STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP NAME OF PROVIDER OR SUPPLIER 345026 B. WING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (04/ 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)	APPROVE
NME DLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 04 NAME OF PROVIDER OR SUPPLER 345026 # WING STREET ADDRESS, CITY, STRE, 2IP CODE ROVAL PARK REHAB & HEALTH CTR OF MATTHEWS STREET ADDRESS, CITY, STRE, 2IP CODE 04 V(N) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS NOT, SHOULD DE 04 V(N) ID SUMMARY STATEMENT OF DEFICIENCIES IDENTIFICATION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE V(N) ID SUMMARY STATEMENT OF DEFICIENCIES IDENTIFICATION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE V(N) ID SUMMARY STATEMENT OF DEFICIENCIES IDENTIFICATION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE V(N) ID SS-D INVESTIGATE/REPORT F 225 F 225 ALLEGATIONS/INDIVIDUALS F 225 F 225 The facility must not employe, which would indicate unfitness or service as a nurse aide registry concerning abuse, neglect, mistreatiment, of residents by a court of her property; and report ay k nowledge it has a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. F 10 The facility must neure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and missignation are thorough) investigated, and must prevent further potential abuse while the involving mistreatment accordance with State law through estate survey and certification agency). The facility must have evidence that all alleged v	0. 0938-039
345026 B. WING	LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAFE, 2P CODE ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS Image: Comparing the image of the	
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS MATTHEWS, NC 28105 (XX) (0) PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECT VALUES DEPECIPED BY PLUL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PREVIX PREFIX TAG PREVIX PREVIX PREVIX PREVIX PREVIX F 225 483.13(c)(1)(i)-(ii), (c)(2) - (4) SS=D F 225 F 225 PREVIX PREVIX F 225 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misopropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfilmess for service as a nurse aide or other facility staff to the State nurse aide or other facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation or resident property are reported immediately to the administrator of the facility and to other officials in accordance while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State surv	13/2016
Paylo MATTHEWS, IX 23106 Previx TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTEYING INFORMATION) IPREVX TAG PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTEYING INFORMATION) IPREVX TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS F 225 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is vorking d	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH DEFICIENCY INFORMATION) F 225 483.13(c)(1)(ii), (iii), (c)(2) - (4) F 225 SS=D INVESTIGATE/REPORT ALLEGATIONS/INDI/IDUALS F 225 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a count of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employe, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property ar reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	(X5) COMPLETION DATE
 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified 	5/5/16
 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified 	
prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	
	<u> </u>
	(X6) DATE 05/02/201

Electronically Signed

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/06/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345026	B. WING		C 04/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				2700 ROYAL COMMONS LANE	
ROYAL PA	ARK REHAB & HEALTH (CTR OF MATTHEWS		MATTHEWS, NC 28105	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 225		e 1 ¯ is not met as evidenced	F 22	5	
	facility failed to thorou 24 hour and 5 workin Personnel Registry for for abuse (Resident # The findings included Resident #1 was adm 02/09/16 with diagnos depression and was o 03/21/16. Review of the admiss dated 02/16/16 revea cognitively intact and rejection of care durin	hitted to the facility on ses of paraplegia and discharged home on sion Minimum Data Set aled Resident #1 was had no behaviors or ng the lookback period.		The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta Regulations the facility has taken on take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility □s allegation compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic F 225 INVESTIGATE / REPORT ALLEGATIONS / INDIVIDUALS Corrective Action:	and do e te r will n of of be
	03/14/16 revealed Re against Nurse Aide # disrespectful to her d stated NA#1 came in get into bed and NA # be her room, was hid came out to help NA they started talking al Resident #1 further s NA #1 was rough with to get her into bed an electric wheelchair. T Assistant Director of I Resident #1, her fam come into her office to 03/14/16. The ADON became very heated	uring care. Resident #1 to her room to help her to #2, who was not supposed to ing in the bathroom and #1 transfer her to bed and bout her and laughing at her. tated in the grievance that h her, pulled her shirt collar d broke something on her the grievance revealed the		Resident #1 On April 13, 2016, the facility initiate faxed a 24 hour initial report to the I Care Personnel Registry Section of North Carolina Department of Healt Human Services, regarding resider (S.G.)□s grievance filed on 3-14-16 DON, ADON and Social Worker init and conducted another investigation that grievance and then reviewed fil with the Administrator. On April 18, a follow up 5 working day report wa submitted to the Health Care Perso Registry Section of DHHS. On Apr 2016, the Administrator was contact Athena Foreman, HCP Investigator advised the Department has determ that an investigation will not be com	Health i the i h and h and h and h and i the i ated n into ndings 2016, s nnel ril 20, ted who nined

Facility ID: 923542

If continuation sheet Page 2 of 17

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	. ,	DATE SURVEY
			A. BUILDIN	G		С
		345026	B. WING			04/13/2016
AME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		04/13/2016
				2700 ROYAL COMMONS LAN		
OYAL PA	RK REHAB & HEALTH	CTR OF MATTHEWS		MATTHEWS, NC 28105	-	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S F	LAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	COMPLETIO DATE
F 225	Continued From page	e 2	F 2	25		
	care for Resident #1.	The grievance further		in this case.		
		the evening on 03/14/16				
		ne hall and told the other		Identification of othe		
		NA #1 to bring her dinner tray		be involved with this	practice:	
	because she might s	pit in it.				
	Peview of the nurse's	s notes from 02/09/16		All residents have th affected by this prac		
		ealed Resident #1 had no		filed within the last th	-	
	negative behaviors o			reviewed to identify a		
				neglect. If identified		
	Review of the Directo	or of Nursing (DON)		or neglect, files were		
	investigation folder for	or Resident #1 for incidents		that a complete inve		
		16/16 revealed on 03/16/16		conducted and if req		
		ed NA #1 was passing trays		5day report was con		
		ook Resident #1's tray into		submitted. This was		
		n her over bed table. The d NA#1 hit Resident #1's		Director of Nursing, Administrator as of 5		
		d hurt her hand, then ripped		Authinistrator as or t	0/2/2010.	
		f the wall and broke her		Systemic Changes:		
		stated NA#1 harassed her				
		plice and wanted to press		As of 5/5/2016 all sta	aff (including contract	
	charges. The report s	stated the police came and		service staff) were re	e-educated /	
		e until further investigation.		-	dministrator regarding	
	There was no follow			the facility s policy of		
		folder for the 03/14/16		included, but not lim		
	incident or the 03/16/	/16.			er witnesses potential	
	Peview of the facility	24 hour and 5 day reports to		responsibility is to re	e staff member⊡s first	
		sonnel Registry (HCPR) for		from potential harms		
		12/16 revealed no reports			ily, visitor or staff	
	-	for the incidents of 03/14/16		member reports that	•	
	or 03/16/16.			abuse or neglect has		
				Administrator and or		
		empted on 04/12/16 at 1:00		Nursing must be not	-	
	PM with Resident #1	-			vritten or verbal)	
	numbers had been d	isconnected.		stating possible / pot		
	During an interview	venducted or 04/40/40 -t		neglect has occurred		
	During an Interview C	conducted on 04/12/16 at		investigation will be	conducted. I NIS	

Facility ID: 923542

If continuation sheet Page 3 of 17

CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	PLE CONSTRUCTION	(Va) D	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>	G		OMPLETED
			A. BOILDIN			С
		345026	B. WING			04/13/2016
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C		• • • = • • •
				2700 ROYAL COMMONS LANE		
ROYAL PA	ARK REHAB & HEALTH (CTR OF MATTHEWS		MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	- 3	F 2	25		
		er job to pass supper trays		from all witnesses, the acc	used and the	
		ate in their rooms. She		accuser.		
		dent #1's supper tray into her		" The Abuse and Prohib	ition policy for	
		r over bed table. She stated		how to complete an investi		
		#1 if she wanted her to open		reporting abuse / neglect a	-	
		and she told her no. NA #1		the NC DHHS HCPR Section		
		ent #1's room at that point.		includes completion and su	ubmission of 24	
		nt #1 was on the phone ay into her room but stated		hour and 5 day report. " Investigation files will	ha kant hy tha	
		hone cord out of the wall nor		Administrator.	be kept by the	
		phone on the floor. NA #1				
		call bumping Resident #1's		All staff who were not inser	rviced /	
		er tray down and Resident		re-educated as of 5/5/16 o	n the facility'⊡s	
		of pain at any time she was		Abuse and Prohibition poli		
		ated Nurse #1 came to her		allowed to work until they h	nave been	
		vered Resident #1's supper		re-educated / inserviced.		
		hat had happened between		This information has been	intograted into	
		NA #1 stated Nurse #1 told very upset and had called		This information has been the facility 's standard original		
		A #1 had hurt her hand/arm		for all newly hired staff.	intation training	
	-	one. NA #1 stated the Unit				
	Manager interviewed			Monitoring:		
	happened and the po	lice came and interviewed				
		ed she wrote a statement for		The Director of Nursing an		
	-	d was sent home for the rest		Worker will monitor this iss	•	
	of her shift. NA #1 sta			QA Survey Tool that will re-		
	returned to work 2 da	OON or the DON when she		grievances submitted to er proper investigations have		
				completed and that a 24 h		
	During an interview c	onducted on 04/12/16 at		reports are submitted if ap	-	
	-	House Supervisor stated he		identified issues will be imr		
		hall by Nurse #1. He stated		reported to the Administrat	•	
		re had been an incident		Nursing for appropriate act		
		and NA #1 where Resident		be done on a daily basis if		
		1 of hitting her arm with the		abuse or neglect is reporte		
		king her cell phone. He		documented on the QA Su	-	
		Resident #1 and found no		grievances are reviewed d allegations of abuse or neg	• •	

Facility ID: 923542

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				E CONSTRUCTION		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345026	B. WING		C 04/13/2016	
NAME OF PR	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
				2700 ROYAL COMMONS LANE		
ROYAL PA	RK REHAB & HEALTH (CIR OF MATTHEWS		MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO	
F 225	Continued From page	a 4	E 22	5		
F 225	go to the hospital due called the police to co he then interviewed N statement. The House police and the Emerg (EMS) arrived at the f questioned Resident questioned NA #1. He go out to the hospital finished questioning N to the abuse allegatio could be completed b He stated he called th inform them of the ind Supervisor further sta evening Resident #1 transportation to be co police station becaus charges. He stated he instructed to tell Resident next morning. During an interview co 4:21 PM Nurse #1 stated stated he (3)/16/16 that Resident #1. Nurse #1 stated stated he (1) the stated he collect he collect the stated he called the collect the stated he called the collect could be completed b the stated he called the collect supervisor further stated he (1) the stated he collect he collect the stated he called the collect the stated he called the collect supervisor further stated he instructed to tell Resident the collect he collect he collect the stated he collect he collect the collect he collect he collect he collect the collect he collect he collect the collect he collect he collect he collect he collect the collect he collect he collect he collect he collect he collect he collect the collect he col	ated Resident #1 wanted to e to arm pain and she had ome to the facility. He stated VA #1 and had her write a e Supervisor stated the gency Management System facility and assessed and #1 and the police e stated Resident #1 did not and when the police NA #1 he sent her home due on until the investigation by the ADON and the DON. The ADON and the DON to cident. The House ated that later on in the came to him and asked for called to take her to the e she wanted to press e called the DON and was dent #1 transportation would e but they could call early the conducted on 04/12/16 at ated a NA informed her on int #1 was very upset at NA she went to see Resident #1	F 22	weekly for 1 month and then more resolved by Quality Assurance Committee, however, this will complete be an ongoing process. Report presented to the weekly QA cont the Administrator, DON or designers ensure corrective action initiated appropriate. Compliance will be monitored and ongoing auditing reviewed at the weekly QA Meet weekly QA Meeting is attended Director of Nursing, Wound Cart MDS Coordinator, RN Unit Man Support Nurse, Therapy Director Dietary Manager and the Admin Date of Compliance: May 5, 200	ontinue to is will be nmittee by gnee to d as e program tting. The by the re Nurse, agers, or, HIM, histrator.	
	her arm when she pu the table and she had of the wall while she	set and stated NA #1 had hit t her supper tray down on d pulled the phone cord out was talking to her family. dent #1 also told her NA #1				
	had broken her cell p	hone. Nurse #1 stated she e ADON to inform her of the				

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 05/06/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345026	B. WING			C 04/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
ROYAL PA	ARK REHAB & HEALTH (CTR OF MATTHEWS		2700 ROYAL COMMONS LAN	E	
				MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	
F 225	Continued From page	5	F 22	5		
F 225	provide care to Resid called the House Sup 100 hall and took ove stated she was never the DON about the inv During an interview of #3 stated she cared for PM to 11:00 PM on 00 was helped in the dini when she returned to Resident #1 was very went in to check on R never seen her that u #1 was normally very stated Resident #1 to her supper tray in and	ent #1. Nurse #1 stated she ervisor and he came to the r the investigation. Nurse #1 interviewed by the ADON or	F 22	5		
	phone and that she w and she had called th one had interviewed h	as going to sue the facility e police. NA #3 stated no her about the incident and red by the police when they				
	1:59 PM the ADON st Resident #1 wanted to stated when she spok revealed NA #1 had h stated she asked Resi to her office so they c together. She stated I family with her and th heated between Resi #1 so the she stopped the resolution that NA care to Resident #1. were in agreement. T	onducted on 04/13/16 at cated she was informed o see her on 03/14/16. She ce to Resident #1 she harassed her. The ADON cident #1 and NA #1 to come ould discuss the issue Resident #1 brought her e discussion became very dent #1, her family and NA d the discussion and made c. #1 would no longer provide The ADON stated all parties he ADON stated she did not in the 100 hall know NA #1				

Facility ID: 923542

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345026	B. WING		04	C 1/13/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				2700 ROYAL COMMONS LANE		
ROYAL PA	RK REHAB & HEALTH	CTR OF MATTHEWS		MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE
F 005						
F 225	Continued From pag		F 22	5		
		re for Resident #1. The				
		as called on 03/16/16 by				
		ouse Supervisor and informed NA #1 had hit Resident #1's				
		tray, pulled the phone cord				
		roke her cell phone and that				
		or had sent NA #1 home. She				
		el the need to come into the				
	facility due to NA #1	being sent home and she				
	was not involved in t	he investigation.				
	During an interview	conducted on 04/13/16 at				
	2:21 PM the DON st	ated she received a call from				
		or on 03/16/16 to inform her				
		gation that NA #1 had hit her				
	,	and hurt her arm, pulled the				
		e wall and broke her cell he did not go into the facility				
	that evening becaus					
	Supervisor had hand					
	-	essing the resident and				
		om Resident #1 and the NA				
	#1 and sending NA					
	allegation. The DON					
		7/16 and she no longer				
		rges against NA #1. The DON te to Resident #1's roommate				
		h what had happened the				
		DN stated she was involved				
	-	ation at the time and did				
	interview any other s	staff or NA #1 about the				
		and did not follow up on the				
		the facility policy. She				
		ould have filed a 24 hour and				
	• •	R due to the allegation of				
F 000	abuse by Resident #		F 00			E/E/40
F 226 SS=D	483.13(c) DEVELOF ABUSE/NEGLECT,		F 22	σ		5/5/16
				1		1

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	
		345026	B. WING			13/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROYAL PA	NRK REHAB & HEALTH (CTR OF MATTHEWS		2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
TAG F 226	Continued From page The facility must dever policies and procedur mistreatment, neglect and misappropriation This REQUIREMENT by: Based on record revif facility failed to impler procedures to thoroug of staff to resident abu 5 working day reports Personnel Registry fo for abuse (Resident # The findings included Review of the facility's Prohibition" with a rev revealed in part under any allegations (regan allegations are substa personnel, including in that appear to involve neglect, misappropria or the facility, commit or facility or diverting	e 7 elop and implement written es that prohibit a, and abuse of residents of resident property. is not met as evidenced ew and staff interviews the ment their abuse policy and ghly investigate an allegation use and submit 24 hour and to the Health Care r 1 of 3 residents reviewed (1) s policy titled "Abuse rised date of 09/2013 r Reportable Incidents that rdless of whether the antiated) against any njuries of unknown origin the conduct of abuse, ting property of the patient ting fraud against a patient drugs belonging to the	F 2:	DEFICIENCY) 26 F 226 DEVELOP / IMPLEMENT AB NEGLECT, ETC. POLICIES Corrective Action: Resident #1 On April 13, 2016, the facility initiater faxed a 24 hour initial report to the H Care Personnel Registry Section of t North Carolina Department of Health Human Services, regarding residem (S.G.)□s grievance filed on 3-14-16. DON, ADON and Social Worker initia and conducted another investigation that grievance and then reviewed fin with the Administrator. On April 18, 1 a follow up 5 working day report was submitted to the Health Care Persor Registry Section of DHHS. On April	USE / d and ealth he and t #1 The ated into dings 2016, nel 20,	DATE
		ses of paraplegia and		2016, the Administrator was contacted Athena Foreman, HCP Investigator was advised the Department has determine that an investigation will not be cond in this case. Identification of other residents who be involved with this practice:	who ned ucted	

Facility ID: 923542

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
						С
		345026	B. WING		0	4/13/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				2700 ROYAL COMMONS LANE		
RUTAL PA	ARK REHAB & HEALTH	CTR OF MATTHEWS		MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 226	Continued From page	e 8	F 22	26		
	1.0	sion Minimum Data Set		All residents have the potent	ial to be	
	dated 02/16/16 revea			affected by this practice. All		
	cognitively intact and			filed within the last three mor	-	
		ng the lookback period.		reviewed to identify a possible		
	,	3		neglect. If identified as a pos		
	Review of the facility	grievance form dated		or neglect, files were checke		
	03/14/16 revealed Re	esident #1 filed a grievance		that a complete investigation	was	
	against Nurse Aide #			conducted and if required, a		
		uring care. Resident #1		5day report was completed a		
		to her room to help her to		submitted. This was comple	-	
	•	#2, who was not supposed to		Director of Nursing, Social W		
	be in her room becau			Administrator as of 5/2/2016.		
		not be allowed to work with and helped NA #1 transfer		Systemic Changes:		
		started talking about her and		Systemic Changes.		
	-	dent #1 further stated in the		As of 5/5/2016 all staff (inclu	ding contract	
		was rough with her, pulled		service staff) were re-educat		
		her into bed and broke		in-serviced by the Administra		
	something on her ele			specifically regarding the fac		
	grievance revealed th	ne Assistant Director of		and procedures on Abuse Pr	ohibition and	
		Resident #1, her family		Abuse Prevention Guidelines	s. Topics	
		come into her office to		included, but not limited to:		
		on 03/14/16. The ADON		" If a staff member witnes		
		on became very heated and		abuse or neglect, the staff m		
		esolution was for NA #1 to		responsibility is to remove th	eresident	
	grievance further rev	e for Resident #1. The		from potential harms way. If a patient, family, visito	r or staff	
	-	Resident #1 was in the hall		member reports that possible		
	•	As she didn't want NA #1 to		abuse or neglect has occurre		
		because she might spit in it.		Administrator and or the Dire		
		. .		Nursing must be notified imm		
		s notes from 02/09/16		" If a grievance (written or		
		ealed Resident #1 had no		stating possible / potential at		
	negative behaviors o	r rejection of care.		neglect has occurred, then a		
				investigation will be conducted		
	Review of the Directo			investigation should include		
	-	or Resident #1 for incidents		from all witnesses, the accus	ed and the	
		6/16 revealed on 03/16/16 ed NA #1 was passing trays		accuser. The Abuse and Prohibiti	on notion for	

Facility ID: 923542

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB N (X3) DAT	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _		CON	IPLETED
						С	
		345026	B. WING			04	4/13/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL PA	ARK REHAB & HEALTH	CTR OF MATTHEWS			700 ROYAL COMMONS LANE		
				M	IATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	e 9	F	226			
		ook Resident #1's tray into			how to complete an investigation and		
	her room and sat it or			reporting abuse / neglect allegations to	0		
	documentation stated			the NC DHHS HCPR Section. This			
	hand with the tray an			includes completion and submission of	of 24		
	the phone cord out of			hour and 5 day report.			
	phone. Resident #1 stated NA#1 harassed her and she called the police and wanted to press				" Investigation files will be kept by t	the	
					Administrator.		
		stated the police came and			All staff who were not inserviced /		
	There was no follow	e until further investigation.			re-educated as of 5/5/16 on the facility	/□'e	
		folder for the 03/14/16			Abuse and Prohibition policy will not b		
	incident or the 03/16/				allowed to work until they have been		
		10.			re-educated / inserviced.		
	Review of the facility	24 hour and 5 day reports to					
		onnel Registry (HCPR) for			This information has been integrated i	nto	
	03/01/16 through 04/	12/16 revealed no reports			the facility' s standard orientation trai	ning	
	filed for Resident #1	for the incidents of 03/14/16			for all newly hired staff.		
	or 03/16/16.						
					Monitoring:		
		conducted on 04/12/16 at					
		ed she helped NA #1 get			The Director of Nursing and Facility S		
		bed on 03/16/16. She			Worker will monitor this issue using th	е	
		t rough with Resident #1 and			QA Survey Tool that will review all		
	#1 when transferring	h or giggle about Resident			grievances submitted to ensure that		
					proper investigations have been completed and that a 24 hour and 5 d	av	
	During an interview o	conducted on 04/12/16 at			reports are submitted if applicable. A	-	
	-	d she worked the 100 hall on			identified issues will be immediately		
		ner job to pass supper trays			reported to the Administrator or Direct	or or	
		ate in their rooms. She			Nursing for appropriate action. This w		
		dent #1's supper tray into her			be done on a daily basis if an allegation		
		er over bed table. She stated			abuse or neglect is reported and then		
	she asked Resident #	#1 if she wanted her to open			documented on the QA Survey Tool.		
		and she told her no. NA #1			grievances are reviewed daily for pote		
		ent #1's room at that point.			allegations of abuse or neglect. This		
		nt #1 was on the phone			be documented daily for 2 weeks, the		
		ay into her room but stated			weekly for 1 month and then monthly	until	
		hone cord out of the wall nor			resolved by Quality Assurance		
	ala she drop her cell	phone on the floor. NA #1			Committee, however, this will continue	e to	

Facility ID: 923542

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		СОМ	PLETED
		345026	B. WING			C 04/13/2016	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	10/2010
ROYAL PA	ARK REHAB & HEALTH (CTR OF MATTHEWS		2700 ROYAL COMMONS LANE MATTHEWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	stated she did not rec hand when she sat he #1 did not complain of in the room. NA #1 st shortly after she deliv tray and asked her wh her and Resident #1. her Resident #1 was the police because N and broke her cell ph Manager interviewed happened and the po her as well. She state the Unit Manager and of her shift. NA #1 state interviewed by the AD returned to work 2 da During an interview c 4:21 PM Nurse #1 stated state and she was very up her arm when she put the table and she had of the wall while she was Nurse #1 stated Resi had broken her cell p immediately called the incident. Nurse #1 state Supervisor and he ca over the investigation never interviewed by the incident.	call bumping Resident #1's er tray down and Resident of pain at any time she was ated Nurse #1 came to her vered Resident #1's supper hat had happened between NA #1 stated Nurse #1 told very upset and had called A #1 had hurt her hand/arm one. NA #1 stated the Unit her about what had dice came and interviewed ed she wrote a statement for d was sent home for the rest ated she was never DON or the DON when she hys later. onducted on 04/12/16 at ated a NA informed her on int #1 was very upset at NA she went to see Resident #1 uset and stated NA #1 had hit t her supper tray down on d pulled the phone cord out was talking to her family. dent #1 also told her NA #1 hone. Nurse #1 stated she e ADON to inform her of the ated she called the House ume to the 100 hall and took a. Nurse #1 stated she was the ADON or the DON about	F	226		re by o ram The se, , 1,	
	3:57 PM the evening was called to the 100	onducted on 04/12/16 at House Supervisor stated he hall by Nurse #1. He stated re had been an incident					

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/06/2016 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345026	B. WING				C / 13/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ROYAL PA	ARK REHAB & HEALTH	CTR OF MATTHEWS			0 ROYAL COMMONS LANE TTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	between Resident #1 #1 had accused NA # supper tray and brea stated he assessed F concerns with injuries arm and interviewed House Supervisor sta go to the hospital due called the police to co he then interviewed N statement. The Hous police and the Emerg (EMS) arrived at the questioned Resident questioned Resident questioned NA #1. Hi go out to the hospital finished questioning I to the abuse allegatic could be completed b He stated he called th inform them of the ind Supervisor further sta evening Resident #1 transportation to be co police station becaus charges. He stated h instructed to tell Resi not come out that late next morning. During an interview of #3 stated she cared f PM to 11:00 PM on 0 was helped in the din when she returned to Resident #1 was very went in to check on F never seen her that u	and NA #1 where Resident #1 of hitting her arm with the king her cell phone. He Resident #1 and found no s or range of motion to her her about the incident. The ated Resident #1 wanted to be to arm pain and she had ome to the facility. He stated NA #1 and had her write a e Supervisor stated the gency Management System facility and assessed and #1 and the police e stated Resident #1 did not and when the police NA #1 he sent her home due on until the investigation by the ADON and the DON. he ADON and the DON to	F	226			

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	ITERS FOR MEDICARE & MEDICAID SERVICES MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		IPLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í	NG	· · /	COMPLETED		
						С	
		345026	B. WING			13/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS				2700 ROYAL COMMONS LANE MATTHEWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F2	226			
	the House Supervisor stated she did not fee facility due to NA #1 k was not involved in th	-					
	2:21 PM the DON sta the House Supervisor	onducted on 04/13/16 at ated she received a call from r on 03/16/16 to inform her gation that NA #1 had hit her					

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CENTER		MEDICAID SERVICES				RM APPROVE IO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345026	B. WING		0	C 4/13/2016
NAME OF P	ROVIDER OR SUPPLIER	•	STRE	EET ADDRESS, CITY, STATE, ZIP COD	E	
ROYAL PA	ARK REHAB & HEALTH	CTR OF MATTHEWS		ROYAL COMMONS LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 226 F 514 SS=D	with the supper tray a phone cord out of the phone. She stated sh that evening because Supervisor had hand appropriately by asse taking statements fro #1 and sending NA # allegation. The DON Resident #1 on 03/17 wished to press charg stated she also spoke but she had not seen night before. The DO with another investiga interview any other st incident on 03/16/16 incident according to further stated she she 5 day report to HCPF abuse by Resident # 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately document systematically organi The clinical record m information to identify resident's assessment services provided; the	and hurt her arm, pulled the e wall and broke her cell he did not go into the facility e she felt the House led the situation essing the resident and m Resident #1 and the NA #1 home due to the stated she spoke to 7/16 and she no longer ges against NA #1. The DON to Resident #1's roommate what had happened the N stated she was involved ation at the time and did taff or NA #1 about the and did not follow up on the the facility policy. She ould have filed a 24 hour and R due to the allegation of 1. ETE/ACCURATE/ACCESSIB main clinical records on each ce with accepted professional ces that are complete; ed; readily accessible; and zed. ust contain sufficient y the resident; a record of the nts; the plan of care and	F 226			5/5/16

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/06 FORM APPR(OMB NO. 0938-	OVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345026	B. WING		C 04/13/2016	6
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		-
				2700 ROYAL COMMONS LANE		
ROYAL PA	RK REHAB & HEALTH	CTR OF MATTHEWS		MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5 ACTION SHOULD BE COMPLI- TO THE APPROPRIATE DAT CIENCY)	ETION
F 514	Continued From page	e 14	F 5	14		
	by:			F 514 RESIDENT REC COMPLETE / ACCUR/ ACCESSIBLE		
	-	esident abuse resulting in a of 3 residents reviewed for		Corrective Action:		
	The findings included	l:		Resident #1		
	02/09/16 with diagnost depression. Review of the admiss dated 02/16/16 revea cognitively intact and			On April 13, 2016, the f faxed a 24 hour initial r Care Personnel Regist North Carolina Departr Human Services, rega (S.G.) s grievance file DON, ADON and Socia and conducted another	eport to the Health ry Section of the nent of Health and rding resident #1 d on 3-14-16. The al Worker initiated	
	03/14/16 revealed Re against Nurse Aide # disrespectful to her d stated NA#1 came in get into bed and NA # be her room, was hid came out to help NA they started talking a	grievance form dated esident #1 filed a grievance 1 (NA) for being uring care. Resident #1 to her room to help her to #2, who was not supposed to ling in the bathroom and #1 transfer her to bed and bout her and laughing at her. tated in the grievance that		that grievance and ther with the Administrator. a follow up 5 working d submitted to the Health Registry Section of DH 2016, the Administrator Athena Foreman, HCP advised the Departmer that an investigation wi in this case.	On April 18, 2016, ay report was Care Personnel IHS. On April 20, r was contacted Investigator who thas determined	
	NA #1 was rough with to get her into bed an electric wheelchair. T Assistant Director of Resident #1, her fam come into her office t 03/14/16. The ADON	h her, pulled her shirt collar nd broke something on her The grievance revealed the		Identification of other re be involved with this pr All residents have the p affected by this practice Director of Nursing rev allegations of abuse or have occurred in the la	actice: potential to be e. On 5/2/2016 the iewed all potential neglect that may	

Facility ID: 923542

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTID	LE CONSTRUCTION	ח (גא)	ATE SURVEY
ID PLAN OF CORRECTION		A. BUILDING			COMPLETED	
						С
		345026	B. WING	·····		04/13/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ROYAL PA	ARK REHAB & HEALTH	CTR OF MATTHEWS		2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 514	Continued From page	e 15	F 51	4		
		4 #1 to no longer provide	1.01	validate that a nursing r	iote was	
		The grievance further		documented regarding		
		the evening on 03/14/16		or mental status, or cha		
		he hall and told the other		the resident if applicable		
	NAs she didn't want l	NA #1 to bring her dinner tray				
	because she might s	pit in it.		Systemic Changes:		
	Review of the Directo			As of 5/5/2016 the Nurs		
	•	or Resident #1 for incidents		Team including Director		
		6/16 revealed on 03/16/16		Assistant Director of Nu	-	
		ed NA #1 was passing trays		Managers and/or design		
		ook Resident #1's tray into n her over bed table. The		full time, part time and F LPNs. Topics included,		
		d NA#1 hit Resident #1's		limited to:	but were not	
		d hurt her hand, then ripped		" Anytime a resident,	family, visitor or	
		f the wall and broke her		staff report an allegation	•	
	-	stated NA#1 harassed her		neglect the Administrate		
		plice and wanted to press		must be notified immed	2	
		stated the police and the		" The nurse on duty		
		the facility and NA #1 was		an assessment of the pa		
		er investigation. There was		document that assessm	•	
	-	ation documentation in the		condition (if any) in the		
	Tolder for the 03/14/1	6 incident or the 03/16/16.		the electronic health rec "Nursing will docum		
	Review of the nurse's	s notes from 03/16/16		significant event, chang	•	
		ealed no documentation of		and/or any changes fou		
		ion of physical abuse by NA		completion of a new ass		
		of Resident #1 after the		residents that reported a		
	allegation was made	on 03/16/16.		allegation of abuse or n		
	-	conducted on 04/12/16 at		This information has be	•	
		ated a NA informed her on		the facility 's standard	prientation training	
		nt #1 was very upset at NA		for all newly hired staff.		
		she went to see Resident #1				
		set and stated NA #1 had hit				
		it her supper tray down on d pulled the phone cord out				
		was talking to her family.		Monitoring:		
		ident #1 also told her NA #1				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345026	B. WING		C 04/13/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS			2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 514		e 16 hone. Nurse #1 stated she	F 514	The Director of Nursing, ADON, L	Init
	immediately called th incident and then call who came to the 100 investigation. Nurse # nurse's note regardin physical abuse by NA been assessed by the During an interview c 3:57 PM the evening conducted the investi allegation of physical 03/16/16. He stated h DON but did not write his assessment of Re- record. He stated he note regarding his ph Resident #1. During an interview c 2:21 PM the DON state expected to see a nu assessment of Residustated a note should	e ADON to inform her of the ed the House Supervisor, hall and took over the #1 stated she did not write a g Resident #1's allegation of A #1 or that Resident #1 had e paramedics. onducted on 04/12/16 at House Supervisor stated he gation of Resident #1's abuse against NA #1 on he wrote a statement for the e a nurse's note regarding esident #1 in her medical should have made a nurse's ysical assessment of		Manager or designee will monitor issue using the QA Survey Tool. A residents that have had an allegal abuse or neglect reported will be to ensure that a progress note has entered into the medical record w assessment. Any identified issue immediately reported to the Admir or Director or Nursing for appropri action. This will be done on a daily an allegation of abuse or neglect if reported and then documented or Survey Tool. All grievances are re daily for potential allegations of at neglect. This will be documented 2 weeks, then weekly for 1 month then monthly until resolved by Qu Assurance Committee, however, for continue to be an ongoing process Reports will be presented to the w QA committee by the Administrato or designee to ensure corrective a initiated as appropriate. Complian be monitored and ongoing auditin program reviewed at the weekly Q Meeting. The weekly QA Meeting attended by the DON, Wound Nur MDS Coordinator, Unit Manager, Nurse, Therapy, HIM, Dietary Mar and the Administrator. Date of Compliance: May 5, 2016	this All tion of reviewed s been ith an es will be histrator iate y basis if is n the QA eviewed buse or daily for and ality this will s. veekly or, DON action ce will g DA j is rse, Support hager

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