STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 A complaint investigation survey was conducted from 10/17/17 through 10/19/17. Immediate Jeopardy was identified at: CFR 483.25 F-323 at a scope and severity of "J". Tag F-323 constituted substandard quality of care. Immediate Jeopardy began on 10/11/17 and was removed on 10/19/17. A partial extended survey was conducted as part of this survey. Event ID #WBCT11. IDR 12/13/17 resulted in changing F 323 from a J to a G	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		11/7/17

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

Electronically Signed | 11/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 1 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to prevent a resident from falling off the bed during a bed bath for 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). The resident required two person assistance for bed bath, however, one nursing assistant provided the bed bath. Resident #1 was turned on his side during the bed bath and proceeded to roll out of the bed to the floor face first. Review of hospital records indicated that Resident #1's fall resulted in a left orbital floor fracture, subarachnoid hemorrhage, and questionable left lower extremity injury. The finding included: Resident #1 was admitted to the facility initially on 03/19/13 and most recently was readmitted to the facility on 08/16/17. Resident #1's diagnoses included: Alzheimer's disease, dementia, hemiplegia, toxic encephalopathy, contracture of shoulder, wrist, and hand and osteoarthritis. Review of a care plan, initiated on 01/06/14 and most recently revised on 10/12/17, revealed, Resident #1 had an activities of daily living (ADL) self-care performance deficit related to the diagnoses of cerebrovascular accident with hemiplegia, contractures to extremities, impaired	F 323	Plan of Correction The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that the deficiencies cited have been corrected by the date certain of 11-7-2017. F323 The Plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency: On October 11, 2017, Resident #1 was transported to the hospital and admitted to CMC Main after sustaining a fall from bed. Resident #1 is currently out of the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 2 cognition, and being non-verbal. The goal of the care plan was: Resident #1 would remain clean, odor free, and neatly dressed through staff anticipation and providing ADL care x 90 days. The interventions included: Resident #1 required total staff assistance to reposition and turn in bed. Review of the most recent quarterly minimum data set (MDS) dated 07/06/17 revealed that Resident #1 had long/short term memory problems and was severely cognitively impaired for daily decision making. The MDS further revealed that Resident #1 required extensive assistance of 2 persons for bed mobility, transfers, and bathing. The MDS also indicated that Resident #1 had impairments to bilateral upper/lower extremities and no falls were identified on the MDS. Review of the MDS Kardex (a system to identify important information about a resident) for Resident #1 dated 07/06/17 revealed that Resident #1 required extensive assistance of 2 staff members with bed mobility and was totally dependent on 2 staff members for bathing. Review of a nurses note, written by Nurse #1 and dated 10/11/17 revealed this nurse was called to Resident #1's room by a nursing assistant (NA) who stated "you need to come to room ASAP (as soon as possible)." This nurse entered the resident's room and noted the resident lying on the floor on his left side with his nose bleeding and a cut over his left eye. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Nurse Practitioner (NP) were made aware and orders were received to transfer the resident to the hospital for evaluation. The nurse placed a phone call to the family and	F 323	On October 12, 2017 his fall was reviewed at the interdisciplinary team meeting , which includes the administrator, the DON, MDS coordinator , a Unit Manager , QA nurse consultant and the rehab director. During this clinical meeting the resident's care plan was reviewed, the IDT indicated that resident #1 would be reassessed on readmission for his care needs . A root cause analysis was completed by the IDT team and it was determined that he will need 2 staff to provide hands on care with bed bath due to an unpredictable body movements. The process of reviewing the kardex was not completed prior to giving care to resident #1 by the nursing assistant providing care. The Corrective action for those residents potentially affected. On October 17, 2017, the nurse managers reviewed each resident□s kardex (this is a shortened version derived from the care plan that identifies key care needs for the residents) in the electronic health record to ensure that each resident had a kardex in the electronic health record. It was found that 100% of the residents had a kardex. On 10/18/2017 all Kardex□s (this is a shortened version derived from the care plan that identifies key care needs for the residents) were reviewed to ensure that they were accurate and appropriate by MDS Coordinators, QA Nurse Consultant and MDS Consultant. October 18, 2017, 4 Nurse Aides, each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 to 911. The resident was transported to the hospital by Emergency Medical Services (EMS). Review of an incident report dated 10/11/17 revealed NA reported that a nurse was needed immediately in room 203 B. The nurse entered the room and observed Resident #1 lying on the floor on his left side. Resident #1 had a nose bleed and a cut over his left eye. Resident #1 was groaning on and off. He did not say anything. Resident #1 was assessed for any other injuries and none was noted. Fall mats were in place at bedside. Medical Doctor (MD) and family were notified. Immediate action taken read in part, DON and ADON were made aware. Resident #1 was made comfortable on the floor while the physical assessment could be done by the nurses. Resident #1 was in a partial fetal position and care was taken to establish his baseline movements of his arms and legs. Nurse noted no open areas to the hands, feet or the back of the head. Resident #1 had a halo assist rail in place in the active position at the head of the bed. Review of a hospital History and Physical dated 10/12/17 revealed that as a result of the fall that occurred on 10/11/17 Resident #1 had suffered a left orbital floor fracture (fracture of the bottom of the eye orbit), subarachnoid hemorrhage (brain bleed), and questionable left lower extremity injury. Review of the Care plan Kardex that was printed 10/17/17 revealed Resident #1 was totally dependent on staff for repositioning and turning in bed. Two or more staff assistance were recommended for turning and repositioning. An interview was conducted with NA #2 on	F 323	working different units were observed by the Quality Assurance Nurse Consultant performing personal care to residents to ensure that care was provided appropriately and safely per the kardex (this is a shortened version derived from the care plan that identifies key care needs for the residents) with no concerns or issues with each Nurse Aide□s performance. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On October 18, 2017, the director of nursing began in servicing all nurses and nursing assistants on the following: You are required to review the kardex of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. If you do not see a kardex then consult with your nurse for further care instructions. You should always follow the plan of care for the residents as outlined on the kardex. If the resident□s condition has changed, you feel that the plan is unsafe, or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care. To access the kardex you can click on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 10/17/17 at 11:09 AM. NA #2 stated that she routinely cared for Resident #1 on the 3rd shift. She added that Resident #1 had to be turned, changed and the staff was supposed to have 2 people when they performed care to Resident #1 due to his size. She added that Resident #1 used to try and hit the staff but lately he had calmed down. NA #2 stated that Resident #1 was very stiff and contracted but at times in the past he would try to swing at staff. NA #2 again stated that she was informed by her nurse to always have 2 people when caring for Resident #1 even before his fall on 10/11/17. An interview was conducted with Nurse #1 on 10/17/17 at 11:38 PM. Nurse #1 stated that on 10/11/17 at approximately 9:50 AM she was providing care to another resident and a NA came to the door and stated she needed her and it was an emergency. Nurse #1 stated she entered Resident #1's room and observed him lying on the floor on his left side with a pillow under his head and observed blood on the pillow. Nurse #2 was already in the room and asked what happened. Nurse #1 stated she was told that NA #1 was giving Resident # 1 a bed bath and when NA #1 turned him on his right side "he just kept going." NA #1 lost contact with him and he fell to the floor. Nurse #1 stated she instructed the staff to leave him where he was and she went to get the DON and management team while Nurse # 2 stayed with the resident. Nurse #1 stated when she returned to the room they were trying to get a Hoyer lift pad under him to get him back in the bed and were having trouble doing that. The DON came in the room and said to put a sheet under him and perform an 8 man lift to get him back in the bed and that was what they did. Nurse #1 stated that at that time she noticed some nasal	F 323	resident□s name in the electronic health record and click on the kardex brick. The Director of Nursing will ensure that all nursing assistants and nurses have received this training. As of October 18, 2017 all nurses and nursing assistants employed have received this training. As of October 18, 2017 no employee will be allowed to work until the training has been completed. The Director of Nursing will work with the nurse secretary to ensure that this occurs. Effective 10/19/2017, this training is incorporated into the new employee orientation program. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and dates when corrective action will be completed 11/07/2017. The Director of Nursing and/or nurse managers will monitor 5 nurse aides change of shift activity to ensure that Nurse Aides are reviewing the Kardex. This will be accomplished by being on site during all three change of shifts for 48 hours. Nurse Managers will make rounds and ask at least 5 NA to demonstrate how they reviewed the kardex prior to resident care. The Director of Nursing and Nurse Managers will make observations of the Nurse Aide staff providing resident care to ensure that the care is being provided is appropriate and safe per the resident□s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 5 bleeding and a laceration over his left eye. The ADON instructed Nurse #1 to call the family and the ADON stated she would call the NP who was on call. Nurse #1 stated she informed Resident #1's family he would be going out via 911 for evaluation and then went ahead and called 911 and they arrived within 10 minutes. They picked him up at 10:20 AM. Nurse #1 stated that Resident #1 was moaning while they were lifting him to the bed and she notified the medics that was not normal for him to moan. Nurse #1 stated she could not asses Resident #1's range of motion (ROM) due to his contractures but could visibly see the bloody nose and laceration over the left eye and his vital signs were stable. Nurse #1 stated that all the NAs had been informed that Resident #1 was to have 2 people when providing care per the family request but sometimes it was "impossible to find a 2nd person." An interview was conducted with NA #1 on 10/17/17 at 12:43 PM. NA #1 confirmed that on 10/11/17 she was responsible for Resident #1. NA # 1 stated that she had cared for Resident #1 several times and had always completed his care by herself. NA #1 stated that some of the NAs were not comfortable with him and they would get someone to help them "but I am very comfortable providing care to him by myself." She added if the family member or the sitter were present sometimes they would help her. NA #1 stated that on 10/11/17 the sitter and family member were not present in the room. She stated that right after breakfast she went to Resident #1's room and started to bathe him. She stated she raised the bed to approximately 4 to 4.5 feet high and removed his clothes and started bathing him. She stated she had bathed his front side and she used his pad and pulled him close to the side of	F 323	Kardex. This will be initiated on 10-19-17 on 7-3 shift. After this is completed, the Director of Nursing or Nurse Manager will monitor one shift a day alternating shifts to ensure that all shifts are monitored at least weekly. During this time, the Director of Nursing or Nurse Manager will ask 5 NA to validate verbally that they checked the Kardex at the beginning of their shift by asking them to describe the care needs of 5 residents and verifying that the plan of care that was verbalized by the NA matches what was in the Kardex. The Director of Nursing and Nurse Managers will make observations of the Nurse Aide staff providing resident care to ensure that the care is being provided is appropriate and safe per the resident□s Kardex. This will be completed daily for 2 weeks and then weekly for 3 months or until resolved by the Quality Assurance Committee. If inconsistencies are identified, the staff member will be reeducated on the need to check the Kardex. (see attachment daily x 2 weeks starting 10-24-2017 through 11-6-2017and weekly starting 11-13-2017 using the Clinical QA survey tool) Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, ADON, MDS Coordinator, Unit Manager, Therapy, HIM, Dietary Manager and the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 6 the bed and turned him on his right side. NA #1 stated Resident #1 was resting on his right side and she had reached for the wash rag and when she turned back to him he was going over the side of the bed and she could not reach him. NA #1 stated that he was on a blow up (air mattress) mattress. NA #1 denied hearing the mattress inflate/deflate or make any noise but the weight of Resident #1 on his side could have shifted the air inside the mattress causing him to turn on over and fall to the floor. NA #1 stated her first response was "oh my God" and ran to the other side of the bed. Resident #1 was contracted lying face down with his head resting against the night stand. NA #1 stated she grabbed a pillow and put it between the night stand and Resident #1's face. She added she could not turn him due to his size but she could turn his head to one side and then ran to the hall to summons help. NA #1 stated she saw NA #2 and told her to go find Nurse #1. NA #1 stated she saw Nurse #2 at the other end of the hall and summoned her to the resident's room. When Nurse #2 arrived to the room she moved the dresser so they could turn Resident #1. Nurse #1 had gone to get the management team. NA #1 stated that Resident #1 moaned a little when they lifted him from the floor to the bed. The DON suggested to put a sheet under him and lift him to the bed and that was what they did and then they waited on the ambulance. NA #1 stated she got him dressed because he was naked except for his brief. NA #1 stated there was a small amount of blood coming from his nose and cut above his left eye. NA # 1 stated she was a floater and worked all over the building and if she was not familiar with a resident she could review the resident's care plan and Kardex. NA #1 stated she had never reviewed Resident #1's Kardex or care plans.	F 323	This will be completed daily for 2 weeks and then weekly for 3 months or until resolved by the Quality Assurance Committee. If inconsistencies are identified, the staff member will be reeducated on the need to check the Kardex .Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. (see attachments daily x 2 weeks starting 10-24-2017 through 11-6-2017and weekly starting 11-13-2017 using the Clinical QA survey tool) The Administrator is responsible for implementing the plan of correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 7 An interview was conducted with Nurse #2 on 10/17/17 at 1:09 PM. Nurse #2 stated she was summoned to Resident #1's room on 10/11/17 by NA #1. Nurse #2 state that when she entered his room, Resident #1 was lying on the floor on his side with his head against the night stand and a pillow was between his head and the night stand. Nurse #2 stated Resident #1 was bleeding from his nose but there were no visible open areas or cuts on his face. She stated she asked what happened and NA #1 stated she was bathing Resident #1 and had turned him over to his right side to wash his back and "he just kept going" and fell to the floor. Nurse #2 stated that Resident #1's bed was approximately 4 foot high and he was resting in a ball on his side due to his contractures. Nurse #2 stated that while Nurse #1 went to get the management team she assisted Resident #1 to his back to assess him visually because he was nonverbal. Nurse #2 stated she assessed him for any cuts, bruises or swelling and noted the left side of his face was swollen. When the management team came into the room Nurse #2 stated she went to look for a lift and when she returned without the lift the staff in the room had already gotten Resident #1 back into bed. She was not sure how they did that and she asked Nurse #1 if she needed any further help and Nurse #1 stated no. So Nurse #2 returned to her assigned area while Nurse #1 waited for the medics to arrive to transport Resident #1 to the hospital. Nurse #2 stated that Resident #1 needed total assistance from staff with all ADLs and required the assistance of 2 persons with transfers. Nurse #2 stated that the NAs could look at the care plan or Kardex which would tell them how many staff were needed for care.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 8 An interview was conducted with the DON on 10/17/17 at 2:42 PM. The DON stated that on the morning of 10/11/17 she was in the facility's morning meeting and was told there had been a fall in Resident #1's room. The DON stated she immediately went to his room and staff were trying to get Resident #1 from the floor to his bed with the use of a mechanical lift. She stated that she asked what happened and what she gathered from the staff in the room was that NA #1 was trying to pull the fitted sheet onto the mattress and this caused the resident to roll and NA #1 could not hold him and he rolled off the bed. She added that Resident #1 had a fall mat to the floor and he had landed on that. She stated that when she entered Resident #1's room he was lying on his right side and they were trying to get the lift pad under him but due to his contractures they were unable to get the pad between his legs. The DON stated that the staff got a sheet and rolled it under him and then 5 or 6 staff members safely transferred Resident #1 back in to the bed. The DON stated that Resident #1's care could be completed with 1 person but since the fall on 10/11/17 the facility determined he would require 2 person assistance. The DON stated that if the MDS and the Kardex indicated that Resident #1 required 2 person assistance then she would expect the staff to use 2 person assistance. An interview was conducted with Resident #1's family member on 10/18/17 at 12:37 PM. The family member stated Resident #1 had resided at the facility for a number of years and had required 2 person assistance with his care for well over a year or so due to his size and his contractures. An interview was conducted with NA #3 on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 9 10/18/17 at 2:17 PM. NA #3 stated that she routinely cared for Resident #1 on the 3rd shift and stated that she had to provide all his personal care for him. NA #3 stated that on her shift she would change him and turn him routinely and he always required 2 person assistance especially with turning from side to side. NA #3 added that Resident #1 also required 2 person assistance with incontinent care and she generally had no trouble finding someone to assist her with providing care to Resident #1. An interview was conducted with NA #4 on 10/18/17 at 2:28 PM. NA #4 stated she cared for Resident #1 at times on 3rd shift and 2nd shift. NA #4 stated that on 3rd shift she assisted the other NA with incontinent care and turning him side to side. NA #4 stated that on 2nd shift she would provide Resident #1 with a shower and that also required 2 person assistance. She added that to her knowledge Resident #1 always required 2 person assistance when providing any type of care to him. An interview was conducted with NA #5 on 10/18/17 at 2:40 PM. NA #5 stated that on 10/11/17 she was walking down the hall and NA #1 hollered for help. She stated that when she entered Resident #1's room he was lying on his side on the floor with a pillow under his head. She stated she noticed some blood on his pillow and could see a cut to the left eye area. NA #5 stated that when she cared for Resident #1 she had 2 people at the request of the family and she always did what was asked of her. She added that once Resident #1 was in the bed she assisted NA #1 with getting him dressed and waited for the medics to arrive.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 10	F 323		

A follow up interview was conducted with the DON on 10/18/17 at 2:58 PM. The DON stated that there was a disconnect in what she stated had occurred on 10/11/17 and what the other staff stated had occurred on 10/11/17. She added that she had gathered that Resident #1 had unpredictable movements during care on 10/11/17 that NA #1 did not observe before. There was no way to stop him from falling once he started to roll off the bed. The DON stated that even if there had been 2 people in the room, because of the position of the staff and the unpredictable movements, Resident #1 may still have fallen.

An interview was conducted with NA #6 on 10/18/17 at 3:28 PM. NA #6 stated she routinely cared for Resident #1 on the weekends. NA #6 stated that he always required 2 people assistance to render care to him. NA #6 stated that on the assignment sheet they would assign Resident #1 to 1 NA and then indicate another NA to assist as needed. She added that she always had 2 person assistance with Resident #1 due to his size and his contractures.

An interview was conducted with NA #7 on 10/18/17 at 4:10 PM. NA #7 stated she routinely cared for Resident #1 and that during her orientation at the facility the nurse and the other NAs had instructed her to never provide care to Resident #1 with 1 person. She added that any time she provided care to Resident #1 she always had 2 person assistance. She stated that she reviewed Resident #1 care plan and Kardex regularly but could not recall what information it contained but she recalled being told by several staff members to always have 2 people while providing care to Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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 11 An interview was conducted with Resident #1's family member on 10/19/17 at 9:30 AM. The family member indicated that she visited the facility every day while the resident was at the facility for a number of years. The family member indicated that she attended regular care plan meetings and had always been told that her family member required 2 person assistance with his care. The family member further stated that Nurse #1 had indicated to her on numerous occasions that Resident #1 required 2 person assistance and the staff was directed as such.	F 323		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		11/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 12 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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 have access to the keys. (2) 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to secure a medication cart when left unattended at the nurse's station for 1 of 3 nursing stations. The Finding included: An observation was made of the 100 hall nursing	F 431	F 431 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10-17-2017 at 100 hall nurse station at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 13 station on 10/17/17 at 12:32 PM. The nurse's station was empty. There was a medication cart parked right outside the nurse's station, the lock on the medication cart was disengaged. Just across from the nurse's station was a dining room that had approximately 20 resident's independently eating lunch. After approximately 3 minutes a nurse emerged from a medication room located behind the nurse's station. An interview was conducted with Nurse #3 on 10/17/17 at 12:35 PM. Nurse #3 was asked to confirm if her medication cart was locked. When Nurse #3 pulled on the top drawer of the medication cart the drawer came open. Nurse #3 stated "I just cleaned everything off the top" and I thought I had locked the medication cart. Nurse #3 stated that anytime the medication was left unattended it should be locked. An interview was conducted with the Director of Nursing (DON) on 10/18/17 at 5:14 PM. The DON stated if the medication cart was left at the nurse's station unattended then it should have been locked. She further stated that the medication cart should be locked any time a nurse is not present.	F 431	12:32pm the medication cart was located outside the nurses station and the lock was disengaged. The nurse was not in attendance for approximately 3 minutes and had just completed her medication pass. Upon interview nurse verbalized that she thought she had locked the cart. There were approximately 20 residents in the dining area 30 feet away eating lunch at the time of the alleged deficient practice. There were no resident identified next to the medication cart on the 100 hall at the nursing station and none were found to be affected. On 10/17/2017 the DON and QA consultant visualized all medications carts and none were found to be unsecured while staff was not in attendance or with medication pass. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents have the potential to be affected by the alleged deficient practice. The DON/ADON/UM will assure that all medication carts are locked when not attended by a nurse, so that all medications and biologics are secured. All nursing stations have medications carts and have potential to be unsecured when nurse is not in attendance or with med pass. On 10/17/2017 the DON and QA consultant visualized all medications carts and none were found to be unsecured while staff was not in attendance or with medication pass. On 10/18/2017 the DON and QA consultant visualized all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 14	F 431	medications and none were found to be unsecured while staff was not in attendance or with medication pass. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The DON/ ADON/UM will educate all nursing staff that all medications and biologicals are stored safely, securely, and properly, following manufacturer□s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . On November 2, 2017 the DON/ADON/Unit Manager began in servicing the full time, part time and prn RN□s and LPN□s, Administrator, on the following topic:. STORAGE OF MEDICATIONS " Medications and biologicals are stored safely, securely, and properly, following manufacturer□s recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. " The provider pharmacy dispenses medications in containers that meet legal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 15	F 431	requirements, including requirements of good manufacturing practices. Medications are kept in these containers. Transfer of medications from one container to another is done only by the pharmacy. " Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Intravenously administered medications are kept separate from orally administered medications. Eye medications are kept separate from ear medications. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 16	F 431	are clearly identified and stored in a locked area separately from medications. Schedule III and IV controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose. In a unit-dose system Schedule III-V medications may be stored in the trays with the other medications. Schedule II medications are then stored in a separate area under double lock. Medications requiring storage at room temperature are kept at temperatures ranging from 15¿C (59¿F) to 30¿C (86¿F). Medications requiring refrigeration or temperatures between 2¿C (36¿F) and 8¿C (46¿F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other foods such as employee lunches, activity department refreshments are not stored in this refrigerator.) Outdated, contaminated, or deteriorated medications and those in containers that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 17	F 431		

are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.

Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.

MEDICATION STORAGE IN THE FACILITY

Medication storage conditions are monitored on a (monthly) basis and corrective action taken if problems are identified.
Source: McNeill's Long Term Care Policy & Procedures

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The DON/Designee will be responsible for conduction the training. All in-servicing to be completed by November 7, 2017. Any in-house nursing staff member who did not receive in-service training by November 7, 2017 will not be allowed to work until training has been completed. Outside agency

Starting November 7 2017 the DON or designee will complete QA tool for drugs and biologic audit observing 3 nurses daily x2, weekly x4 then monthly x2.(see

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	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	Continued From page 18	F 431	attachment)Any discrepancies will be reported to the QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, ADON, Unit manager, Therapy, HIM, Dietary Manager and the Administrator This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The title of the person responsible for implementing the facility□s Allegation of Compliance is the Administrator.	