment to the Administrator, DON, or Maintenance Director for installation. Monday through Friday the Daily Clinical QA meeting will review new falls related to the bathroom threshold for interventions implemented including threshold Adjustment. This falls review will include: Review of incident reports, Nurse Daily Report and Nurses notes to ensure an appropriate intervention is initiated to lessen risk of future falls with injury. At the Daily Meeting the Maintenance Director will report on rooms with threshold repair completed and those scheduled for the week. The Nursing Team will review falls and identify		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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	
F 520	Continued From page 15	F 520	<p>residents that would need their room scheduled in advance of current rooms on the schedule. The Daily Meeting includes Administrator, DON, Unit Managers, Rehab Director, MDS, Wound Nurse, Maintenance Director, Dietary and other clinical staff as needed.</p> <p>The Quarterly QA Meeting will include an agenda item under falls to include environmental, devices or other equipment related issues contributing to a fall and actions taken during the previous quarter. This meeting includes the Medical Director, Nurse Practitioner, Administrator, DON, Unit Managers, Rehab Director, Maintenance Director, Pharmacy Consultant, Dietary Director, HIM and all other staff as needed.</p> <p>Monitoring: To ensure compliance the Supervisor/Unit Manager will conduct a review of fall incidents related to the bathroom to ensure interventions have been implemented appropriately. This will include verifying notification to Maintenance Director and threshold repair complete. This will be done five times a week for 8 weeks or until all thresholds are adjusted. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, HIM, Dietary Manager and the Administrator.</p>		

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(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
F 520	Continued From page 16	F 520	Date of Compliance: December 18, 2014	