PRINTED: 07/07/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED |
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| | | 345026 | B. WING _ | | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STA 2700 ROYAL COMMONS LA MATTHEWS, NC 28105 | • | 1 33/33/2313 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY) | DATE |
| F 000 | INITIAL COMMENT | S | F 0 | 00 | | |
| F 157 SS=D | provided to the facil results of the Inform process with the foll Event ID# CPF411: F241: deletion of example 2 and reduction of s F242: deletion of algoing outside the fadeletion of example F252: deleted by the 483.10(b)(11) NOTI (INJURY/DECLINE/A facility must immer consult with the resist known, notify the reor an interested famaccident involving the injury and has the printervention; a significantly (i.e., a rexisting form of treat consequences, or to treatment); or a decreatment); or a decreatment of the facility must also The facility and The facility must also The facility must also The facility and The | e survey team. FY OF CHANGES ROOM, ETC) diately inform the resident; dent's physician; and if sident's legal representative illy member when there is an ne resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial nreatening conditions or s); a need to alter treatment need to discontinue an tment due to adverse o commence a new form of ision to transfer or discharge the facility as specified in | F 1 | 57 | | 6/3/16 |
| | and, if known, the re or interested family change in room or r | esident's legal representative member when there is a commate assignment as 5(e)(2); or a change in | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER | R/SUPPLIER REPRESENTATIVE'S SIGNATUR | RE | TITLE | | (X6) DATE |

Electronically Signed 05/31/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | 0. | C 5/06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 0. | 3/00/2010 |
| 20141 24 | | | | 2700 ROYAL COMMONS LANE | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | MATTHEWS, NC 28105 | | |
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| F 157 | Continued From pag | ge 1 | F 15 | 7 | | |
| | | r Federal or State law or fied in paragraph (b)(1) of | | | | |
| | the address and pho | ord and periodically update one number of the resident's or interested family member. | | | | |
| | by: Based on staff, nurs member interviews, physician and an int inability to use the ri for assistance with a who experienced a #47). The findings include Resident #47 was a 07/31/13 with diagno | dmitted to the facility on | | The statements made on this Pla Correction are not an admission on the constitute an agreement with alleged deficiencies. To remain in compliance with all land State Regulations the facility taken or will take the actions set this Plan of Correction. The Plan Correction constitutes the facility allegation of compliance such the alleged deficiencies cited have be will be corrected by the date or definidicated. | to and do the Federal has forth in of s at all een or | |
| | Data Set (MDS) date assessment of mode The MDS indicated supervision and set in function range of Review of Resident 04/04/16 revealed R rolling walker with staneeded. | #47's quarterly Minimum ed 03/31/16 revealed an erately impaired cognition. Resident #47 required up to walk with no impairment motion. #47's care plan dated lesident #47 walked with a laff to provide assistance as | | Resident #47's family was notifie 4-24-16 by #47's primary nurse. #47 was assessed by the Nurse Practitioner on 4/25/16 and a neuconsult was ordered. On 4/27/16 #47 was seen by neurologist. Identification of potentially affecter residents and corrective actions the All residents have the potential to affected. The 24 hour report she reviewed for all residents for the | Resident prology resident ed aken: be ets were | |

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| | | 345026 | B. WING | | | I | C |
| NAME OF D | ROVIDER OR SUPPLIER | 343020 | 5: 11::10 | et. | REET ADDRESS, CITY, STATE, ZIP CODE | 1 05/ | 06/2016 |
| NAIVIE OF F | ROVIDER OR SUFFLIER | | | | | | |
| ROYAL PA | ARK REHAB & HEALT | H CTR OF MATTHEWS | | | 00 ROYAL COMMONS LANE | | |
| | | | | M | ATTHEWS, NC 28105 | | |
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| F 157 | Continued From pa | age 2 | F 1 | 157 | | | |
| | - | nted Resident #47 complained | | | days by the DON and QA team to ensu | ıre | |
| | | rm swelling with "noticeable | | | that the responsible parties and familie | | |
| | _ | to use it." Nurse #2 | | | were properly notified of any changes i | | |
| | | lent #47's family member | | | conditions. This was completed by Ma | | |
| | | e practitioner (NP) to see | | | 25 2016. | , | |
| | Resident #47 tomo | | | | | | |
| | | | | | Systematic Changes: | | |
| | Review of the NP a | acute visit note dated 04/25/16 | | | All Nurses, RNs and LPNs (full, part tin | пе | |
| | | ocumented Resident #47 | | | and PRN) were in-serviced by the Dire | ctor | |
| | _ | arm as "useless." The NP | | | of Nursing on the need to notify the | | |
| | | I right facial droop, inability to | | | responsible parties and medical provid | | |
| | | the right hand and right arm | | | of any change in condition. This will be | ; | |
| | | ordered a neurology | | | completed as of June 3, 2016. This | _ | |
| | consultation. | | | | information has been integrated into the | | |
| | Peview of a physic | sian's note dated 04/25/16 | | | standard orientation training and in the required in-service refresher courses for | | |
| | | cian documented Resident | | | all employees and will be reviewed by | | |
| | | sented with complete paralysis | | | Quality Assurance Process to verify that | | |
| | which could indicat | | | | the change has been sustained. | | |
| | | ogist consultation dated | | | Quality Assurance Plan: | | |
| | | the neurologist documented | | | Monday through Friday The Daily Clinic | | |
| | | pited a new right hemianopia | | | Meeting Nurses and DON will review th | | |
| | · · | with diminished strength in the | | | nursing 24 hour report with all progress | | |
| | | I. The neurologist ordered a arotid ultrasound and | | | notes for the last 24 hours and on Mon progress notes for 72 hours in PCC, | uay | |
| | transthoracic echo | | | | incident reports, new MD orders, and a | ınv | |
| | transtrioracic cerio | cardiogram. | | | resident with a change of condition has | | |
| | Interview with Resi | ident #47's family member on | | | documentation that the responsible par | | |
| | | M revealed Resident #47 | | | and medical provider were notified of the | | |
| | | ember the evening of | | | change. This will be done daily Monda | | |
| | 1 | nt #47 informed the family | | | through Friday and on Monday for the | | |
| | | pset due to the inability to use | | | weekend for at least three months. | | |
| | _ | family member explained she | | | Identified issues will be reported | | |
| | - | on 04/24/16, saw Resident # | | | immediately to DON or Administrator for | r | |
| | | ne right arm and spoke to | | | appropriate action. The weekly QA | | |
| | | nily member reported Nurse #2 | | | Meeting is attended by the DON, ADOI | | |
| | | lent #47's name would be | | | Administrator, SDC, MDS, HIM, Dietary | | |
| | placed on the list to | be seen the next day since it | | | Manager and Social Services. Results | of | |

Facility ID: 923542

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | B. WING | | C 5/06/2016 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | | 3/00/2010 | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | 2700 ROYAL COMMONS LANE | | | |
| | | | | MATTHEWS, NC 28105 | | | |
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| F 157 | Continued From pag | ge 3 | F 15 | 7 | | | |
| | was Sunday and no was available. Interview with Nurse revealed she cared and 04/24/16 during reported Resident # gait to stand at the vight she did not take Resphysically assess al nursing supervisor. Not notify Resident # physician. Telephone interview 4:25 PM revealed sl 04/23/16 and 04/24/Nurse #2 reported F the right arm and reassistance of 2 pers Nurse #2 explained #47's family member Resident #47 be seen Nurse #2 reported sphysician. Telephone interview (NP) on 05/05/16 at #47's loss of right arm weakness of both letransient ischemic as | #1 on 05/04/16 at 3:25 PM for Resident #47 on 04/23/16 Ithe evening shift. Nurse #1 47 required 2 persons and a valker. Nurse #1 reported sident #47's vital signs, I extremities or notify the Nurse #1 reported she did #47's family member and with Nurse #2 on 05/04/16 at the cared for Resident #47 on If 6 during the day shift. Resident #47 could not use quired the extensive tons to stand at the walker. She spoke with Resident on 04/24/16 who requested ten by a physician or NP. The did not notify the with the Nurse Practitioner 8:57 AM revealed Resident on use and increased gs could be indicative of a ttack or another stroke | | the audits will then be shared Quarterly QA Meeting with the Director with verification of his along with all members of the and Department Heads. Date of Completion: June 3, | ne Medical is attendance e QA Team | | |
| | outcome. The NP respectively notify the physician in condition such as occur. | treatment would not alter the eported the facility should or NP on-call when changes experienced by Resident #47 irector of Nursing (DON) on M revealed she expected staff | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBED: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | C 05/06/2016 | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 00/00/2010 | |
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| F 157 F 241 SS=D | member when loss of increased assistance 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an erenhances each residull recognition of his full recognition of his the second of the | an and Resident #47's family of right arm use and e required to walk occurred. AND RESPECT OF mote care for residents in a avironment that maintains or dent's dignity and respect in sor her individuality. T is not met as evidenced ons, record review, resident, the facility failed to obtain unitively intact residents in their personal belongings is to feel childlike and f 5 residents sampled for (Resident #9). d: as initially admitted to the and was re-admitted on oses which included kidney sleep apnea, gout, heart | F 15 | | ally ed ly, il e full | |
| | | lesident #9 utilized a walker | | This information has been integrated the standard orientation training and i | into | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | | 05/ | 06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 2 | 700 ROYAL COMMONS LANE | | |
| ROYAL PA | ARK REHAB & HEALTH (| JIR OF MATTHEWS | MATTHEWS, NC 28105 | | MATTHEWS, NC 28105 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | <u> </u> | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 241 | Continued From page | ÷ 5 | F | 241 | | | |
| | Review of the monthly | y Resident Council Minutes | | | required in-service refresher courses for | or | |
| | | gh 04/12/16 revealed the | | | all employees and will be reviewed by | :he | |
| | following: | | | | Quality Assurance Process to verify that | at | |
| | · On 09/25/15 a "s | pecial" resident council | | | the change has been sustained. | | |
| | | nd led by the Administrator | | | | | |
| | | ursing (DON). Per the | | | Quality Assurance: | | |
| | | ned to the residents in | | | The Nurse Unit Mangers will monitor th | | |
| | | nain priority of the facility | | | issue using the QA Survey Tool. Interv | | |
| | | afety of all residents. The | | | 5 alert and oriented patients to determi | | |
| | residents were advise | emoved in accordance to the | | | if they have had anything removed from their rooms without permission. Any | ı | |
| | | and Medicaid Services | | | issues will be reported to the | | |
| | | pational Safety and Health | | | Administrator and Director of Nursing. | | |
| | | A) guidelines. The resident | | | This will be done weekly for one month | | |
| | · · | er revealed the personal | | | and then monthly for at least three mor | | |
| | | any items which had a label | | | or until resolved by Quality Assurance | | |
| | | out of reach of children" and | | | Committee. Reports will be presented | to | |
| | all aerosol sprays suc | ch as hairsprays and | | | the weekly QA committee by the | | |
| | deodorants, rubbing a | | | | Administrator/ whoever to ensure | | |
| | _ | il polish remover, and mouth | | | corrective action initiated as appropriat | e. | |
| | | ich were permitted was hair | | | Compliance will be monitored and | | |
| | • | ohol free mouthwash, and | | | ongoing auditing program reviewed at | :he | |
| | non-aerosol deodorar | | | | weekly QA Meeting. The weekly QA | | |
| | | pecial" resident council | | | Meeting is attended by the DON, Wour | | |
| | meeting was called a | | | | Nurse, MDS Coordinator, Unit Manage | Γ, | |
| | and apologized to the | resent during the meeting | | | Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. | | |
| | | nal hygiene belongings in the | | | Manager and the Administrator. | | |
| | manner in which they | | | | Date of Completion: June 3, 2016 | | |
| | - | resident council meeting | | | | | |
| | | staff will be met with to | | | | | |
| | | ase the room inspections to | | | | | |
| | ensure corrections we | • | | | | | |
| | management and res | ident expectations." | | | | | |
| | On 05/03/16 at 8:45 A | | | | | | |
| | | ent #9. The resident stated | | | | | |
| | | a dictatorship, a prison." | | | | | |
| | ⊢kesident #9 further st | tated the Administrator and | 1 | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRU | | (X3) DATE COMP | SURVEY |
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| | | | A. BOILD | | | , | C |
| | | 345026 | B. WING | | | | 06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET AD | DRESS, CITY, STATE, ZIP CODE | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | 2700 ROYA | AL COMMONS LANE | | |
| ROIALIA | ANN NEHAD & HEALIN | OIR OF MATTIEWS | | MATTHEV | VS, NC 28105 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 241 | go through the reside and all of their personal aerosol sprays, rowith alcohol content Resident #9 indicate permission to go throwas done while he was told by administitems had been colle locked office, and thowould be given to the further stated he had facility rules/regulation to being allowed or nothing had ever be #9 indicated the resistems were removed especially the reside wandered in and our Resident #9 stated in irresponsible, angry, the porch." Also, Recused rubbing alcoholand had used Lister life, and was now become his personal hydrogene it am the color to the don't have dementian on 05/04/16 at 3:00 was conducted with stated the Administratended some of the and had apologized hygiene items without the content is the color of the state of the some of the and had apologized hygiene items without the content is the color of the state of the some of the and had apologized hygiene items without the content is the color of the state of the some of the and had apologized hygiene items without the state of the some of the and had apologized hygiene items without the state of the state of the some of the and had apologized hygiene items without the state of the state of the some of the state | ents' rooms, their drawers, and belongings, and removed abbing alcohol, mouthwash, and perfumes/colognes. It was out of his room at a seting. Resident #9 stated he tration after the fact that the ected, placed in a bag in a at the personal hygiene items e families. Resident #9 dasked for a copy of the ons in regards to these items in the facility's premises and en provided to him. Resident dent's had been told that the for the safety of all residents ents with dementia that to of other residents' rooms. It made him feel like a child, and "like a dog underneath sident #9 indicated he had of on his face after he shaved time mouthwash all of his adult eing told he could no longer giene items due to the safety with dementia. He further one being punished since I | F | 241 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | INSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345026 | B. WING _ | | | | C 06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 2700 | EET ADDRESS, CITY, STATE, ZIP CODE ROYAL COMMONS LANE THEWS, NC 28105 | <u>, </u> | <u> </u> |
| (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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 241 | | e 7 ents were told that their items d nor were they allowed to be | F2 | 241 | | | |
| | she was not employer resident's personal hy confiscated. NA #4 further informed by her superemove all aerosol specontained an alcohol to give them to the flosupervisor. NA #4 incany items from a resident | e Aide (NA) #4. She stated d with the facility when the avgiene items were wither stated she had been rivisor that she should brays or products which content and was instructed for nurse or the nurse licated she had not removed dent's room. | | | | | |
| | aware administration through the resident's aerosol sprays, any palcohol content, or ar read "keep out of rea further stated the NA remove the items was facility. Nurse #5 indiinstructed should any observed in a resider be collected, locked a room until the resider up, and also the staff Director of Nursing (ACC) On 05/05/16 at 6:05 ACC CONDUCTED TO THE CONDUCT | e #5. She stated she was had instructed an NA to go s rooms and collect all of the products which contained an my item with a label which ch of children." Nurse #5 which was instructed to so no longer employed at the cated all staff had been of the items be found or not's room the items were to up in the medication storage int's family could pick them was to inform the Assistant ADON) or the DON. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | PLE CONSTRUCTION IG | , , | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | I | 03/06/2016 | |
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| F 241 | conducted with NA a instructed by manage which contained an which were labeled reach of children" we residents' rooms. No never removed a resident from their room. On 05/05/16 at 6:22 conducted with Nurse a resident have any rooms due to a fire the dementia reside instructed by manage and to give them to stated she was unal removed any persor from a resident's room. On 05/06/16 at 9:15 conducted with NA a informed by manage allowed to have any further stated she we should she see any contained an alcoholabel which read "ke children" that they we items and turn them. On 05/06/16 at 10:1 conducted with Nurse and turn them. | AM an interview was #6. NA #6 stated she was rement that all aerosols, items alcohol content, and items with the words "keep out of ere to be removed from the A #6 further stated she had sident's personal hygiene m. AM an interview was se #6. Nurse #6 stated should type of aerosols in their nazard and for the safety of ement to remove those items that she had been rement to remove those items the ADON. Nurse #6 further pole to recall if she had hal hygiene items or aerosols om. AM an interview was #7. NA #7 stated she was rement that a resident was not aerosols in their rooms. She has informed by management aerosols, products which all content, or an item with a rep out of the reach of rere expected to remove the | F 2 | 41 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING _ | | | C 05/06/2016 | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | • | 55/55/2515 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | ((EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 241 | of all residents. Nurs not read or seen a p | ge 9 related to ensuring the safety se #7 further stated she had rolicy in regards to the nts' personal belongings. | F 2 | 241 | | | |
| | conducted with the aunaware of a policy OSHA in regards to resident rooms. She unaware if the requior if it was for their bindicated she was in Administrator and Dallowed to have hair polish remover, any which included mouspray deodorants, codor reducing spray rooms. She further in | 5 AM an interview was ADON. She stated she was or guidelines from CMS or aerosols and toxins being in a further stated she was also rement was corporation wide building only. The ADON aformed by management, the ON, that residents were not esprays, any aerosols, nail alcohol containing contents; th wash and rubbing alcohol, colognes/perfumes, or any s, such as "febreze" in their indicated she expected the ove the items mentioned as acted to do so by | | | | | |
| | conducted with the I the Administrator wa the residents and ha there were to be no polish remover, alco hairsprays allowed i stated the residents advised they could I a non-alcohol conta also stated that sho rubbing alcohol, and alcohol pads the fact be kept in the medic | PM an interview was DON. She stated that she and anted to ensure the safety of ad made it a requirement that aerosols, air fresheners, nail shol containing items, or in the facility. She further and family members were nave pump type hairsprays or ining mouth wash. The DON ald a resident want to keep I did not want to use the ility had, then that item would aation cart and the resident use that item as they | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION B | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 1 00/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| F 242 SS=E | are not allowed in the DON was asked if the could a copy of that is stated "I don't known or not." There was not 483.15(b) SELF-DET MAKE CHOICES The resident has the schedules, and health her interests, assess interact with member inside and outside the | further stated "but the items e residents' rooms." The ere was a facility policy and policy be obtained. The DON if the policy has been written to policy provided. TERMINATION - RIGHT TO right to choose activities, the care consistent with his or ments, and plans of care; as of the community both the facility; and make choices or her life in the facility that | F 24 | | 6/3/16 |
| | by: Based on observation and staff interviews to residents their choice products causing the irresponsible. The faresident's choice for week causing the resident's choice for week causing the resident sample and #192). The findings included 1. a. Resident #9 was facility on 11/07/13 at 06/13/14 with diagnor | cility also failed to honor a the number of showers in a sident to feel un-clean for 4 ed for choices (Residents #9, d: s initially admitted to the nd was re-admitted on ses which included kidney sleep apnea, gout, heart | | F 242 On 5-30-16, the Administrator met w and reviewed the revised policy for personal hygiene products with resid #9, #165 and #69. On 5-30-16, Resi #9 was evaluated by the Interdiscipli Care Plan Team to determine if he conself-administer rubbing alcohol. The facility provided a new bottle of rubbinal alcohol for Resident #9. On 5-30-16, the MDS Nurse met with resident #192 to determine shower preferences. Corrective Action for Resident Poten Affected: | lent ident nary buld ng |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
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| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | X | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 242 | Continued From page | e 11 | F 2 | 242 | | | |
| | • • | rly Minimum Data Set (MDS) | | | All residents have the potential to be | | |
| | - | d Resident #9 as cognitively | | | affected by this practice. By 6-3-16, the | | |
| | | mited assistance from staff | | | RN Nurse Unit Managers will meet with | | |
| | • | sfers, dressing, toileting, | | | cognitively intact residents to determine | | |
| | | d bathing. Further review of | | | shower preferences, ensure that they | | |
| | | esident #9 utilized a walker | | | know where they can go outside and | | |
| | and a wheelchair for | | | | reviewed the updated personal hygiene | <u>.</u> | |
| | | | | | product policy. The policy has been | | |
| | On 05/03/16 at 8:45 | AM, an interview was | | | updated to include: Aerosols cannot be | Э | |
| | conducted with Resid | dent #9. The resident stated | | | stored near heat producing devices. The | | |
| | "this is not home, it is | a dictatorship, a prison." | | | includes heater units, hair dryers, TVs, | | |
| | Resident #9 further s | tated the Administrator and | | | and oxygen concentrators. We prefer | hat | |
| | Director of Nursing (I | DON) had a nurse aide (NA) | | | non-aerosol products be used when | | |
| | go through the reside | ents' rooms, their drawers, | | | possible. Over the counter medication: | 3 | |
| | · | nal belongings, and removed | | | cannot be stored in a patients room | | |
| | | bbing alcohol, mouthwash | | | unless the patient has been evaluated | by | |
| | | and perfumes/colognes. | | | the care plan team to determine if they | | |
| | Resident #9 indicate | | | | are safe to self-administer. If they are | | |
| | - | ough his belongings and it | | | deemed safe an MD order must be | | |
| | | as out of his room at a | | | obtained. All over the counter | | |
| | | ting. Resident #9 stated he | | | medications must be stored in a locked | | |
| | | ration after the fact that the | | | drawer in the patient's room. It is | | |
| | | cted, placed in a bag in a at the personal hygiene items | | | preferred that any item that is labeled "keep out of the reach of children" shou | ıld | |
| | | e families. Resident #9 | | | be stored either behind the bathroom d | | |
| | ~ | asked for a copy of the | | | or in the locked bedside drawers. | 001 | |
| | | ons in regards to these items | | | of in the locked bedside drawers. | | |
| | | the facility's premises and | | | | | |
| | • | en provided to him. Resident | | | Systemic Changes | | |
| | | dent's had been told that the | | | Systemic smanges | | |
| | | for the safety of all residents | | | The Director of Nursing in-serviced the | full | |
| | | nts with dementia that | | | time, part time and PRN nursing and | | |
| | | of other residents' rooms. | | | CNAs. This is to be completed by June | 3, | |
| | | made him feel like a child, | | | 2016. Topics included: | , | |
| | | and "like a dog underneath | | | Shower preferences and schedule | s | |
| | | sident #9 indicated he had | | | should be followed. Shower schedules | | |
| | | on his face after he shaved | | | can be located on CNA tasks in POC a | | |
| | _ | ne mouthwash all of his adult | | | at nurse's station on assignment sheet | | |
| | | ng told he could no longer | | | Aerosols cannot be stored near he | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | : | | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | 2700 ROYAL COMMONS LANE | | | | |
| | | | | MATTHEWS, NC 28105 | | | | |
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| F 242 | Continued From page | e 12 | F 2 | 42 | | | | |
| | use his personal hyginal aspect of residents with indicated "I am the ordon't have dementia." On 05/04/16 at 3:43 Ficonducted with Nurses she was not employed resident's personal hyginal actions of the superior of the sup | ene items due to the safety ith dementia. He further ne being punished since I " PM an interview was e Aide (NA) #4. She stated d with the facility when the sygiene items were urther stated she had been rvisor that she should brays or products which | | producing devices. This include units, hair dryers, TVs, and oxygen conce We prefer that non-aerosol proused when possible. • Over the counter medication be stored in a patients room un patient has been evaluated by plan team to determine if they self administer. If they are dean MD order must be obtained the counter medications must | entrators. coducts be ions cann nless the the care are safe to emed safe d. All over | not to e | | |
| | contained an alcohol content and was instructed to give them to the floor nurse or the nurse supervisor. NA #4 indicated she had not removed any items from a resident's room. | | | a locked drawer in the patient' It is preferred that any iter labeled "keep out of the reach should be stored either behind | m that is of childre | en" | | |
| | On 05/04/16 at 3:47 ff conducted with Nurse aware administration through the resident's aerosol sprays, any palcohol content, or ar read "keep out of rea further stated the NA remove the items was facility. Nurse #5 indic | PM an interview was e #5. She stated she was had instructed an NA to go so rooms and collect all of the products which contained an early item with a label which ch of children." Nurse #5 which was instructed to so no longer employed at the cated all staff had been | | bathroom door or in the locked drawers. This information has been inte the standard orientation training required in-service refresher of all employees and will be revied Quality Assurance Process to the change has been sustained. | egrated into egrated into ourses for ewed by the | to the r he | | |
| | observed in a resider be collected, locked upon until the resider up, and also the staff Director of Nursing (ACO 05/05/16 at 6:05 ACO | • | | Quality Assurance: The Nurse mangers will monitusing the QA Survey Tool. Interpretation alert and oriented patients to or they have been allowed to have items of their choice, and if she preferences have been honore issues will be reported to the Administrator. This will be dor for one month and then month least 3 month or until resolved | erview 5 determine ve person ower ed. Any ne weekly ly for at | if al | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | 5/06/2016 | |
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| ROYAL PA | ARK REHAB & HEALTH | CIR OF MAITHEWS | | MATTHEWS, NC 28105 | | | |
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| F 242 | Continued From pag | e 13 | F 24 | 42 | | | |
| | hygiene items from to On 05/05/16 at 6:15 conducted with NA # instructed by manag which contained an a which were labeled with reach of children" we residents' rooms. NA never removed a resitems from their room. On 05/05/16 at 6:22 conducted with Nurse a resident have any rooms due to a fire the dementia resider instructed by manag and to give them to to stated she was unable. | AM an interview was 6. NA #6 stated she was ement that all aerosols, items alcohol content, and items with the words "keep out of ere to be removed from the a #6 further stated she had ident's personal hygiene | | Assurance Committee. Reppresented to the weekly QA the Administrator/ whoever to corrective action initiated as Compliance will be monitore ongoing auditing program reweekly QA Meeting. The we Meeting is attended by the D Nurse, MDS Coordinator, Ur Support Nurse, Therapy, HIM Manager and the Administrational Date of Completion: June 3, | committee by o ensure appropriate. d and viewed at the ekly QA DON, Wound hit Manager, M, Dietary tor. | | |
| | from a resident's roo On 05/06/16 at 9:15 conducted with NA # informed by manage allowed to have any further stated she was should she see any a contained an alcoholabel which read "ke- children" that they witems and turn them On 05/06/16 at 10:19 conducted with Nurshad been advised by | AM an interview was F7. NA #7 stated she was ment that a resident was not aerosols in their rooms. She as informed by management aerosols, products which I content, or an item with a ep out of the reach of ere expected to remove the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | · / | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | I CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 33/00/2010 | |
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| F 242 | in their possession of all residents. Nurs not read or seen a premoval of a resider. On 05/06/16 at 11:5 conducted with the Administrator and Dallowed to have hair polish remover, any which included mou spray deodorants, codor reducing spray rooms. She further in nursing staff to remote they had been instrumanagement. On 05/06/16 at 4:50 conducted with the Administrator wather esidents and hat there were to be no polish remover, alcohairsprays allowed istated the residents advised they could have not also stated that sho rubbing alcohol, and alcohol pads the face | mouth wash in their rooms or related to ensuring the safety se #7 further stated she had policy in regards to the ents' personal belongings. 5 AM an interview was ADON. She stated she was or guidelines from CMS or aerosols and toxins being in a further stated she was also rement was corporation wide puilding only. The ADON informed by management, the entry in the entry is any aerosols, nail alcohol containing contents; the wash and rubbing alcohol, polognes/perfumes, or any is, such as "febreze" in their indicated she expected the over the items mentioned as | F 24 | 2 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
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| | NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS | | | s 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 ROYAL COMMONS LANE 1ATTHEWS, NC 28105 | 05/ | 06/2016 | |
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| F 242 | are not allowed in the DON was asked if the could a copy of that p | further stated "but the items e residents' rooms." The ere was a facility policy and policy be obtained. The DON of the policy has been written | F | 242 | | | | |
| | on 08/12/15 with diag chronic Clostridium d cause symptoms ran- life-threatening inflam | s re-admitted to the facility gnoses which included ifficile (a bacterium that can ging from diarrhea to nmation of the colon), ancreas, type II diabetes | | | | | | |
| | Data Set (MDS) date Resident #192 was c decision making. The Resident #192 requir hygiene but extensive | recent quarterly Minimum d 03/08/16 indicated ognitively intact for daily e MDS further indicated red limited assistance with e assistance with bathing pehaviors or rejection of | | | | | | |
| | for the last 30 days reshowers on Wednesor 7:00 AM - 3:00 PM st 04/13/16; 04/16/16; 05/04/16. Further revealed Resident #1 04/20/16 and 04/27/1 shower on an alternation | | | | | | | |
| | During an interview of | on 05/03/16 at 08:18 AM | | | | | | |

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| F 242 | a week but he prefiveek. He explained he washed off in the could. He further easked him about his showers after he washed his shower. Showers washed his shower than 2 showers were provised an addit fit it into the shower showers were provised and third shift or on Surburing an interview Director of Nursing admitted to the fact receive 2 showers residents could ask week but they did received as week but they did residents as washed as washe | ed he usually had 1-2 showers erred to have 3 showers a ed when he didn't get a shower e bathroom as best as he explained facility staff had not is preferences or choices for ras readmitted to the facility. You on 05/06/16 at 9:40 AM ed she was assigned to care and he was scheduled to a week. She explained is cooperative with care but e felt bad he did not want to e further explained if he er on another day they would try edule. You on 05/06/16 at 10:30 AM the it Manager/Assistant Director of residents were provided with a ek and on non-shower days bed bath or sponge off in the atted they did not offer residents ers a week but if a resident ional shower they would try to rechedules. She explained did to residents on first and day through Saturday. She o showers were provided on | F 2- | 42 | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED C | |
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| F 244 SS=E | must listen to the vie grievances and reco and families concern | ted to the facility. I/ACT ON GROUP MMENDATION amily group exists, the facility | F 244 | | 6/3/16 | |
| | by: Based on a review of minutes for 3 months 2016, and April 2016 minutes for 1 month observations on 4 of interviews (Resident interviews, and a review facility failed to resol expressed during Recommittee Meetings The findings included 1 a. Review of April 2 Meeting minutes revithat 2nd shift nurse a instead of passing of delivered meals to the that they received conot passing out mea. The facility response manager of resident nurse aides on the contractions of the contraction of | 2016 Food Committee ealed residents expressed aides were on the computer ut meal trays after kitchen he units. Residents expressed hold food related to nurse aides | | F 244 Corrective Action for Resident Affecte On 5-31-16, the Administrator will mewith resident council (via Special Res Council Meeting) to go over plans to resolve the concerns of late meal delication Corrective Action for Resident Potential Affected: All residents have the potential to be affected by this practice. See systemic changes below for corrective action for residents. Systemic Changes: On May 31, 2016 the Vice President of Liberty Healthcare Clinical Services in-serviced the administrator and active coordinator on the following: To provimore timely response to resident cour and food committee concerns meeting be held monthly. The Administrator we provide a brief update at the beginning | et ident very. ally c or of vity de a ncil g will vill | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| PREFIX (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| certified dietary man was aware of resider meals and that some that they would like to before 6:30 PM. The of this concern, he condend and staff distributes and staff distribut | on 05/05/16 at 03:23 PM, the ager (CDM) stated that he nt complaints regarding late e residents expressed to him to receive their supper meal e CDM stated that as a result onducted tray delivery audits the meal cart reached the outed the trays, some neir supper as late as 7:00 ne continued to review the dent Council, Food and customer satisfaction olution to the concerns on 05/05/16 at 3:52 PM, the that due to continued the tray earlier supper as late as 7:00 ne continued to review the dent Council, Food and customer satisfaction olution to the concerns on 05/05/16 at 3:52 PM, the that due to continued the earlier supper as late as 7:00 ne contract in place to address the next annual survey, but the earlier that since the survey in October 2015 some made in the dietary se corrections did not stay inistrator further stated that resident/family concerns with the timeliness of meal ff was working to address 2016 Resident Council ealed residents expressed | F 2 | the meeting regarding the chan corrections made regarding corvoiced at the previous meeting. Administrator will not attend the session of the meeting unless at the committee members. If an resolved after two months the Administrator will notify the Reg Service Director of Operations discussion to develop an action This information has been integ the standard orientation training required in-service refresher coall employees and will be review Quality Assurance Process to with the change has been sustained. Quality Assurance: The QA Nurse Consultant will not issue using the QA Survey Tool month a review will be conducted Food Committee minutes and the Resident Council to ensure that to grievances and concerns occurred and concerns occurred to the Administrator. This will be done for at least 3 months or until resulting Quality Assurance Committee. Will be presented to the weekly committee by the Administrator designee to ensure corrective a initiated as appropriate. Complishe monitored and ongoing audit program reviewed at the weekly Meeting. The weekly QA Meeting attended by the DON, Wound MDS Coordinator, Unit Manage Nurse, Therapy, HIM, Dietary Mand the Administrator. | ncerns The closed asked to by area is not gional Food for plan. grated into g and in the purses for wed by the rerify that t. nonitor this Every ed of the he tresolution cur timely. he e monthly solved by Reports QA or action ance will ting y QA ing is Nurse, er, Support | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | ` IDENTIFICATION NUMBED: | |) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 244 | F 244 Continued From page 19 | | F 2 | 244 | | | | |
| | cart instead of being passed out in a timely manner. | | | | Date of Completion: June 3, 2016 | | | |
| | conducting audits on | d to this grievance by meal delivery and noted sent for meals and passing nanner. | | | | | | |
| | During an interview on 05/05/16 at 03:23 PM, the certified dietary manager (CDM) stated that he was aware of resident complaints regarding late meals and that some residents expressed to him that they would like to receive their supper meal before 6:30 PM. The CDM stated that as a result of this concern, he conducted tray delivery audits and noted that once the meal cart reached the units and staff distributed the trays, some residents received their supper as late as 7:00 PM. He stated that he continued to review the concerns from Resident Council, Food Committee Meetings and customer satisfaction surveys to bring resolution to the concerns voiced. | | | | | | | |
| | Administrator stated family/resident conce expressed during Re Committee Meetings and timeliness of me have a new dietary of these issues before to this was still in proce facility's last annual simprovements were redepartment, but these consistent. The admit he was aware of the | erns expressed to him and sident Council/Food regarding food palatability all delivery, his plan was to ontract in place to address he next annual survey, but ss. He stated that since the survey in October 2015 some | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | H CTR OF MATTHEWS | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 1 03/00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEI | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE COMPLETION | |
| F 244 | delivery and that st this. c. Review of February Meeting minutes rethat nurse aides we in a timely manner announce to nurse the way to the units. Review of the facility 2016 meeting reveal documentation of a concern. During an interview certified dietary man was aware of residemeals and that some that they would like before 6:30 PM. The of this concern, he and noted that once units and staff districts residents received PM. He stated that concerns from Res Committee Meeting surveys to bring residents received. During an interview Administrator state of family/resident concerns expressed during FC Committee Meeting and timeliness of minutes and timeliness of minutes of the concerns from the concerns from Res Committee Meeting and timeliness of minutes of the concerns from | aff was working to address ary 2016 Food Committee vealed residents expressed ere not passing out meal trays and requested to have staff aides when the trays were on s. ty response to the February aled there was no facility response to this voiced on 05/05/16 at 03:23 PM, the nager (CDM) stated that he ent complaints regarding late he residents expressed to him to receive their supper meal he CDM stated that as a result conducted tray delivery audits he the meal cart reached the help to the trays, some their supper as late as 7:00 he continued to review the | F 24 | 4 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345026 | B. WING | | | C 05/06/2016 | | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 2700 | ET ADDRESS, CITY, STATE, ZIP CODE ROYAL COMMONS LANE THEWS, NC 28105 | 1 001 | 00/2010 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 244 | facility's last annual simprovements were redepartment, but these consistent. The adminhe was aware of the food palatability and the delivery and that staff this. d. Review of November Meeting minutes reverthat nurse aides were meals which caused to have their food to be advise nursing of resources aides taking to trays. During an interview of certified dietary manawas aware of residented meals and that some that they would like to before 6:30 PM. The of this concern, he countries and staff distributes and staff distribu | ss. He stated that since the urvey in October 2015 some made in the dietary ecorrections did not stay nistrator further stated that resident/family concerns with the timeliness of meal f was working to address of ealed residents expressed etaking too long to deliver residents to have to request the reheated due to late trays. It to this grievance was to ident complaints regarding to long to pass out meal on 05/05/16 at 03:23 PM, the eager (CDM) stated that he are complaints regarding late residents expressed to him to receive their supper meal CDM stated that as a result anducted tray delivery audits the meal cart reached the lated the trays, some eir supper as late as 7:00 econtinued to review the ent Council, Food and customer satisfaction lution to the concerns | F2 | 244 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | |
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| | | 345026 | B. WING | | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | - 1 | 05/06/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 244 | expressed during Re Committee Meetings and timeliness of me have a new dietary of these issues before this was still in proof facility's last annual improvements were department, but the consistent. The adm he was aware of the food palatability and delivery and that stathis. e. Resident #329 was 03/08/16. Review of Set (MDS) assessm Resident #329 with able to understand, supervision with me 05/02/16 at 03:46 Pher lunch was late of was not unusual, she meals 30 - 40 minut times and that occas advise her that the reside meals and that som that they would like before 6:30 PM. The of this concern, he cand noted that once units and staff distril | erns expressed to him and esident Council/Food s regarding food palatability eal delivery, his plan was to contract in place to address the next annual survey, but ess. He stated that since the survey in October 2015 some | F 2- | 44 | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | 345026 B. WING | | | C 05/06/2016 | |
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| F 244 | times according to n times and that he co times unless nursing administration times the dietary department he went to the units residents as to where delivered. He stated the concerns from R Committee Meetings surveys to bring reservoiced. During an interview Administrator stated family/resident concexpressed during Recommittee Meetings and timeliness of meanity have a new dietary of these issues before this was still in procefacility's last annual improvements were department, but the consistent. The adminestent. The adminestent he was aware of the food palatability and delivery and that stathis. f. Resident #54 was 05/08/15. Review of 04/14/16 assessed I speech, understood cognition and requiremeals. During an interview. | d the he had to arrange meal nedication administration uld not change meal delivery changed the medication. The CDM also stated that if ent ran late with meal delivery, to inform nursing staff and the meal trays would be that he continued to review esident Council, Food and customer satisfaction plution to the concerns on 05/05/16 at 3:52 PM, the that due to continued the erns expressed to him and esident Council/Food as regarding food palatability eal delivery, his plan was to contract in place to address the next annual survey, but the essurvey in October 2015 some | F 24 | 14 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 244 | receiving her meals I she received lunch/si late because of some kitchen and that she that morning (05/05/² the posted meal deliv breakfast trays to this 9:00 AM. During an interview of certified dietary manawas aware of resider meals and that some that they would like to before 6:30 PM. The of this concern, he country and staff distributes and staff distributes and staff distributes are ceived the PM. The CDM stated times according to mutimes and that he coutimes unless nursing administration times, the dietary department he went to the units to residents as to when delivered. He stated the concerns from Recommittee Meetings surveys to bring resovoiced. During an interview of Administrator stated family/resident concerns from Recommittee Meetings surveys to bring resovoiced. | to staff regarding routinely ate. Resident #54 stated that upper on 05/01/16 (Sunday) ething that happened in the did not receive her breakfast 16) until 10:15 AM. Review of very schedule revealed as Resident's hall were due at the on 05/05/16 at 03:23 PM, the ager (CDM) stated that he ager (CDM) stated that he ager (CDM) stated that he ager esidents expressed to him to receive their supper meal CDM stated that as a result enducted tray delivery audits the meal cart reached the uted the trays, some eir supper as late as 7:00. If the he had to arrange meal edication administration all on the change meal delivery changed the medication. The CDM also stated that if not ran late with meal delivery, to inform nursing staff and the meal trays would be that he continued to review esident Council, Food and customer satisfaction lution to the concerns | F2 | 244 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 244 | have a new dietary these issues before this was still in proc facility's last annual improvements were department, but the consistent. The adm he was aware of the food palatability and delivery and that stathis. 2. A review of the prevealed supper traaccording to the foll 200 hall - Cart 6:05 PM 500 hall - 6:15 PM 400 hall - 6:35 During an observation of the supper meal, PM. The tray line wuntil 07:25 PM with that resulted in a decentified dietary chicken for resident At 05:59 PM the conduct temperatur on the tray line due identified with foods Fahrenheit (F). At 06:09 PM, D she had run out of vegetables to continuous departments. | eal delivery, his plan was to contract in place to address the next annual survey, but ess. He stated that since the survey in October 2015 some made in the dietary se corrections did not stay ministrator further stated that e resident/family concerns with the timeliness of meal aff was working to address the tast of the timeliness of the dilivery schedule the timeliness of the delivered owing schedule: 1 at 5:55 PM and Cart 2 at PM PM on in the kitchen on 05/01/16 the tray line began at 05:15 as observed from 05:15 PM the following concerns noted that of the meal delivery: iterary staff (DS) #1 requested manager (CDM) prepare son a mechanical soft diet. The company of all hot foods a resident's meal tray the seless than 135 degrees PS #1 informed the CDM that regetables and needed more | F2 | 244 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | H CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | ' | 33,733,2310 |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 244 | 135 degrees F and At 6:52 PM, DS she had run out of regetables. At 6:56 the 600 hall while at to continue to tray I vegetables were predelivered to the 600 During a dining obseon 05/01/16 (Sundatimes were noted: 200 hall (Cart than the posted delivery time: 400 hall - 06:50 posted delivery time: 600 hall (Cart than the posted delivery time: 600 hall (Cart due to a delay in the | preparature that was less than the soup was reheated. 8 #1 informed the CDM that mashed potatoes and PM, Cart 1 was delivered to dditional foods were prepared ine. Black eyed peas and epared and Cart 2 was 0 hall at 7:28 PM. Servation of the supper meal ay), the following meal delivery 1) - 06:17 PM; 22 minutes later ivery time 7 PM; 22 minutes later than the ee of PM; 20 minutes later than the eerometric than the end of PM; 20 minutes later than the eerometric than the end of PM; 20 minutes later than | F 2 | 44 | | |
| | #8 revealed she rou weekend and obse meal from the dieta between 7 PM to 7: as 8 PM. An interview on 05/ Aide (NA) #7 revea the 400 hall usually department between During an interview | 01/16 at 06:34 PM with Nurse utinely worked every other reved delivery of the supper ry department to the 600 hall 30 PM and sometimes as late 01/16 at 06:41 PM with Nurse led the supper meal cart for arrived from the dietary n 06:45 PM and 07:00 PM. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 05/06/2016 | |
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| F 244 | routine 2nd shift cook #1 stated "We need a help, it slows me dow everything on the line if we run out of some more, sometimes we because of this." During an interview of the certified dietary methat, in terms of the tidelivery, the cook should foods so that "we dorn line" and that the methave been prepared In The CDM stated that have anyone assisting preparation and had the line on their own. During an interview of Administrator stated the family/resident conce expressed during Resident this was still in processification in processifications and the state of | nother person on the line to n when I have to try to keep and do all of my own prep, hing I have to prepare are late with the meals n 05/01/16 at 07:36 PM with anager (CDM) he revealed meliness of the meal ould have had a back-up of trun out of food during the chanical soft chicken should before the tray line began. The cook usually did not get them with meal to learn to manage the tray n 05/05/16 at 3:52 PM, the hat due to continued respectively his plan was to contract in place to address the next annual survey, but its. He stated that since the curvey in October 2015 some nade in the dietary expressed that esident/family concerns with | F 244 | | | |
| F 246 SS=D | 483.15(e)(1) REASO | NABLE ACCOMMODATION ENCES | F 246 | 6 | 6/3/16 | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C | |
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| F 246 | services in the facili accommodations of preferences, except | ght to reside and receive | F 2 | 46 | | |
| | by: Based on observation interviews, the facility with getting out of besupervised scheduled of 2 residents who the findings included Resident #239 was 04/22/15 with diagnostic statement with the findings included the fi | on, resident and staff ty failed to provide assistance ed to be able to attend a ed 9:30 AM smoking time for o smoke (Resident #239). ed: admitted to the facility on oses which included hiparesis following cerebral | | F 246 Resident #239 did get up after the smoke break and was able to at next scheduled smoke time. Identification of potentially affect residents and corrective actions. All residents who have a schedule smoke time have the potential to affected by this practice. See sychanges below for corrective actions. | tend the ted taken: uled b be retemic | |
| | Data Set (MDS) datassessment of intactindicated Resident # assistance of 2 personal Review of the facility 04/19/16 revealed soccurred at 9:30 AMPM and 8:00 PM. Observation on 05/0 Resident #239 awall | y's smoking policy dated upervised smoking times 1, 12:00 PM, 2:30 PM, 5:00 | | Systemic Changes All Nurses, RNs and LPNs, CNA Transportation/Central supply po (full, part time and PRN) were in by the Director of Nursing that s smokers will require supervision smoke. Times have been arran these residents and staff must to patients to smoke at this time. In-servicing is to be completed to 2016. This information has beed integrated into the standard orie training and in the required in-se refresher courses for all employ will be reviewed by the Quality A | As and ersonnel not serviced ome not one ake the copy June 3, on entation ervice ees and | |

Facility ID: 923542

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| ROYAL PA | ARK REHAB & HEALTH (| CTR OF MATTHEWS | | | 700 ROYAL COMMONS LANE IATTHEWS, NC 28105 | | |
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| F 246 | 6 Continued From page 29 | | F 2 | 246 | | | |
| | Resident #239 awake Interview with Reside she required assistant wheelchair. Resident smoked and missed to #239 reported she mittimes a week because time." Resident #239 get an extra smoke be missed. Interview with Nurse of 10:01 AM revealed do Resident #239's out or residents' needs. Interview with the transported to residents' needs. Interview with the transported to 19:30 AM smoking breatimes a week since standard with the Direction of 105/06/16 at 11:32 AM aware Resident #239 smoking breaks due to fobed. The DON expenses the sistence of the side of the sid | e and in bed. Int #239 at 9:49 AM revealed ce of staff to transfer into a #239 explained she he smoke break. Resident ssed smoke breaks several e staff did not "get me up in explained she would not reak to make up for the one Aide (NA) #3 on 05/04/16 at elays occurred at times with of bed time due to other Asportation/central supply 16 at 12:02 PM revealed 30 AM smoking break 5 insportation/central supply Resident #239 missed the aks approximately "2 to 3 aff are busy with others." Dector of Nursing (DON) on revealed she was not missed the 9:30 AM inability to be assisted out olained she expected staff to the in order for Resident #239 | | 40 | Process to verify that the change has been sustained. The Unit Manager will check daily that the residents assigned scheduled smoke breaks have been Or of Bed for their scheduled times. If the resident chose to not get up for that scheduled time the Unit Manager will check that there is documentation. On May 31, 2016 the Director of Nursing in-serviced the unit manager on this systemic change. Quality Assurance Plan: To ensure compliance the DON will interview all smokers weekly to ensure that they have been allowed to smoke according to the scheduled times. Identified issues will be reported the Administrator and the Quality Assurance Committee for appropriate action and intervention. This will be done weekly one month and then monthly for at least three months. The QA Meeting is attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results the audits will then be shared in the Quarterly QA Meeting with the Medical Director, with verification of his attendance, along with all members of QA Team and Department Heads until resolved. | ee for et / of | |
| F 253 SS=E | MAINTENANCE SER | | F 2 | 253 | Date of Completion: June 3, 2016 | | 6/3/16 |
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| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| ROYAL PA | RK REHAB & HEALTH | CTR OF MATTHEWS | | MATTHEWS, NC 28105 | | | |
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| F 253 | Continued From pag | e 30 | F 25 | 53 | | | |
| | | s necessary to maintain a l comfortable interior. | | | | | |
| | by: | Γ is not met as evidenced | | F253 | | | |
| | facility failed to failed care equipment to prove wrong resident in 3 resident hallways (round failed to store who bathroom floor under halls (room #202). Trepair resident doors laminate for 18 reside (Resident room #102 #117, #201, #203, #2 | to label resident personal event use of items to the esident bathrooms on 2 of 6 om #116, #118 and #211) neelchair footrests off the the sink on 1 of 6 resident he facility also failed to with broken and splintered ent rooms on 3 of 6 hallways 2, #103, #109, #110, #111, 209, #210, #215, #217, #219, 510 and #514) and failed to | | Personal items for residents #116 and #211 were labeled by staff on Wheelchair foot rests were stored closets on 5-6-16 by staff for residence room 202. Doors and splintered lawere repaired by maintenance on for Rooms 102, 103, 109, 110, 11 201, 203, 209, 210, 215, 217, 219 506, 507, 510 & 514. Smoke previous for the previous statement of the previous st | n 5-6-16. I in the dent aminate 5-10-16 1, 117, 0, 505, vention | | |
| | repair smoke preven | tion doors with broken and n the edges on 2 of 6 sets of | | Identification of potentially affected residents and corrective actions to All residents have the potential to | aken: be | | |
| | The findings included | d: | | affected by this practice. On 5-10 Administrator and Maintenance D rounded on all rooms and general | irector | | |
| | on 05/03/16 at 10:08 in a clear plastic bag next to the commode resident's name. Observations in the b 05/04/16 at 9:05 AM | the bathroom of room #116 AM revealed a bedpan was hanging from the handrail that was not labeled with a pathroom of room #116 on revealed a bedpan was in a ging from the handrail next | | A list of needed repairs to laminat doors were noted. This list was the utilized to establish a maintenance schedule for repairs. The Nursing Supervisor also observed every semi-private room to ensure that pitems were labeled. Items were elabeled or replaced when found. | nen e g personal either | | |
| | to the commode that resident's name. Observations in the t 05/05/16 at 9:19 AM clear plastic bag han | was not labeled with a pathroom of room #116 on revealed a bedpan was in a ging from the handrail next was not labeled with a | | also looked for storage of wheelch footrest to ensure that they were sthe patient room not the bathroom Systemic Changes: All Nurses and CNAs (full, part tin | hair stored in า. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | 2700 ROYAL COMMONS LANE | | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | MATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 253 | Continued From pag | ne 31 | F 25 | 3 | | | |
| 1 255 | b. Observations in the 05/03/16 at 10:12 Alclear plastic bag har shower that was not name. Observations in the 05/04/16 at 9:12 Alclear plastic bag har shower that was not name. Observations in the 05/05/16 at 9:25 Alclear plastic bag har shower that was not name. | ne bathroom of room #118 on M revealed a bedpan was in a nging from the handrail in the labeled with a resident's bathroom of room #118 on revealed a bedpan was in a nging from the handrail in the labeled with a resident's bathroom of room #118 on revealed a bedpan was in a nging from the handrail in the labeled with a resident's | F 25 | PRN) were reeducated by the Din Nursing on the facility infection of policy which included the proper of personal equipment/items. This education will be completed by Ju 2016. This information has beer integrated into the standard orient training and in the required in-ser refresher courses for all employe will be reviewed by the Quality As Process to verify that the change been sustained. A repair list was established with completion time lines by the Admand Maintenance Director. The Maintenance Director was in-sen 5-30-16 regarding the need for was rounding to update the repair list timely completion of identified regarding the second completion of identified regarding the need for was in-sen for the second completion of identified regarding the process to the process of t | ontrol storage s une 3, n ntation rvice es and ssurance has unistrator viced on reekly and | | |
| | 05/03/16 at 10:22 Al clear plastic bag har shower that was not name. Observations on 05/bathroom of room # a clear plastic bag h the shower that was name. Observations on 05/bathroom of room # a clear plastic bag h the shower that was name. 2. Observations in the 05/03/16 at 10:30 Al wheelchair footrests the sink. | M revealed a bedpan was in a nging from the handrail in the labeled with a resident's 104/16 at 9:20 AM in the 211 revealed a bedpan was in anging from the handrail in not labeled with a resident's 105/16 at 9:42 AM in the 211 revealed a bedpan was in anging from the handrail in not labeled with a resident's 105/16 at 9:42 AM in the 211 revealed a bedpan was in anging from the handrail in not labeled with a resident's 105 and 105 are bathroom of room #202 on 105 and 105 are sident's 105 and 105 are sident's 105 are bathroom of room #202 on 105 are sident's 105 are bathroom of room #202 on 105 are sident's 105 are bathroom of room #202 on 105 are sident's 105 ar | | Quality Assurance Plan: The infection control nurse and of designee will make weekly infect control rounds to ensure compliathe facilities infection control policy procedure to include labeling and of personal care equipment. Add weekly, the Administrator will rouse every room and general area with Maintenance Director to update the list and ensure that other items how completed according to the designation frame. This will be done weekly for one than monthly for at least three months compliance will be monitored and ongoing auditing program review quarterly QA Meeting to ensure compliance. Identified issues will | or ion nce with cy and d storing ditionally, nd on n the he repair ave been gnated month onths. d ed at the | | |

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| | | 345026 | B. WING | | | C 05/06/2016 | |
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| F 253 | wheelchair footrests the sink. Observations on 05 bathroom of room # wheelchair footrests the sink. During an interview Nurse Aide #10 stat 100 hall and resided should be put away stored on the floor. and bath basins showith the resident's rule long term care to Director of Nursing expectation that resident had the black permanent meach resident had the tand personal care if kept in a clean plass bedside table or in 10 she stated no residincluded bedpans of stored on the floor in 10:40 AM with the lomanager/ADON she #118 there were 3 to each other and were shower and were not mame. She also verification in the state of | 202 revealed a pair of a were lying on the floor under 2/05/16 at 9:30 AM in the 202 revealed a pair of a were lying on the floor under 3 on 05/06/16 at 10:25 AM and the she was assigned on the nt's personal care items and were not supposed to be She further stated bed pans and were not in the bathroom name written on it. On 05/06/16 at 10:30 AM with Unit Manager/Assistant (ADON) she stated it was the ident care equipment should resident's last name with a larker. She further stated their own shelf in the bathroom tems were supposed to be the bathroom on the shelf. The shelf is a state of the care equipment which a bathroom on the shelf. The bath basins were to be an the resident's bathroom. | F 25 | reported immediately to the Ad DON or ADON for appropriate. The quarterly QA Meeting is att the DON, ADON, Administrator MDS, HIM, Dietary Manager ar Services. Results of the audits be shared in the Quarterly QA with the Medical Director with v of his attendance along with all of the QA Team and Department Date of Completion: June 3, 26 | action. tended by r, SDC, nd Social s will then Meeting verification I members nt Heads. | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| F 253 | bag that was hangir without a resident's there was a bedpant that was not labeled acknowledged there footrests lying on the #202 and stated the stored on the floor ubathroom. During an interview Director of Nursing that personal care ewith the resident's lapermanent marker a plastic bag on the sin the bottom drawer table. She explained usually stored in the closet but should not the sink in the bathroom. 3. a. Observations of 11:25 AM revealed room had broken are edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. Observations on 05 the door of resident splintered laminate half of the door. | is 1 bedpan in a clear plastic and from a handrail in bathroom name. She also confirmed in the shower of room #211 d with a resident name. She was a pair of wheelchair e floor under the sink in room by were not supposed to the under the sink in the resident's supposed to the under the sink in the resident's supposed to the under the sink in the resident's supposed to the under the sink in the resident's supposed to the stated it was her expectation equipment should be labeled ast name with a black and should be stored in a shelf in the bathroom or placed or of the resident's bedside at wheelchair footrests were be bottom of the resident's between the stored on the floor under room. | F2 | 253 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | • | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 33.03.20.13 |
| (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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 253 | Continued From pag | ge 34 | F 2 | 53 | | |
| | the door of resident splintered laminate of half of the door. Observations on 050 the door of resident | half of the door. 04/16 at 9:09 AM revealed room #103 had broken and on the edges of the bottom 05/16 at 1:47 PM revealed room #103 had broken and on the edges of the bottom | | | | |
| | 11:29 AM revealed to room had broken an edges of the bottom Observations on 05, the door of resident splintered laminate of half of the door. Observations on 05, the door of resident the door of resident | coom #109 on 05/03/16 at the door of the resident's d splintered laminate on the half of the door. 04/16 at 9:12 AM revealed room #109 had broken and on the edges of the bottom 05/16 at 1:50 PM revealed room #109 had broken and on the edges of the bottom | | | | |
| | 11:30 AM revealed to room had broken an edges of the bottom Observations on 05/2 the door of resident splintered laminate of half of the door. Observations on 05/2 the door of resident | Room #110 on 05/03/16 at he door of the resident's d splintered laminate on the half of the door. 104/16 at 9:15 AM revealed room #110 had broken and on the edges of the bottom 105/16 at 1:54 PM revealed room #110 had broken and on the edges of the bottom | | | | |
| | 11:33 AM revealed t | Room #111 on 05/03/16 at he door of the resident's d splintered laminate on the | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | ' ' | (X3) DATE SURVEY COMPLETED | |
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| F 253 | F 253 Continued From page 35 | | F 2 | 53 | | | |
| | the door of resident splintered laminate half of the door. Observations on 05 the door of resident splintered laminate half of the door. f. Observations of F | /04/16 at 9:17 AM revealed room #111 had broken and on the edges of the bottom /05/16 at 1:55 PM revealed room #111 had broken and on the edges of the bottom | | | | | |
| | room had broken at edges of the bottom bathroom door had laminate and wood of the door. Observations 05/04 door of resident roosplintered laminate half of the door and broken and splintered edges of the lower lobservations on 05 the door of resident splintered laminate | the door of the resident's and splintered laminate on the half of the door and the broken and splintered on the edges of the lower half 16 at 9:21 AM revealed the m #117 had broken and on the edges of the bottom the bathroom door had ed laminate and wood on the half of the door. 1/05/16 at 1:57 PM revealed room #117 had broken and on the edges of the bottom the bathroom door had | | | | | |
| | g. Observations of I 11:38 AM revealed room had broken at edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. | ed laminate and wood on the nalf of the door. Room #201 on 05/03/16 at the door of the resident's and splintered laminate on the | | | | | |

| · · · · · · · · · · · · · · · · · · · | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 253 | splintered laminate of half of the door. h. Observations of Ro 11:40 AM revealed the room had broken and edges of the bottom hobservations on 05/0 the door of resident resplintered laminate of half of the door. Observations on 05/0 the door of resident resplintered laminate of half of the door. i. Observations of Ro 11:42 AM revealed the room had broken and edges of the bottom hobservations on 05/0 the door of resident resplintered laminate of half of the door. Observations on 05/0 the door of resident resplintered laminate of half of the door. j. Observations of Ro 11:45 AM revealed the room had broken and edges of the bottom hobservations on 05/0 the door of resident resplintered laminate of half of the door. | com #201 had broken and in the edges of the bottom from #203 on 05/03/16 at it is edoor of the resident's it is plintered laminate on the half of the door. from #203 had broken and in the edges of the bottom from #203 had broken and in the edges of the bottom from #203 had broken and in the edges of the bottom from #209 on 05/03/16 at it is edoor of the resident's it is plintered laminate on the half of the door. from #209 had broken and in the edges of the bottom from #209 had broken and in the edges of the bottom from #209 had broken and in the edges of the bottom from #209 had broken and in the edges of the bottom from #209 had broken and in the edges of the bottom from #210 on 05/03/16 at it is edoor of the resident's it is plintered laminate on the insplintered laminate on | F | 2253 | | | |
| | splintered laminate of half of the door. | n the edges of the bottom 05/16 at 2:07 PM revealed | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRU A. BUILDING A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| F 253 | Continued From page | ge 37 | F 2 | 53 | | |
| | | room #210 had broken and on the edges of the bottom | | | | |
| | 11:47 AM revealed room had broken ar edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. Observations on 05 the door of resident | Room #215 on 05/03/16 at the door of the resident's and splintered laminate on the half of the door. /04/16 at 9:33 AM revealed room #215 had broken and on the edges of the bottom /05/16 at 2:09 PM revealed room #215 had broken and on the edges of the bottom | | | | |
| | 11:49 AM revealed room had broken ar edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. Observations on 05 the door of resident | toom #217 on 05/03/16 at the door of the resident's and splintered laminate on the half of the door. /04/16 at 9:35 AM revealed room #217 had broken and on the edges of the bottom /05/16 at 2:11 PM revealed room #217 had broken and on the edges of the bottom | | | | |
| | 11:51 AM revealed room had broken ar edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. | Room #219 on 05/03/16 at the door of the resident's and splintered laminate on the half of the door. /04/16 at 9:37 AM revealed room #219 had broken and on the edges of the bottom | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| F 253 | Continued From pag | ge 38 | F 2 | 253 | | |
| | the door of resident | room #219 had broken and on the edges of the bottom | | | | |
| | 11:54 AM revealed to room had broken an edges of the bottom Observations on 05/2 the door of resident splintered laminate of half of the door. Observations on 05/2 the door of resident | Room #505 on 05/03/16 at he door of the resident's d splintered laminate on the half of the door. 04/16 at 9:40 AM revealed room #505 had broken and on the edges of the bottom 05/16 at 2:18 PM revealed room #505 had broken and on the edges of the bottom | | | | |
| | 11:56 AM revealed to room had a curved of splintered laminate of half of the door and Observations on 05/2 the door of resident out section of broker the edges of the bot rough to the touch. Observations on 05/2 the door of resident out section of broker the edges of the bot rough to the touch. p. Observations of Fig. 11:58 AM revealed to the curve of the section of the touch. | Room #506 on 05/03/16 at the door of the resident's put section of broken and on the edges of the bottom was rough to the touch. 104/16 at 9:43 AM revealed room #506 had had a curved in and splintered laminate on tom half of the door and was 105/16 at 2:20 PM revealed room #506 had had a curved in and splintered laminate on tom half of the door and was 105/16 at 2:20 PM revealed room #506 had had a curved in and splintered laminate on tom half of the door and was 105/03/16 at the door of the resident's | | | | |
| | edges of the bottom Observations on 05/ | d splintered laminate on the half of the door. 04/16 at 9:45 AM revealed room #507 had broken and | | | | |

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| F 253 | | | F 2 | 253 | | |
| | half of the door. Observations on 05 the door of resident splintered laminate half of the door. q. Observations of 12:01 PM revealed room had broken a edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. Observations on 05 door of resident room of the door of room of th | on the edges of the bottom 5/05/16 at 2:22 PM revealed to room #507 had broken and on the edges of the bottom Room #510 on 05/03/16 at the door of the resident's not splintered laminate on the half of the door. 5/04/16 at 9:47 AM revealed to room #510 had broken and on the edges of the bottom 5/05/16 at 2:25 revealed the om #510 had broken and on the edges of the bottom | | | | |
| | 12:04 PM revealed room had broken a edges of the bottom Observations on 05 the door of resident splintered laminate half of the door. Observations on 05 the door of resident splintered laminate half of the door. 4. a Observations of on the 100 hall on 05 the doors had broke the edges of the bot Observations on 05 the doors on 05 the doors had broke the edges of the bot Observations on 05 the doors on 05 the doors on 05 the doors had broke the edges of the bot Observations on 05 the doors | Room #514 on 05/03/16 at the door of the resident's and splintered laminate on the half of the door. 6/04/16 at 9:50 AM revealed at room #514 had broken and on the edges of the bottom 6/05/16 at 2:27 PM revealed at room #514 had broken and on the edges of the bottom 6/05/16 at 2:27 PM revealed at room #514 had broken and on the edges of the bottom 6/05/03/16 at 12:10 PM revealed en and splintered laminate on attom half of the door. 6/04/16 at 10:00 AM revealed on doors on the 100 hall had | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l l | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 253 | broken and splintered the bottom half of the Observations on 05/0 the smoke prevention broken and splintered the bottom half of the b. Observations of the doors had broken the edges of the bottom broken and splintered the bottom half of the Observations on 05/0 the smoke prevention broken and splintered the bottom half of the Observations on 05/0 the smoke prevention broken and splintered the bottom half of the During an interview of long term care Unit M. Nursing explained sta Maintenance staff who made. She further expressions on stated the Maintenance staff to fill of each nurse's station is stated the Maintenance staff to stated the Maintenance staff to stated the Maintenance staff the observations on 05/0 the smoke prevention broken and splintered the bottom half of the state of the | d laminate on the edges of edoor. 25/16 at 2:30 PM revealed of doors on the 100 hall had d laminate on the edges of edoor. e smoke prevention doors //03/15 at 12:15 PM revealed of and splintered laminate on the half of the door. 24/16 at 10:13 AM revealed of doors on the 200 hall had d laminate on the edges of edoor. 25/16 at 2:34 PM revealed of doors on the 200 hall had d laminate on the edges of edoors on the 200 hall had d laminate on the edges of | F | 253 | DETICIENCY) | | |
| | that needed to be ma rounds or was workin explained staff could Director on the overh report to her and she the Maintenance Dire | ad various hours dependent | | | | | |

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| | | | 7 55.25 | | | С |
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| F 278 SS=D | O5/06/16 at 4:35 PM Director of Nursing th Maintenance Director day. He stated staff i maintenance when rehad hired a temporary patching of walls. He worked on some door During the tour the Adsplintered piece of lar resident's door of roo expected for staff to repairs were needed. During an interview or Director of Nursing st splintered laminate or doors and had not the 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status. A registered nurse must each assessment with participation of health A registered nurse must assessment is complete Each individual who cassessment must sign that portion of the asset Under Medicare and | and environmental tour on with the Administrator and e Administrator stated the had left the facility for the in the facility could report to pairs were needed and he worker to do painting and stated the worker may have is but he was not sure. Idministrator removed a minate from the edge of the im #215 and stated he eport to maintenance when in 05/06/16 at 5:08 PM the lated she had not noticed the in the edges of the resident's bught to look at them. INSMENT INNATION/CERTIFIED it accurately reflect the last conduct or coordinate in the appropriate professionals. Lest sign and certify that the lated. Completes a portion of the in and certify the accuracy of | F 2 | | | 6/3/16 |

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| F 278 | false statement in a subject to a civil mor \$1,000 for each assewillfully and knowing to certify a material aresident assessment penalty of not more transported assessment. Clinical disagreement material and false statement a | resident assessment is ney penalty of not more than essment; or an individual who ly causes another individual and false statement in a is subject to a civil money than \$5,000 for each at does not constitute a latement. This not met as evidenced views, physician's orders and tion Administration Record, ssess the use of pain impleting an admission ssessment for 1 of 3 leviewed for pain (Resident dd: | F 2' | F278 Corrective Action: Resident #87: A Modification Requests assessment with Assessment Reference Date of 3/31/2016. This corrected record hattems included, not just the items in The Correction Request Section X is were completed on 5/5/2016 and incompleted on 5/5/2016 and incompleted on 5/5/2016. Item J0100A is submitted to the QIES ASAP system 5/5/2016. Identification of other residents who be involved with this practice: All residents have the potential to be affected by this practice. All assessing within the last 6 months are currently being reviewed for accuracy for Item J0100A started on 5/9/2016. | the as all error. tems cludes nas a was n on may ements | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | 0.0020 | | STREET ADDRESS, CITY, STATE, ZIP COD | | 5/06/2016 | |
| NAME OF T | TOVIDER OR OUT LIER | | | 2700 ROYAL COMMONS LANE | <i>,</i> _ | | |
| ROYAL PA | RK REHAB & HEAL | TH CTR OF MATTHEWS | | MATTHEWS, NC 28105 | | | |
| | | | | <u>, </u> | | | |
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| F 278 | Continued From p | age 43 | F 27 | 8 | | | |
| | receive scheduled | - | | | | | |
| | | · pain moulouiem | | Systemic Changes: | | | |
| | Review of the Mar | rch 2016 medication | | On 5/27/2016 The RN MDS (| Coordinator | | |
| | administration rec | ord (MAR) revealed Resident | | and any other Interdisciplinar | y team | | |
| | #87 received Neu | rontin 100 mg every evening for | | member that participates in the | ne MDS | | |
| | pain from 03/24/1 | 6 - 03/30/16. | | assessment process was in s | | | |
| | | | | /educated by the QA Consult | | | |
| | | the medical record revealed a | | The education focused on the | | | |
| | | d 03/26/16 which documented | | regulations at 42 CFR 483.20 | ` ' ' ' | | |
| | | ninistered scheduled Neurontin | | (xviii),(g), and (h) require that | | | |
| | 100 mg to Reside | nt #67 for pain. | | assessment accurately reflect residents status. A registered | | | |
| | During an intervie | w on 05/05/16 at 12:02 PM, the | | conducts or coordinates each | | | |
| | _ | stated when she completed the | | with the appropriate participa | | | |
| | | or Resident #87, she reviewed | | professionals. The assessme | | | |
| | | IAR, using 03/24/16 - 03/31/16 | | includes direct observation, a | - | | |
| | as reference dates | s, to assess whether or not | | communication with the resid | ent and | | |
| | | eived scheduled pain | | direct care staff on all shifts. | | | |
| | | IDS Coordinator stated she | | assessment requires collecting | | | |
| | | dent #87 received Neurontin | | information from multiple sou | | | |
| | | ning for pain and that she | | of which are mandated by reg | | | |
| | | ssed that Resident #87 did | | Those sources must include | | | |
| | | I pain medication when she | | and direct care staff on all sh should also include the reside | | | |
| | completed the Ne | sident's admission MDS. | | record, physician, and family, | | | |
| | During an intervie | w on 05/05/16 at 1:01 PM, the | | significant other as appropria | • | | |
| | _ | g stated she would expect the | | acceptable. The information of | | | |
| | | reflect the use of scheduled | | should cover the same obser | | | |
| | pain medication fo | | | as specified by the MDS item | • | | |
| | | | | assessment, and should be v | alidated for | | |
| | | | | accuracy (what the resident's | actual | | |
| | | | | status was during the observe | • • | | |
| | | | | the interdisciplinary team con | npleting the | | |
| | | | | assessment. | \ D \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | |
| | | | | The Observation (Look Back) | | | |
| | | | | the time period over which the | | | |
| | | | | condition or status is captured assessment. The observation | • | | |
| | | | | particular assessment for a p | • | | |
| | l | | | particular assessificit iol a p | ai iloulai | 1 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 278 | Continued From page | e 44 | F2 | resident will be chosen be regulatory requirements of and the ARDs of previous Most MDS items themsel observation period, such depending on the item. S begins at 12:00 a.m. and p.m., the observation per cover this time period. We the MDS, only those occur the look back period will be did not occur during the left it is not coded on the MD of Nursing or RN Designed OBRA assessments to er coding for item set J0100 will be reported to the Dir or Administrator for approduring the daily Clinical Methough Friday), the RN Mor Designee will review a reference dates for OBRA The Daily Clinical Meeting the Director of Nursing, LMDS Coordinators, Support Therapy, HIM, Dietary May Worker, The Administrator needed. Monitoring: To ensure compliance, the Nursing or Designee will using the QA Assessment Five residents OBRA asserviewed weekly for one monthly for at least three items reviewed on the QA Accuracy Tool will include Accuracy of Section J010 | concerning times assessment. In the sassessment of | ning nys, nys, g g g f it od, or e s ng day utor s. by , l as | | |

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| F 278 | Continued From page | e 45 | F 2 | | issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing programeviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy HIM, Dietary Manager, and the Administrator. Date of Completion: June 3, 2016 | m ne | |
| F 279 SS=D | to develop, review an comprehensive plan of the facility must developed plan for each resident objectives and timetal medical, nursing, and needs that are identificated assessment. The care plan must do to be furnished to attain highest practicable plant psychosocial well-being 483.25; and any serbe required under §4 due to the resident's description of the sident's description. | e results of the assessment de revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's mysical, mental, and | F2 | 279 | | | 6/3/16 |
| | under §483.10(b)(4). This REQUIREMENT | is not met as evidenced | | | | | |

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| F 279 | facility failed to dever plan for activities of residents whose car (Resident #258). The findings include Resident #258 was 10/13/15 with diagn blood pressure, thyroderical terms of the adm (MDS) dated 10/20/ was severely impair decision making an assistance with Actifor hygiene and batter A review of a Care A | views and staff interviews the elop a comprehensive care daily living for 1 of 27 re plans were reviewed ed: admitted to the facility on coses which included high roid disease and dementia. ission Minimum Data Set 15 indicated Resident # 258 red in cognition for daily direquired extensive vities of Daily Living (ADLs) | F 27 | F279 Corrective Action: Resident #258 Resident Care plareviewed and updated. Identification of other residents whe involved with this practice: All residents have the potential to affected by the alleged practice. Accomprehensive assessments with last 6 months are being reviewed review of each Care Area Assess (CAA) for each respective comprehensive assessment was reviewed to enseach Care Area Assessment trigg that had a Care Plan Consideration checked "YES" has a care plan a with interventions in place. This we started on 5/9/16 by the MDS Co | who may be be All hin the d: a sment ehensive sure that gered on ddressed vas | |
| | Daily Living (ADL) F Potential triggered f included a check ma section on the CAAs considerations indic #258's current level for rationale for care part Resident #258 all ADLs including c participate and had safety awareness. A review of care pla there was no care p | functional/Rehabilitation or Resident #258 and ark to address in care plan. A s labeled care plan ated to maintain Resident of functioning and a section e plan decision indicated in required extensive assist with ues and instructions to memory impairment and poor ns for Resident #278 revealed lan for ADLs and there were s listed in any of the care | | Systemic Changes: On 5/27/16 The LPN/RN MDS Coordinators and any other Interdisciplinary team member the participates in the MDS assessm process was in serviced /educate QA consultant. The education focused on Faciliti the findings from the comprehens assessment to develop an individ care plan to meet each resident's (42 CFR 483.20(b)). The Facility CAAs in identifying and clarifying concern that are triggered based specific MDS items are coded on | ent ed by the lies use sive dualized s needs uses the areas of on how | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| F 279 | Continued From p | age 47 w on 05/06/16 at 2:15 PM with | F 2 | MDS. The process focuses of | on evaluating | | |
| | the long term care Director of Nursing plan for ADLs for I did not know why ADLs and MDS st further stated she plan for ADLs or in | e Unit Manager/Assistant g she verified there was no care Resident # 258. She stated she there was no care plan for aff would have to explain. She would expect to see a care nterventions for ADLs since quired extensive assistance by | | these triggered care areas use CAAs, but does not provide a on how to select pertinent into care planning. Interventions individualized and based on effective problem solving and making approaches to all of the information available for each Care Area Triggers (CATs) id | sing the exact detail erventions for must be applying d decision the h resident. lentify | | |
| | During an interview on 05/06/16 at 2:25 PM with the MDS nurse she explained Resident #258's last comprehensive MDS assessment was completed in October 2015 and it triggered a Care Area Assessment (CAA) for physical mobility and it should have had ADL interventions listed in it. She stated she had identified a problem with some of the CAAs where physical mobility had triggered but did not have ADL interventions and she had been trying to correct them. She confirmed she was unaware Resident #258 did not have an ADL care plan or that her other care plans did not have ADL interventions in them. She stated after the comprehensive assessment triggered ADLs there should have been a care plan completed for ADLs but she was not sure why it had not been | | | conditions that may require ferevaluation because they may impact on specific issues and conditions, or the risk of issue conditions for the resident. Extrem must be assessed further the use of the CAA process to care plan decision making, borrow may not represent a condition or will be addressed in the cast significance and causes of an attrigger may vary for different in different situations for the resident. Different CATs may common causes, or various if associated with several CATs connected. CATs provide a "flag" for the | evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be | | |
| | the Director of Nu expectation for res on their comprehe | w on 05/06/16 at 5:08 PM with rsing she stated it was her sident's who triggered for ADLs ensive assessments to have a erventions to address their ADL | | care area needs to be asses completely prior to making care decisions. Further assessme triggered care area may iden risk factors, and complication with the care area condition. care then addresses these fathe goal of promoting the reshighest practicable level of further possible. | are planning ent of a utify causes, ns associated The plan of actors with ident's unctioning: (1) | | |

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| F 279 | Continued From p | age 48 | F 2 | maintenance and prevention of declines. The CAA process may help the Identify and address associated and effects; Determine whether multiple triggered conditions as Identify a need to obtain additional, functional, psychosominancial, or other information resident's condition that may be from sources such as the resident's family or other resperty, the attending physician staff, rehabilitative staff, or the laboratory and diagnostic test whether and how a triggered cactually affects the resident's quality of life, or whether their particular risk of developing the conditions; Review the residentifular risk of developing the conditions; Review the residentifular risk of developing the conditions; attending physician, medirector, or nurse practitioner) identify links among causes a causes and consequences, and pertinent tests, consultations, interventions; Determine when resident could potentially benerehabilitative interventions; Bedevelop an individualized care measurable objectives and time meet a resident's medical, fur mental and psychosocial need identified through the compreled assessment. Good assessment is the starting good clinical problem solving making and ultimately for the sound care plan. The CAAs personal care plan. | ne IDT: ed causes er and how are related; cional cial, about a be obtained dent, the onsible , direct care at requires s; Identify condition function and resident is at ne ent's actitioner dical dical to try to nd between nd to identify and ther a efit from egin to e plan with netables to nctional, ds as hensive ing point for and decision creation of a | |

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| F 279 | Continued From page | e 49 | F 2 | between the MDS and car care plan should be revise ongoing basis to reflect chresident and the care that receiving (see.42 CFR 48: Comprehensive Care Plan The RN coordinator is req and date the Care Area As (CAA) Summary after all thave been reviewed to ce of the comprehensive ass Completion Date, V0200B have 7 days after complet assessment to develop or resident's care plan. Facilithe date at V0200B2 to dedate at V0200B2 to dedate at V0200C2 by which must be completed (V020 The 7-day requirement for modification of the care plandmission, SCSA, SCPA, RAI assessments. A new not need to be developed SCSA, SCPA, or Annual relasted, the nursing home existing care plan using the latest comprehensive asses Facilities should also evaluate appropriateness of the cartimes including after Quarassessments, modifying a The Director of Nursing or will review comprehensive to ensure that a comprehe is completed for each resirequirements as listed about Any issues will be reported of Nursing or Administrator action. | ed on an anages in the the resident 3.20(k), as). uired to sign assessment riggered CAA rify completic essment (CA (2)). Facilities ing the RAI revise the ities should uptermine the anapplies to and/or Annual care plan doe after each eassessment emay revise a fer results of the essment. Unate the re plan at all terly as needed. RN Designe eassessment ensive care pladent per the I bye. d to the Direct and the control of the Direct dots and the control of the Direct dots are plan at all terly as needed. RN Designe eassessment ensive care plan at all terly as needed. | As on As or the al es the As on As or the As or th |

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| F 279 | Continued From page | ÷ 50 | F 2 | 279 | During the daily Clinical Meeting (Monothrough Friday), the RN MDS Coordinator Designee will review assessment reference dates for OBRA assessment The Daily Clinical Meeting is attended the Director of Nursing, Unit Managers MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Socia Worker, The Administrator and others a needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a revusing the QA Tool. Five residents comprehensive OBRA assessments wibe reviewed weekly for one month, and then monthly for at least three months. The items reviewed on the QA Care plate Tool will include: CAAs triggered reviewed, Care plan considerations reviewed, Care plan considerations reviewed, Comprehensive care plan for activities for activities of daily living completed, Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manages, and the Administrator. Date of Completion: June 3, 2016 | ettor s. s. soy lass liew ll d an | |
| F 309 SS=D | l <u>.</u> <u></u> | | F3 | 309 | Date of Completion. June 3, 2010 | | 6/3/16 |

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| F 309 | provide the necess or maintain the hig mental, and psycho | age 51 t receive and the facility must ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment | F3 | 09 | |
| | by: Based on staff, numember interviews to the inability to us need for assistance residents who experiments which experiments who experiments where the exper | NT is not met as evidenced rse practitioner and family the facility failed to respond se the right arm and increased with ambulation for 1 of 3 erienced a change in condition | | F309 Resident #47 was assessed by the Practitioner on 4/25/16 and a neur consult was ordered. On 4/27/16 r #47 was seen by neurologist. | rology resident |
| | 07/31/13 with diagon hemiplegia and he infarction. | ed: admitted to the facility on noses which included miparesis following cerebral t #47's quarterly Minimum | | Identification of potentially affected residents and corrective actions to All residents have the potential to affected. The 24 hour report sheer reviewed for all residents for the ladays by the DON and QA team to that changes in condition were ideand the medical providers were not to the condition of the condi | aken: be ets were east 7 ensure entified otified. |
| | Data Set (MDS) da assessment of more The MDS indicated supervision and set in function range of Review of Residen 04/04/16 revealed rolling walker with needed. | ated 03/31/16 revealed an derately impaired cognition. I Resident #47 required t up to walk with no impairment | | Systematic Changes All Nurses, RNs and LPNs (full, pa and PRN) were in-serviced by the of Nursing on the need to notify pr of changes in condition. This is to completed by June 3, 2016 This information has been integrated in standard orientation training and in required in-service refresher cours all employees and will be reviewed Quality Assurance Process to veri | art time Director roviders be ato the n the ses for d by the |

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| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 ROYAL COMMONS LANE IATTHEWS, NC 28105 | | 00/2010 |
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| F 309 | decrease in ability to documented Resident requested the nurse president #47 tomorror Review of the NP active revealed the NP documented a mild riggrasp a walker with the weakness. The NP occumented a mild riggrasp a walker with the weakness. The NP occumented a mild riggrasp a walker with the weakness. The NP occumented a mild riggrasp a walker with the weakness. The NP occumented in the sex of a physiciar revealed the physiciar revealed the physiciar which could indicate a Review of a neurolog 04/27/16 revealed the Resident #47 exhibite (decreased vision) wiright arm and hand. MRI of the brain, card transthoracic echocal | swelling with "noticeable use it." Nurse #2 tr #47's family member practitioner (NP) to see ow. Intervisit note dated 04/25/16 amented Resident #47 m as "useless." The NP ght facial droop, inability to the right hand and right armordered a neurology In some dated 04/25/16 m documented Resident and with complete paralysis another stroke. In this is the consultation dated the neurologist documented and a new right hemianopia the diminished strength in the The neurologist ordered a bit of the control of the con | F | 309 | the change has been sustained. Quality Assurance Plan: Monday through Friday The Daily Clinic Meeting Nurses and DON will review the nursing 24 hour report with all progress notes for the last 24 hours and on Mon progress notes for 72 hours in PCC, incident reports, new MD orders, and a resident with a change of condition has documentation to show that medical providers were notified. To ensure compliance the DON and Nurse Managers will document their review of the daily clinical checklist. This will be done daily Monday through Friday and Monday for the weekend for three months. Identified issues will be report immediately to DON or Administrator for appropriate action. The weekly QA Meeting is attended by the DON, ADOI Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendar along with all members of the QA Team and Department Heads. | ne s day any s on ted or N, y s of | |
| | chair with both feet an #47 did not use the ri- Interview with Reside AM revealed the right functioned. Resident not hurt but he now re transfer and could no | nd the left arm. Resident ght arm or hand. Int #47 on 05/03/16 at 10:18 arm and hand no longer #47 reported the arm did equired assistance to | | | Date of Completion: June 3, 2016 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRU | CTION | | LETED |
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| | | 345026 | B. WING _ | | | | C 06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 2700 ROYAL | DRESS, CITY, STATE, ZIP CODE L COMMONS LANE IS, NC 28105 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 309 | called the family mem 04/23/16. Resident # member, he was upshis right arm. The far came to the facility or 47 could not use the Nurse #2. The family informed her Resider placed on the list to b was Sunday and no cowas available. Interview with the occ 05/04/16 at 12:10 PM discharged from OT afor left shoulder arthrio OT reported she asse NP's request on 04/2 Resident #47's right addifferent. The OT exp to have active streng right upper extremity. #47 required stand by with a walker when di 04/14/16. Interview with Nurse 2:47 PM revealed she 04/23/16 and 04/24/1 #1 reported Resident walker and required 2 walk a few steps. Na could not use the right reported Resident #4 assistance to Nurse # Interview with Nurse # Interview | revealed Resident #47 aber the evening of 47 informed the family et due to the inability to use mily member explained she a 04/24/16, saw Resident # right arm and spoke to a member reported Nurse #2 at #47's name would be e seen the next day since it alloctor or nurse practitioner supational therapist (OT) on a revealed Resident #47 was after successful treatment tic pain on 04/14/16. The assed Resident #47 at the 65/16. The OT explained form was flaccid which was colained Resident #47 used th and range of motion in the The OT reported Resident assistance with ambulation scharged from therapy on Aide (NA) #1 on 05/04/16 at the cared for Resident #47 on 6 during the day shift. NA at #47 could not hold on to the to persons and a gait belt to to at arm. NA #1 explained she at arm. NA #1 explained she arm. NA #1 explained she arm. NA #1 explained she arm. Na #1 explained for | F | 309 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | ATE SURVEY DMPLETED |
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| | | 345026 | B. WING | | | C 05/06/2016 |
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| F 309 | and 04/24/16 durin reported Resident; gait to stand at the she did not take Rephysically assess a nursing supervisor. Interview with NA # revealed she cared and 04/24/16 durin reported Resident; which she reported. Telephone interview 4:25 PM revealed sout of the right arm and reported the reported t | g the evening shift. Nurse #1 #47 required 2 persons and a walker. Nurse #1 reported esident #47's vital signs, all extremities or notify the #2 on 05/04/16 at 3:45 PM If for Resident #47 on 04/23/16 g the evening shift. NA #2 #47 could not use the right arm If to Nurse #1. W with Nurse #2 on 05/04/16 at the cared for Resident #47 on 14/16 during the day shift. Resident #47 could not use required the extensive resons to stand at the walker. If she spoke with Resident er on 04/24/16 who requested the extensive resons to stand at the walker. If she spoke with Resident reconsidered the extensive resons to stand at the walker. If she spoke with Resident reconsidered the extensive resons to stand at the walker. If she spoke with Resident reconsidered the extensive resons to stand at the walker. If she spoke with Resident reconsidered the spoke with recall if she took regions or assessed his #2 reported she did not notify | F 3/ | 09 | | |

| | | IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| PRÉFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION | |
| F 309 | should include a doo | | F 30 | 9 | | |
| | | | F 31 | 2 | 6/3/16 | |
| | daily living receives maintain good nutrit | the necessary services to | | | | |
| | by: Based on observati and family interview facial hair for 1 of 6 Activities of Daily Liv The findings include Resident #258 was 10/13/15 with diagne blood pressure, thyr Alzheimer's disease A review of the most Data Set (MDS) date Resident #258 was for daily decision materials as a second of the second of the most During an observation observation observation observation of the living root served and had long served and had long the second of the most observed of the most observation of the second observation observation observation observation of the living root served and had long observation observation of the living root served and had long observation | ons, record reviews and staff is the facility failed to remove sampled residents for ving (Resident #258). d: admitted to the facility on oneses which included high oid disease, dementia and trecent quarterly Minimum and 04/19/16 indicated severely impaired in cognition asking and required extensive | | Resident #258 is cognitively impaired daily decision making and requires extensive assistance with hygiene and bathing. The chin hair was removed at family's request. Identification of potentially affected residents and corrective actions taken All residents have the potential to be affected by this deficient practice. All residents were assessed for unwanted facial hair and assistance to remove we provided if the resident or RP requested Those residents who identified they dienot want facial hair removed will be caplanned as a personal preference and added as a task reminder on ADL task assignment in POC. Those residents to require assistance with removal of facinar will have this added to their ADL to assignment in POC. This was completely assigned CNA on 5-6-16. | t the t the d vas ed. d ure chat ial ask | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| NAME OF D | ROVIDER OR SUPPLIER | 343020 | 1 2: | C- | TREET ADDRESS, CITY, STATE, ZIP CODE | 05/ | 06/2016 |
| NAIVIE OF PI | ROVIDER OR SUPPLIER | | | | | | |
| ROYAL PA | RK REHAB & HEALTI | H CTR OF MATTHEWS | | | 700 ROYAL COMMONS LANE | | |
| | | | | M | IATTHEWS, NC 28105 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 312 | | ge 56 ion on 05/05/16 at 6:23 AM sitting in a wheelchair in the | F3 | 312 | Systemic Change: | | |
| | | s holding her right hand up to ong white chin hairs on the left | | | All CNAs (full, part time and PRN) were reeducated on the facility's shaving pol | | |
| | | I at the bottom of her chin. | | | by the Director of Nursing. This is to be completed by June 3, 2016. All resider | nts | |
| | Resident #258 was | ion on 05/06/16 at 9:37 AM seated in the living room with | | | will have their task assignments update as to the preference of facial hair if | : d | |
| | | s on the left side of her chin | | | required. This information has been | | |
| | | o 1/2 inch in length and at the | | | integrated into the standard orientation | | |
| | | approximately 1/4 to a 1/2 inch | | | training and in the required in-service | | |
| | in length. | | | | refresher courses for all employees and | | |
| | During on observet | ion and intension on 05/06/16 | | | will be reviewed by the Quality Assurar | ce | |
| | _ | ion and interview on 05/06/16 long term care Unit | | | Process to verify that the change has been sustained. | | |
| | | Director of Nursing she | | | been sustained. | | |
| | | #258 had long white hairs on | | | Quality Assurance Plan: | | |
| | | chin and at the bottom of her | | | The Don and or designee will monitor | | |
| | | Resident #258 was usually | | | residents for facial hair and resident's | | |
| | · | re but sometimes staff had to | | | preference weekly for one month and to | hen | |
| | - | tated she did not know if | | | monthly for at least three months. | | |
| | | dent #258's facial hair | | | Compliance will be monitored and | | |
| | • | did she would have expected | | | ongoing auditing program reviewed at | he | |
| | for staff to have sha | | | | quarterly QA Meeting to ensure compliance. Identified issues will be | | |
| | During an interview | on 05/06/16 at 2:19 PM with | | | reported immediately to the Administra | tor. | |
| | _ | mily she confirmed she wanted | | | DON or ADON for appropriate action. | , | |
| | | in hairs removed and she | | | Compliance will be monitored and | | |
| | expected the staff to | o remove them when they | | | ongoing auditing program reviewed at t | :he | |
| | • | She explained she had | | | quarterly QA Meeting. The quarterly Q | | |
| | | oval product to the facility for | | | Meeting is attended by the DON, ADOI | | |
| | • | ve Resident #258's facial hair | | | Administrator, SDC, MDS, HIM, Dietary | | |
| | and she expected f | or them to use it. | | | Manager and Social Services. Results the audits will then be shared in the | of | |
| | During an interview | on 05/06/16 at 5:08 PM the | | | Quarterly QA Meeting with the Medical | | |
| | _ | stated resident's facial hair | | | Director with verification of his attendar | | |
| | | as part of their Activities of | | | along with all members of the QA Team | | |
| | Daily Living (ADL) | care. She further stated if a | | | and Department Heads. | | |
| | resident could not t | all staff they wanted facial hair | | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER | I CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 1 33/33/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE | JLD BE COMPLETION |
| F 312 | removed then staff responsible party if facial hair removed requested. | ge 57 should ask the resident's they wanted the resident's and should do what they ENT DIETARY SUPPORT | F 3 ⁻ | Date of Completion: June 3, 2016 | 6/3/16 |
| SS=E | PERSONNEL The facility must empersonnel competer the dietary service. | oploy sufficient support nt to carry out the functions of | | | |
| | by: Based on 1 of 2 dir halls, 1 of 1 tray line resident interviews interviews, a review review of the facility facility failed to serv schedule with a pot receipt of medicatio activities and therap The findings include A review of the post revealed supper tra according to the foll 200 hall - Cart 6:05 PM 500 hall - 6:30 600 hall - 6:35 During an observati of the supper meal, | ed: ed meal delivery schedule ys were to be delivered owing schedule: 1 at 5:55 PM and Cart 2 at PM PM | | Corrective Action for Resident Affe An audit tool was immediately put place by the Dietary Manager to m daily meal service. Additionally, th Dietary Manager or designee bega conducting daily meal meetings wirdietary staff on both shifts. Corrective Action for Resident Pote Affected: All residents have the potential to be affected by this alleged deficient properties that the potential tool began on 5-2-16, to meal schedule, meal delivery and pexpedition of meal service. Daily more meetings began 5-30-16 to address previous days concerns/issues, if a planning of that days meals. Systemic Changes: A follow-up in service will be conducted. | into conitor ce an th entially oe ractice. monitor proper neal es any and |

PRINTED: 07/07/2016 FORM APPROVED OMB NO. 0938-0391

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , , | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 03/ | 06/2016 |
| NAME OF T | TOVIDER OR OUT FEILER | | | | 700 ROYAL COMMONS LANE | | |
| ROYAL PA | RK REHAB & HEALTH | H CTR OF MATTHEWS | | | | | |
| | | | | IV | MATTHEWS, NC 28105 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 362 | Continued From pa | ge 58 | F3 | 362 | | | |
| | • | the following concerns noted | | | the Contracted Corporate Registered | | |
| | | elay of the meal delivery: | | | Dietitian on June 1, 2016. All dietary st | aff. | |
| | | ietary staff (DS) #1 requested | | | including dietary managers, were in | , | |
| | | manager (CDM) prepare | | | attendance. Any in-house staff member | r | |
| | - | s on a mechanical soft diet. | | | who did not receive in-service training | | |
| | | e CDM instructed DS #1 to | | | not be allowed to work until training ha | | |
| | conduct temperatur | e monitoring of all hot foods | | | been completed. Information presented | | |
| | on the tray line due | a resident's meal tray | | | included adhering to posted meal | | |
| | identified with foods | less than 135 degrees | | | schedule, results due to delays of mea | I | |
| | Fahrenheit (F). | | | | service; e.g.; mediation pass, therapy, | | |
| | | OS #1 informed the CDM that | | | Kitchen production to be planned timel | | |
| | | regetables and needed more | | | with sufficient quantities to begin tray li | | |
| | vegetables to contin | | | | according to schedule, preparing speci | al | |
| | | OS #1 plated vegetable soup | | | order items timely so process is not | | |
| | | perature that was less than | | | delayed. | | |
| | _ | the soup was reheated. | | | All monitoring tools/audits will be | 1.4- | |
| | | 6 #1 informed the CDM that | | | completed and findings will be reported | | |
| | | nashed potatoes and PM, Cart 1 was delivered to | | | the weekly and quarterly QA meetings. This information has been integrated in | | |
| | | dditional foods were prepared | | | the standard orientation training and in | | |
| | | ine. Black eyed peas and | | | required in-service refresher courses for | | |
| | | epared and Cart 2 was | | | all Dietary employees and will be revie | | |
| | delivered to the 600 | - | | | by the Quality Assurance Process to ve | | |
| | | | | | that the change has been sustained. | , | |
| | During a dining obs | ervation of the supper meal | | | | | |
| | on 05/01/16 (Sunda | ay), the following meal delivery | | | | | |
| | times were noted: | | | | Quality Assurance: | | |
| | · 200 hall (Cart 1 | 1) - 06:17 PM; 22 minutes later | | | The Dietary Manager or Consultant | | |
| | than the posted del | | | | Dietitian for the Contracted Dining and | | |
| | · 500 hall - 06:37 | 7 PM; 22 minutes later than the | | | Nutrition Services will monitor this issu | е | |
| | posted delivery time | | | | using the "Dietary QA Audit" tool. All | | |
| | | PM; 20 minutes later than the | | | areas will be monitored daily. This will | be | |
| | posted delivery time | | | | completed daily for four weeks, then | 4 | |
| | , | 1) - 06:56 PM; 16 minutes later | | | weekly for one month, then monthly for | | |
| | than the posted del | | | | least three months. Identified issues w | 111 | |
| | , | 2 - a second cart was delivered e tray line) - 7:28 PM; 52 | | | be reported immediately to the Administrator and DON for appropriate | | |
| | _ | he posted delivery time | | | action. Compliance will be monitored | | |
| | minutes later triall t | no postou uchvery time | | | ongoing auditing program reviewed at | | |

Facility ID: 923542

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION | | E SURVEY PLETED |
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| | ROVIDER OR SUPPLIER | H CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP COE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 700/2010 |
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| F 362 | #8 revealed she rou weekend and obser meal from the dietar between 7 PM to 7: as 8 PM. An interview on 05/Aide (NA) #7 reveat the 400 hall usually department between the 2nd shift confusion the line and the line were the certified the delivery that, in terms of the delivery, the cook is foods so that "we do line" and the mechan have been prepared the CDM stated the have anyone assist preparation and halline on their own. Resident #329 was 03/08/16. Review of Set (MDS) assessing Resident #329 with | o1/16 at 06:34 PM with Nurse utinely worked every other red delivery of the supper ry department to the 600 hall 30 PM and sometimes as late o1/16 at 06:41 PM with Nurse led the supper meal cart for arrived from the dietary n 06:45 PM and 07:00 PM. on 05/01/16 at 07:10 PM, 1 stated that she was the ok every other weekend. DS dianother person on the line to own when I have to try to keep the and do all of my own prep, the thing I have to prepare the are late with the meals on 05/01/16 at 07:36 PM with manager (CDM) he revealed timeliness of the meal hould have had a back-up of on't run out of food during the anical soft chicken should dibefore the tray line began. The tray line began at the cook usually did not ing them with meal did to learn to manage the tray admitted to the facility on fan admission Minimum Datament dated 03/15/16 assessed clear speech, understood, | F 36 | quarterly QA Meeting to ensucompliance. The quarterly QA attended by the DON, ADON Administrator, SDC, MDS, HI Manager and Social Services the audits will then be shared Quarterly QA Meeting with the Director with verification of his along with all members of the and Department Heads until Date of Completion: June 3, | A Meeting is , M, Dietary s. Results of I in the e Medical s attendance e QA Team resolved. | |
| | Set (MDS) assessn Resident #329 with able to understand, supervision with me | nent dated 03/15/16 assessed | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 345026 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 05/06/2016 |
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| F 362 | was not unusual, she meals 30 - 40 minut times and that occas advise her that the resident #54 was a 05/08/15. Review of 04/14/16 assessed speech, understood cognition and requir meals. During an int PM, Resident #54 sconcerns in the pass receiving her meals she received lunch/slate because of som kitchen and that she that morning (05/05) the posted meal del breakfast trays to the 9:00 AM. During a follow up in PM, the CDM stated resident complaints some residents explike to receive their some residents and that he conducted tray donce the meal cart of distributed the trays their supper as late the he had to arrange medication administ not change meal dechanged the medicat The CDM also states. | on Sunday, 05/01/16, which he routinely received her ses after the posted meal sionally a staff member would meal was going to be late. dmitted to the facility on an annual MDS dated Resident #54 with clear, able to understand, intact red set up assistance only with terview on 05/05/16 at 01:08 tated that she had voiced to staff regarding routinely late. Resident #54 stated that supper on 05/01/16 (Sunday) hething that happened in the edid not receive her breakfast (16) until 10:15 AM. Review of ivery schedule revealed is Resident's hall were due at that he was aware of regarding late meals and that ressed to him that they would supper meal before 6:30 PM. At as a result of this concern, relivery audits and noted that reached the units and staff, some residents received as 7:00 PM. The CDM stated as 7:00 PM. The CDM stated are meal times according to tration times and that he could divery times unless nursing ation administration times. | F 3 | 62 | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 363 SS=E | to when the meal trade During an interview Administrator states family/resident concregarding food palar delivery, his plan was contract in place to the next annual surprocess. He stated annual survey in Ocimprovements were department, but the consistent. The admined he was aware of the food palatability and delivery and that stathis. 483.35(c) MENUS MADVANCE/FOLLOV Menus must meet the residents in accordadictary allowances of Board of the National Academy of Science and be followed. This REQUIREMENT by: Based on an observeriew of approved serve a 4 ounce por vegetables and rice menu, to 6 of 6 residents. | ursing staff and residents as ays would be delivered. on 05/05/16 at 3:52 PM, the I that due to continued the erns expressed to him that the stability and timeliness of meal as to have a new dietary address these issues before every, but this was still in that since the facility's last stober 2015 some made in the dietary se corrections did not stay inistrator further stated that a resident/family concerns with I the timeliness of meal of the stay of the st | F 36 | | nd |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BOILDI | | | Ι, | С |
| | | 345026 | B. WING | | | | 06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 00/2010 |
| | | | | 27 | 00 ROYAL COMMONS LANE | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | M | ATTHEWS, NC 28105 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | • | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI: TAG | X | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 363 | Continued From page | e 62 | F: | 363 | | | |
| | 1 tray line meal obse | rvations. | | | reserved with correct portion sizes. An | | |
| | The findings included | | | | audit tool was immediately put into place | | |
| | _ | e supper tray line on 05/01/16 | | | by the Dietary Manager to monitor daily | | |
| | at 5:32 PM revealed | the tray line included | | | meal service. Additionally, the Dietary | | |
| | mashed potatoes, ric | ce, green beans and | | | Manager or designee began conducting | g | |
| | | nixed vegetables. Review of | | | daily meal meetings with dietary staff o | n | |
| | | nat the rice and vegetables | | | both shifts. | | |
| | | a ½ cup (4 ounce) portion. | | | | | |
| | . , | was observed serving 3/8 | | | Corrective Action for Resident Potentia | lly | |
| | | n of mashed potatoes, rice, | | | Affected: | | |
| | | reed broccoli/cauliflower OS #1 stated she had already | | | All residents have the potential to be affected by this alleged deficient practic | 20 | |
| | | the 100 hall and she was | | | The audit tool began on 5-2-16, to mor | | |
| | | cart to the 100 hall. Review | | | the correct usage of appropriate scoop | | |
| | _ | evealed DS #1 plated 3/8 cup | | | sizes, compliance with established | | |
| | - | d potatoes, rice, green | | | recipes and adhering to appropriate | | |
| | beans or pureed veg | etables for Residents #141, | | | portions sizes. Also on 5-2-16, | | |
| | #69, #58, #165, #98, | and #169. DS #1 stated that | | | spreadsheets were reprinted and made | 9 | |
| | _ | menu and the "Scoop | | | available to all dietary staff. Copies of | | |
| | | n was posted next to the | | | scoop size sheets were provide to dieta | ary | |
| | | e set up the tray line, but she | | | staff to use for reference. | | |
| | stated "I did not do th | | | | Customia Changes | | |
| | • | on 05/01/16 at 05:59 PM the ager (CDM) stated staff are | | | Systemic Changes: A follow-up in service will be conducted | lby | |
| | | coop (Disher) Chart" to setup | | | the Contracted Corporate Registered | ГБу | |
| | | ould compare the portion | | | Dietitian on June 1, 2016. Those requi | red | |
| | • | menu to the posted chart to | | | to be in attendance include all dietary s | | |
| | | ns are served. He stated that | | | and dietary managers. Any dietary staf | | |
| | when he was in the k | | | | not available on 6-1-16 will not be allow | | |
| | | ne for correct portions, but | | | to work until they are in-serviced. | | |
| | | that the tray line was set up | | | Information presented will include | | |
| | with the wrong utens | ils. | | | compliance with established recipes, | | |
| | | | | | adhering to appropriate portions sizes, | | |
| | | | | | reviewing spreadsheets during product | ion, | |
| | | | | | using appropriate portioning tools and | | |
| | | | | | checking portion accuracy on tray line | | |
| | | | | | prior to tray leaving the kitchen. All monitoring tools/audits will be | | |
| | | | | | completed and findings will be reported | l to | |

| AND PLAN OF CORRECTION INTEREST. | | ` ′ | (2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|----------------------------------|------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|
| | | 345026 | B. WING_ | | | | C 06/2016 |
| | ROVIDER OR SUPPLIER | 1 11 1 | | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 ROYAL COMMONS LANE IATTHEWS, NC 28105 | 1 03/ | 00/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 363 | Continued From page | e 63 | F3 | 363 | the weekly and quarterly QA meetings. This information has been integrated in the standard orientation training and in required in-service refresher courses for all Dietary employees and will be review by the Quality Assurance Process to verthat the change has been sustained. Quality Assurance: The Dietary Manager or Consultant Dietitian for the Contracted Dining and Nutrition Services will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. This will completed daily for four weeks, then weekly for one month, then monthly for least three months. Identified issues we be reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at a quarterly QA Meeting to ensure compliance. The quarterly QA Meeting attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietary Manager and Social Services. Results the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendar along with all members of the QA Team and Department Heads until resolved. | to the or wed erify be the the g is of | |
| F 364 SS=E | 483.35(d)(1)-(2) NUT PALATABLE/PREFER | RITIVE VALUE/APPEAR, R TEMP | F3 | 364 | Date of Completion: June 3, 2016 | | 6/3/16 |
| | Each resident receive | es and the facility provides | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION UILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | 0 | C 5/06/2016 | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 364 | value, flavor, and appalatable, attractive, temperature. This REQUIREMEN by: Based on a review minutes for 4 month January 2016 and E resident interviews (#54), a test tray, 1 ohot foods less than | ethods that conserve nutritive pearance; and food that is and at the proper T is not met as evidenced of Food Committee Meeting (April 2016, March 2016, Pecember 2015), 4 of 4 (Pesident #9, #345, #329 and f 1 tray line observations with 135 degrees Fahrenheit | F 36 | F364 Corrective Action for Resident A An audit tool was immediately p place by the Dietary Manager to utilization of recipes by all produ | out into monitor uction staff, | | |
| | #204 and #49), staff medical records, the foods to preserve not foods per resident p temperature during observed. The findings include 1. a. Review of Food for April 2016 reveal | d Committee Meeting minutes ed residents expressed that s melted when getting it, food | | monitoring safe cooking temper recording on log, tasting foods p service for palatability, offering is substitutions and honoring residences on a daily basis. Corrective Action for Resident F Affected: All residents have the potential affected by this alleged deficien Recipes were reprinted and manavailable to all dietary staff, procounts being provided prior to e | orior to meal/food dent's Potentially to be t practice. de duction each meal | | |
| | 06/13/14. A quarterly assessment dated 0 #9 with clear speech understand, and ind Resident #9 attended Committee Meeting cornbread falls apart were served cold relout late and boiled estated in an interview | admitted to the facility on y Minimum Data Set 4/07/16 assessed Resident a, understood, able to ependent with eating. d the April 2016 Food and expressed that the t, beans were dry, meals ated to trays being passed ggs were cold. Resident #9 y on 05/03/16 at 08:45 AM orrible and that he often | | service and re-education provid cooks on preferred palatability, appearance and temps of foods Dietary Manager is also to atten resident/food council meeting at feedback from residents to enharms resident satisfaction, interview radmitted residents daily for food preferences and complete a we audit of dietary orders. The audited begin on 6-1-16 to monitor the acceptance of the satisfaction is serviced by the sa | ed to s. The nd nd obtain ance newly d ekly chart dit tool will | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | | 1 | C 5/06/2016 | |
| NAME OF P | ROVIDER OR SUPPLIER | 3.0020 | | ς. | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 05 | 100/2016 | |
| THANKE OF TH | TO VIDER OR GOL LIER | | | | 700 ROYAL COMMONS LANE | | | |
| ROYAL PA | ARK REHAB & HEALT | H CTR OF MATTHEWS | | | | | | |
| | | | | IV | IATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 364 | Continued From pa | age 65 | F: | 364 | | | | |
| | · · | t was tough all around the | | | Systemic Changes: | | | |
| | | ed that on 05/01/16 he | | | An in-service was conducted on May 5 | | | |
| | | unch that tasted burned and | | | 2016 by the Dietary Manager. Those w | | | |
| | | too tough to chew, so the | | | attended were all dietary production sta | | | |
| | | back to the kitchen. | | | The in-service topic included following | | | |
| | | | | | standardized recipes, serving palatable |) | | |
| | The facility respond | ded to the grievances on | | | foods and safe foods. The meeting also | o | | |
| | 04/14/16 with "Che | | | addressed the initiation of daily stand-u | ıp | | | |
| | | nust make sure cold products | | | meetings for both Dietary shifts. | | | |
| | are iced down and | | | A follow-up in service will be conducted | l by | | | |
| | Fahrenheit before | serving on hall." | | | the Contracted Corporate Registered | | | |
| | Di | | | | Dietitian on June 1, 2016. Those who | | | |
| | | ommittee Meeting minutes for ed Resident #9 stated that he | | | attended were all dietary staff. Any in-house staff member who did not | | | |
| | | , vegetables tasted watery, | | | receive in-service training will not be | | | |
| | | dry, and cornbread falls apart | | | allowed to work until training has been | | | |
| | every time. | ary, and compress rane apart | | | completed. Information presented | | | |
| | | | | | included following standardized recipes | 3, | | |
| | The facility respond | ded to the grievances on | | | tasting foods prior to service for | , | | |
| | 3/10/16 with "Adjus | st tray card to reflect resident | | | palatability, monitoring tray line | | | |
| | preferences." | | | | temperatures, meal presentation, | | | |
| | | | | | adhering to meal delivery schedule to | | | |
| | | ommittee Meeting minutes for | | | ensure optimal food temps at point of | | | |
| | | aled residents expressed that | | | service, monitoring food temps for safe | ty, | | |
| | "Sometimes food is | s cold when they get it." | | | corrective action for food items not at | | | |
| | The facility recessor | ded to grieveness on 01/11/16 | | | appropriate temps and honoring food | | | |
| | • | ded to grievances on 01/14/16, did not include a response to | | | preferences of residents. All monitoring tools/audits will be | | | |
| | cold foods. | did not include a response to | | | completed and findings will be reported | 1 to | | |
| | cola locas. | | | | the weekly/quarterly QA meeting. | 0 | | |
| | Review of Food Co | ommittee Meeting minutes for | | | This information has been integrated in | ıto | | |
| | | vealed Resident #9 stated he | | | the standard orientation training and in | | | |
| | | sentation of the food and | | | required in-service refresher courses for | | | |
| | vegetables and co | rnbread was not done. | | | all Dietary employees and will be revie | | | |
| | | | | | by the Quality Assurance Process to ve | erify | | |
| | | ded to the grievances on | | | that the change has been sustained. | | | |
| | _ | ust tray card to reflect resident | | | | | | |
| | preferences." | | | | Quality Assurance: | | | |
| | | | | | The Dietary Manager or Consultant | | 1 | |

PRINTED: 07/07/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | | C | |
| NAME OF D | ROVIDER OR SUPPLIER | 343020 | 1 | STREET ADDRESS, CITY, STATE, 2 | | 05/06/2016 | |
| NAME OF F | ROVIDER OR SUFFLIER | | | | IF CODE | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | 2700 ROYAL COMMONS LANE | | | |
| | | | | MATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY) | (X5) COMPLETION DATE | |
| F 364 | Continued From pag | e 66 | F3 | 364 | | | |
| 1 304 | During an interview of certified dietary man routinely worked with temperature monitor procedures/recipes, doing things right. The monitored for the use and conducted test the stated that during tempreviously identified recipes and as a resumake sure the right. He further stated that expressed in Reside Committee meetings surveys, the dietary until they were resolved. During an interview of Administrator stated family/resident concerns exhis plan was to have place to address the annual survey, but the stated that since the October 2015 some the dietary department of stay consistent. Stated that he was a food palatability and address this. b. Resident #345 was 04/18/16. An admiss 04/25/16 assessed F | on 5/05/16 at 3:23 PM the ager (CDM) stated that he astaff to educate them on ing, following customer service issues, and the CDM stated that he are of recipes 3 times weekly trays twice weekly. The CDM states are tray audits he had concerns with following that the re-educated staff to seasonings were being used. It if food concerns were not Council meetings, Food for customer satisfaction staff worked on the concerns weed. On 05/05/16 at 3:52 PM the that due to continued the erns expressed to him and expressed in Resident Council, and a new dietary contract in see issues before the next his was still in the process. He facility's last annual survey in improvements were made in that, but these corrections did The administrator further ware of the concerns with that the staff was working to sadmitted to the facility on ion Minimum Data Set dated Resident #345 with clear able to understand, intact | | Dietitian for the Contract Nutrition Services will musing the "Dietary QA A areas will be monitored completed daily for four weekly for one month, the least three months. Ideast | nonitor this issue Audit" tool. All I daily. This will be revealed, then then monthly for at entified issues will be revealed to the I for appropriate I be monitored and am reviewed at the poensure terly QA Meeting is ADON, DS, HIM, Dietary ervices. Results of shared in the with the Medical of the QA Team is until resolved. | | |

Facility ID: 923542

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 345026 | B. WING | | C 05/06/2016 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLETION | |
| F 364 | PM with her supper received baked chic rice, salad, roll, tea, if she liked her suppresponded "food is I sometimes its cold." During an interview certified dietary mar routinely worked wit temperature monitor procedures/recipes, doing things right. To monitored for the us and conducted test stated that during terpreviously identified recipes and as a resmake sure the right. He further stated the expressed in Reside Committee meetings surveys, the dietary until they were resoluting an interview. Administrator stated family/resident concresident concerns en his plan was to have place to address the annual survey, but the stated that since the October 2015 some the dietary department stay consistent. | meal. Resident #245 ken, cauliflower/broccoli mix, water and cake. When asked er meal, Resident #345 halfway, not like home, on 5/05/16 at 3:23 PM the hager (CDM) stated that he h staff to educate them on ring, following customer service issues, and he CDM stated that he e of recipes 3 times weekly trays twice weekly. The CDM st tray audits he had concerns with following sult he re-educated staff to seasonings were being used. at if food concerns were ent Council meetings, Food s or customer satisfaction staff worked on the concerns | F 36 | 4 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | | | C /06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 2700 ROY | ADDRESS, CITY, STATE, ZIP CODE YAL COMMONS LANE EWS, NC 28105 | 1 03/ | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFII TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 364 | address this. c. Resident #329 was 03/08/16. An admissi 03/15/16 assessed R speech, understood, cognition, and require person with meals. During an interview or Resident #329 stated food provided by the staff that the food did #329 stated that in or could eat for breakfast dry cereal, milk and a stated her supper me a ham and cheese crenjoyed her supper m food." During an interview or certified dietary manar routinely worked with temperature monitoring procedures/recipes, of doing things right. The monitored for the use and conducted test the stated that during test previously identified or recipes and as a resumake sure the right selections. He further stated that expressed in Resider Committee meetings | s admitted to the facility on on minimum data set dated esident #329 with clear able to understand, intact ed supervision of one staff In 05/02/16 at 3:46 PM that she did not like the facility and had expressed to not taste good. Resident der to have something she est, she had begun requesting a boiled egg. Resident #329 al on Sunday, 05/01/16 was oissant; when asked if she neal, she replied, "It was neal, she replied, "It was not staff to educate them on neal, following customer service issues, and the concerns with following alt he re-educated staff to easonings were being used. If food concerns were not Council meetings, Food or customer satisfaction taff worked on the concerns | F | 364 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | I CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 3,00,20.13 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 364 | Administrator stated family/resident concerns e his plan was to have place to address the annual survey, but it stated that since the October 2015 some the dietary department stated that he was a palatability and that address this. d. Resident #54 was 05/08/15. An annua 04/14/16 assessed speech, understood cognition and requir meals. Resident #54 was o PM in her room feed #54 received baked cauliflower/broccoli When asked about #54 stated regarding it." Resident #54 furequested hot water is never hot enough food that is not cook. | on 05/05/16 at 3:52 PM the I that due to continued erns expressed to him and expressed in Resident Council, a a new dietary contract in ese issues before the next his was still in process. He a facility's last annual survey in improvements were made in ent, but these corrections did The administrator further aware of the concerns with the staff was working to a admitted to the facility on I Minimum Data Set dated Resident #54 with clear able to understand, intact ed set up help only with bserved on 05/01/16 at 07:31 ding herself supper. Resident chicken, mashed potatoes, mix, roll, milk, and water. The supper meal, Resident githe chicken "They burned enther stated that she has a with her meals, but the water and sometimes she receives seed enough. on 5/05/16 at 3:23 PM the hager (CDM) stated that he h staff to educate them on ring, following | F3 | | | | |
| | temperature monito procedures/recipes, | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | ' ' | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 03/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 364 | and conducted test to stated that during test previously identified recipes and as a rest make sure the right. He further stated that expressed in Reside Committee meetings surveys, the dietary until they were resolved. During an interview of Administrator stated family/resident concerns exhis plan was to have place to address the annual survey, but the stated that since the October 2015 some the dietary department of stay consistent. | e of recipes 3 times weekly rays twice weekly. The CDM st tray audits he had concerns with following ult he re-educated staff to seasonings were being used. It if food concerns were nt Council meetings, Food so or customer satisfaction staff worked on the concerns | F 3 | 64 | | |
| | tray for a regular die to the 600 hall at 07: cart. The supper mewith an insulated doi included baked chickmixed, black-eye per Certified Dietary Managarine to the bromargarine did not mechicken was observed. | ccoli/cauliflower mix but the elt. The skin of the baked | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING _ | | | C 05/06/2016 | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 33.00.20.10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 364 | after all residents or the CDM and surve agreed that the black broccoli/cauliflower skin of the chicken I the milk was warm. he served margarin margarine "did not estated that the food piping hot." During a follow up in PM the CDM stated staff to educate their following procedure issues, and doing that he monitored for weekly and conduct The CDM stated that had previously iden recipes and as a remake sure the right He further stated the expressed in Reside Committee meeting surveys, the dietary until they were resord During an interview Administrator stated family/resident conditions. | On 05/01/16 at 07:36 PM, in the 600 hall were served, yor both tasted the food and ok-eyed peas were bland, the mix was cool and bland, the mad a burned/bitter taste and. The CDM stated that since it is and in the could be hotter and was "not interview on 5/05/16 at 3:23. That he routinely worked with in on temperature monitoring, is/recipes, customer service in the use of recipes 3 times it is during test tray audits he it ified concerns with following sult he re-educated staff to seasonings were being used. It is food concerns were in customer satisfaction staff worked on the concerns | F3 | 364 | | | |
| | place to address the annual survey, but t stated that since the October 2015 some the dietary departm | e a new dietary contract in ese issues before the next his was still in process. He e facility's last annual survey in improvements were made in ent, but these corrections did The administrator further | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345026 | B. WING | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 05/06/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY) | JLD BE COMPLETION |
| F 364 | palatability and that address this. f. During an interview dietary staff (DS) #1 weekend dinner cood #1 stated that she is meal about 1:00 PM the oven to bake be 350 degrees Fahrer she planned to leave 5:00 PM. On 5/01/16 from 02:0 observation of meal tray line revealed the palatability: The convection long sheet pans of the convection long | ware of the concerns with the staff was working to w on 05/01/16 at 2:54 PM, stated that she was the k every other weekend. DS tarted preparing the supper and placed the chicken in tween 1:45 PM to 2:00 PM on theit (F). DS #1 stated that the the chicken in the oven until 54 PM until 03:31 PM an preparation for the supper to following concerns with food oven was observed with 6 thicken. The oven to 350 degrees F. The the dwith a darkened/black by liquid chicken fat that was 3:31 PM, DS #1 was 3 pans of baked chicken operature monitoring revealed the chicken with 3 pans of chicken in the the to 210 degrees F. DS #1 was the chicken in the warmer supper tray line around 5:00 ucced the convection oven degrees F and stated she maining pans of chicken in arted the supper tray line at the to was observed with a | F 36 | 34 | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345026 | B. WING | | | C 5/06/2016 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 5/06/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 364 | concerns related to Baked chicken 192.3 degrees F Broccoli/cauliflowater-logged appear Rice had a bro 14 bowls of vectovered with lids are a direct heat source was placed on their tray was placed on Temperature monitor Resident #49 was 1 The supper metallog plate and then placed and remaine from 05:40 PM to 0 plate and then placed elivery. Temperature Resident 's baked rice was 56.4 degree mix was 118 degree On 05/01/16 at 07:3 with the CDM, he side broccoli/cauliflower beginning of the sum shy." The CDM scould be cooked in minutes. The CDM maintain hot foods degrees, cover food and to keep foods liserved. He stated in the cooks on the appreparation. On 05/05/16 at 01:2 | supper tray line and ring revealed the following food palatability: had a dark/black exterior; ower had a brownish, arance; 184.9 degrees F whish color; 200.2 degrees F getable soup were plated and id left on the stove, away from e. A bowl of vegetable soup meal tray for Resident #49; the the cart for delivery. Oring revealed the soup for 19.1 degrees F. all for Resident #204 was id on the tray line uncovered 5:46 PM. Staff covered the ed it on the meal cart for irre monitoring revealed the chicken was 118 degrees F, es F and broccoli/cauliflower es F. | F 36 | 54 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | E SURVEY IPLETED |
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| | | 345026 | B. WING _ | | | C 5/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 3/00/2010 |
| (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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 364 | stated she typically of hours. DS #1 stated think it (chicken) nee recipes, I just wanted was done." DS #1 fur soup should have be rather than left on the heat source. DS #1 are plated, the foods sure the foods stay houring a follow up into PM the CDM stated the staff to educate them following procedures issues, and doing this that he monitored for weekly and conducted The CDM stated that had previously identified previously identified in the procession of the concerns and as a resumake sure the right stated that since the annual survey, but the stated that since the October 2015 some in the dietary department of stay consistent. It stated that he was an palatability and that the address this. | ven by 02:30 PM. DS #1 cooked baked chicken for 2 ½ 'I' go by how much time I ds and I also use the I to make sure the chicken of the stated that the bowls of en placed in the warmer electore stove away from a direct also stated that once meals should be covered to make out. cerview on 5/05/16 at 3:23 that he routinely worked with on temperature monitoring, frecipes, customer service angs right. The CDM stated the use of recipes 3 times and test trays twice weekly. during test tray audits he fied concerns with following all the re-educated staff to the asonings were being used. on 05/05/16 at 3:52 PM the that due to continued terns expressed to him and pressed in Resident Council, a new dietary contract in the issues before the next is was still in process. He facility's last annual survey in mprovements were made in ont, but these corrections did the administrator further ware of the concerns with the staff was working to | F3 | | | |
| F 371 | 483.35(i) FOOD PRO | OCURE, | F 3 | 71 | | 6/3/16 |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
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| | | 345026 | B. WING | | 05/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | , 33/30/20/3 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| F 371 SS=E | considered satisfact authorities; and | m sources approved or ory by Federal, State or local istribute and serve food | F 371 | | |
| | by: Based on observatireview of facility recoplate hot foods that a Fahrenheit for 2 of 2 (Residents #49 and hygiene between cletomaking direct conof 6 resident observed #335, #220, #110, at to wear beard restrator 1 of 1 tray lines of The findings include 1. a. During an observed to pla #204 to include bake vegetables and a rolleft uncovered on the which time DS #2 cothe meal tray on the Temperature monito 05/01/16 at 05:48 Pitemperatures: | #204), 2) conduct hand ean and dirty tasks and prior tact with resident's food for 6 ed (Residents #347, #351, nd #136) and 3) 3 staff failed ints during meal preparation, observed. d: rvation of the supper tray line D PM, dietary staff (DS) #1 te a supper meal for Resident ed chicken, rice, mixed I. The Resident's plate was the tray line until 05:46 PM at the powered the meal and placed | | F371 Corrective Action for Resident Affecter Resident #49 and #204 meals were reheated to proper serving temperatural. The Dietary Manager completed an immediate in-service with all staff on 5-1-16, regarding taking food temps, hygiene, cross contamination and us beard/hair restraints. Corrective Action for Resident Potent Affected: All residents have the potential to be affected by this alleged deficient pract An audit tool was immediately put into place by the Dietary Manager to mor daily meal service and to monitor saffood handling. The Dietary Manager completed an in-service with all staff 5-1-16, regarding taking food temps, hygiene, cross contamination and us beard/hair restraints. | hand e of tially ctice. o hitor e on hand |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | A. BUILDI | NG | | Ι, | C |
| | | 345026 | B. WING _ | | | | 06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | , | ST | REET ADDRESS, CITY, STATE, ZIP CODE | : | |
| DOVAL D | ADV DELIAD & LIEALT | LL CTD OF MATTHEWS | | 27 | 00 ROYAL COMMONS LANE | | |
| ROYAL PA | ARK REHAB & HEALI | H CTR OF MATTHEWS | | M | ATTHEWS, NC 28105 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL | ID PREFIX | | | | (X5) COMPLETION |
| TAG | , | OR LSC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | DATE |
| F 371 | Continued From pa | age 76 | F; | 371 | | | |
| | Rice 56.4 degr | rees F | | | Systemic Changes: | | |
| | _ | oles 118 degrees F | | | An in-service was conducted on May 5 | | |
| | _ | ne certified dietary manager | | | 2016 by the Dietary Manager. Those w | | |
| | | at 05:59 PM revealed he | | | attended were all dietary production sta | | |
| | trained staff to kee | p hot foods at least 141 | | | The in-service topic included taking foo | | |
| | degrees F or above | e on the tray line. The CDM | | | temps, hand hygiene, cross contamina | tion | |
| | instructed DS #1 to | recheck temperatures of all | | | and use of beard/hair restraints. The | | |
| | foods on the tray li | ne and foods that were less | | | meeting also addressed the initiation of | f | |
| | _ | were placed in the steamer | | | daily stand-up meetings for both Dietar | y | |
| | and re-thermalized | | | shifts. | | | |
| | An interview on 05/05/16 at 01:40 PM with DS #1 revealed hot foods should be 180 degrees F on | | | | A follow-up in service will be conducted | i by | |
| | | - | | | the Contracted Corporate Registered | | |
| | 1 | sidents' meals should be | | | Dietitian on June 1, 2016. Those who | | |
| | covered as soon as | | | | attended were all dietary staff. Any | | |
| | | m 05:08 PM to 05:20 PM 3 was observed to plate 14 | | | in-house staff member who did not | | |
| | | soup for the supper meal. The | | | receive in-service training will not be allowed to work until training has been | | |
| | | e left on the stove without a | | | completed. Information presented | | |
| | direct heat source. | o lott of the otoro without a | | | included ensuring optimal food temps a | at | |
| | | 22 PM, DS #1 gave DS #2 a | | | point of service, monitoring food temps | | |
| | | soup for Resident #49. DS #2 | | | safety, corrective action for food items | | |
| | _ | ble soup on the Resident's meal | | | at appropriate temps, hand hygiene, cr | | |
| | tray and placed the | e tray on the cart for delivery. | | | contamination and use of beard/hair | | |
| | | oring revealed the vegetable | | | restraints. | | |
| | | grees F. The CDM stated that | | | All monitoring tools/audits will be | | |
| | | reheated and was observed | | | completed and findings will be reported | to | |
| | ' | n the microwave and | | | the weekly/quarterly QA meeting. | | |
| | re-thermalized. | /05/40 | | | This information has been integrated in | | |
| | | /05/16 at 01:40 PM with DS #1 | | | the standard orientation training and in | | |
| | | should be 180 degrees F on | | | required in-service refresher courses fo | | |
| | 1 | e soup should be plated as | | | all Dietary employees and will be review | | |
| | | in advance, soup should be rather than plated and left on | | | by the Quality Assurance Process to ve | шу | |
| | the stove without a | • | | | that the change has been sustained. | | |
| | | m 06:07 PM to 07:10 PM, | | | Quality Assurance: | | |
| | | 11 was observed, while wearing | | | The Dietary Manager or Consultant | | |
| | , , , | visibly soiled oven mittens | | | Dietitian for the Contracted Dining and | | |
| | | ins) to remove hot foods from | | | Nutrition Services will monitor this issue | a | |
| | | the mittens, opened oven | | | using the "Dietary QA Audit" tool. All | - | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | | FE SURVEY MPLETED |
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| | | 345026 | B. WING _ | | | , | C 5/06/2016 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | <u>, , , , , , , , , , , , , , , , , , , </u> | 3/00/2010 |
| D01/41 D4 | | | | 27 | 700 ROYAL COMMONS LANE | | |
| ROYAL PA | ARK REHAB & HEALTH (| STR OF MATTHEWS | | M | IATTHEWS, 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 | | | | (X5) COMPLETION DATE |
| F 371 | Continued From page | e 77 | F: | 371 | | | |
| | food debris) to wipe s with the same gloves rolls for Residents #3 and #136 with gloved conduct hand hygiene During an interview o #1 stated she did not items without changir she was trained to wa gloves out whenever to use utensils to plat During an interview o CDM stated that staff hand hygiene anytime contacted non-food it should not use soiled | n 5/05/16 at 03:23 PM, the were trained to conduct the their hands or gloves ems, and they know they mittens during meal prep, to be laundered or we will | | | areas will be monitored daily. This will completed daily for four weeks, then weekly for one month, then monthly for least three months. Identified issues we reported immediately to the Administrator and DON for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at quarterly QA Meeting to ensure compliance. The quarterly QA Meeting attended by the DON, ADON, Administrator, SDC, MDS, HIM, Dietar Manager and Social Services. Results the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendar along with all members of the QA Tean and Department Heads until resolved. | r at vill and the g is y s of | |
| | during meal preparati without beard restrair On 05/01/16 at 03:13 was observed with fa face and no beard resobserved to pour tea residents iced tea for On 05/01/16 from 05 was observed with fa beard restraint in place plate 14 bowls of veg meal. On 05/01/16 at 05:25 manager (CDM) was his cheeks and chin a place. On 05/01/16 from 05/01/ | PM dietary staff (DS) #2 cial hair to both sides of his straint in place. DS #2 was into cups of ice to serve | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | | 345026 | B. WING | | | | C 06/2016 |
| | ROVIDER OR SUPPLIER | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 ROYAL COMMONS LANE IATTHEWS, NC 28105 | 1 03/ | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 431 SS=E | cook black-eyed pearmonitoring. During an interview of CDM stated that the use beard guards; he use them, I am not roforgot to wear my be stated that he did no dietary staff with facia a beard restraint. 483.60(b), (d), (e) DE LABEL/STORE DRU The facility must empa licensed pharmacis of records of receipt controlled drugs in staccurate reconciliation records are in order accurated drugs is more controlled drugs is more controlled drugs is more controlled. Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. In accordance with Seculity must store all locked compartments controls, and permit have access to the keyengard. | ve, cook mashed potatoes, is and conduct temperature on 05/05/16 at 03:23 PM, the staff with facial hair should be stated "We have them and putinely on the tray line, so I hard restraint." The CDM is notice that there were all hair who were not wearing RUG RECORDS, GS & BIOLOGICALS of the who establishes a system and disposition of all difficient detail to enable an one; and determines that drug and that an account of all aintained and periodically as used in the facility must be evith currently accepted es, and include the ry and cautionary expiration date when that an account of all aintained and periodically accepted es, and include the ry and cautionary expiration date when that an account of all aintained and periodically accepted es, and include the ry and cautionary expiration date when that and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to | | 431 | | | 6/3/16 |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | ATE SURVEY OMPLETED |
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| | | 345026 | B. WING _ | | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 431 | Comprehensive Dru Control Act of 1976 abuse, except wher package drug distril | ed in Schedule II of the ag Abuse Prevention and and other drugs subject to a the facility uses single unit bution systems in which the inimal and a missing dose can | F 4 | 31 | | |
| | by: Based on observat facility failed to refri as per the affixed la to remove expired in tuberculin purified p bacteriostatic agent bottle of nitroglyceri medication carts. The findings include A review of the facil Storage in the Facil medications requirin "temperatures betw (F) and 46 degrees refrigerator with a th contaminated, and those in containers without secure clos from stock, dispose for medication dispo pharmacy, if a curre 1) During medicatio 05/05/16 at 6:45 AM | ity's policy titled "Medication ity" undated read in part ing "refrigeration" or it | | F 431 All identified open, unlabeled, no refrigerated or expired medication (insulin pens, TB serum, bacter agent, lidocaine and a bottle of nitroglycerin) were returned to por destroyed. The medication checked for proper storage of no and cleaned. No other items on were found to be unlabeled, exprequired refrigeration. This was by the cart nurse and the Unit Non 5/6/16. All nurses were reed the proper storage and labeling medication on the medication of lidentification of potentially affect residents and corrective actions All residents have the potential affected by the deficient practice 5/6/16 all medications in the medication of expired medication cart nurses and Unit Managers, additional expired medication of issues were identified. | ons iostatic charmacy carts were nedication the carts pired or completed Managers ucated on of arts. cted s taken: to be e. On edication d ns by the | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | TIPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | | | 2700 ROYAL COMMONS LANE | | |
| ROYAL PA | RK REHAB & HEALT | H CTR OF MATTHEWS | | MATTHEWS, NC 28105 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 431 | Continued From pa | age 80 | F 4 | 131 | | |
| | Novolog and one prodispensed date frow as unrefrigerated pens. The pharmar insulin pen until op. An interview was composed to recall if some in the medication of delivered the medicologo of the product of o | pen of Lantus) unopened with a m pharmacy of 05/02/16 that as per the affixed label on the cy label read in part "refrigerate ened." onducted with Nurse #7 on M. Nurse #7 stated she was the had placed the insulin pensitart when the pharmacy had cations on Monday night of confirmed the 2 insulin pensistored in the medication opening instead of being | | Systemic Change: All Nurses, RNs and LPNs and PRN) were in- service to date and label all open medications. This educati provided by an Education on Medication Storage. A or LPN will receive in-serv Medication Storage as of I This information has been the standard orientation trarequired in-service refresh all employees and will be a Quality Assurance Process the change has been sustant and LPN with the standard orientation trarequired in-service refresh all employees and will be a Quality Assurance Process the change has been sustant and LPNs an | Indicate the need multi-use on was a second multi-use on was 18, 2016. Integrated into paining and in the er courses for reviewed by the second multi-use on was a second mult | |
| | Nursing (DON) on stated she would h have been refrigera 2) During an obser | onducted with the Director of 05/06/16 at 4:50 PM. She ave expected the insulin to ated prior to opening. vation on 05/05/16 at 1:55 PM rehab 1 medication cart | | Quality Assurance: The Pharmacy Consultant medication carts monthly f and expired medications a open medications are date stored correctly. The 11 to check carts daily for prope | will check for cleanliness lso to ensure ed, labeled and 7 cart nurse will | |
| | revealed an insulin a dispensed date from the was unrefrigerated pens. The pharmacinsulin pen until op During an observation of the also revealed an indated as being open observations of the opened pen of Hurdate as to indicate | pen of Novolog unopened with rom pharmacy on 05/02/16 that as per the affixed label on the cy label read in part "refrigerate | | medications. This will be one month and then month three months. Compliance monitored and ongoing au reviewed at the quarterly (ensure compliance. Identibe reported immediately to for appropriate action. The Meeting is attended by the Administrator, SDC, MDS, Manager and Social Service the audits will then be sha Quarterly QA Meeting with Director with verification of along with all members of | done weekly for haly for at least will be diting program QA Meeting to fied issues will be DON or ADON e quarterly QA DON, ADON, HIM, Dietary ces. Results of red in the lathe Medical finis attendance | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | COMPLETED |
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| | ROVIDER OR SUPPLIER | H CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | 1 00/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | JLD BE COMPLETION |
| F 431 | opened vial of tuber serum) that contain when it had been of the med cart reverse bacteriostatic agent reproducing) that contained that had been of the med cart reverse bacteriostatic agent reproducing) that contained it had been of the med cart reverse because the management of the medical cart reverse bacteriostatic agent reproducing) that contained (numbing date as to indicate the management of the medical cart reverse because the medical cart reverse bec | an opened vial of 1% medication) that contained no opened. an opened vial of 1% medication) that contained no when it had been opened. 25/05/16 at 2:10 PM of the caled an opened bottle of sed for chest pain) that is to indicate when the bottle of sed for unopened insulin pens to rigerator. Nurse #8 further staff was expected to date the hey open them. Nurse #8 lalog insulin should be | F 43 ² | and Department Heads until resolve Date of Completion: June 3, 2016 | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | | | E SURVEY IPLETED | |
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| | | | 7 55.25. | | | (| c | |
| | | 345026 | B. WING | | | 05/ | 06/2016 | |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE 700 ROYAL COMMONS LANE IATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 441 SS=E | expired. A telephone interview at 4:35 PM with the p Novolog insulin was suntil it was opened. H Humalog insulin was opening. An interview was con Nursing (DON) on 05 stated she would hav have been refrigerate insulin pens were to b DON further stated sh to have a date on the medication was open 483.65 INFECTION C SPREAD, LINENS The facility must esta Infection Control Progsafe, sanitary and cort to help prevent the de of disease and infection (a) Infection Control F The facility must esta Program under which (1) Investigates, contributed in the facility; (2) Decides what progshould be applied to a | was conducted on 05/05/16 harmacist. He stated the supposed to be refrigerated e further stated the good for 28 days after ducted with the Director of /06/16 at 4:50 PM. She e expected the insulin to d prior to opening and be dated when opened. The ne expected all medications m as to indicate when the ed. CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions. | | 441 | | | 6/3/16 | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | OATE SURVEY COMPLETED |
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| | | 345026 | B. WING _ | | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CO 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | DDE | 00/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 441 | prevent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will track (3) The facility must hands after each direct after each direct washing is indiprofessional practices. (c) Linens Personnel must hand | on Control Program sident needs isolation to of infection, the facility must prohibit employees with a use or infected skin lesions with residents or their food, if nsmit the disease. require staff to wash their ect resident contact for which cated by accepted | F 4 | 141 | | |
| | This REQUIREMEN by: Based on observation interviews the facility instructions for contafailed to follow infect cleaning and moppin resident with physici and then went direct room who was not omopped and cleaned water, the cleaning recontamination for 1 corders for contact iso The findings included Resident # 62 was a | T is not met as evidenced ons, record review and staff of failed to post signage with act isolation precautions and ion control procedures during ag of resident rooms for a an orders for contact isolation ly into another resident's an isolation precautions and did without changing the mop ag or gloves to prevent cross of 3 residents sampled with olation (Resident # 62). d: dd: dmitted to the facility on oses of chronic kidney | | F441 Resident #62 was diagnose after seeing the eye doctor with conjunctivitis. The sign applied to the door along w cart after this visit. On 5/6/1 documents at 10:08am the present along with the isola The housekeeping supervis aware of this deficient clear for isolation room of resider employee was properly edutime according to the facilitic control policy on daily clear precaution rooms along with procedure on isolation rooms | in the facility lage was ith the isolation 6 the surveyor sign was ition cart. For was made ning practice in #62 and the located at that les infection ning of h the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING | | | 1 | C (06/2046 | |
| NAME OF P | ROVIDER OR SUPPLIER | 3.5525 | <u> </u> | STE | REET ADDRESS, CITY, STATE, ZIP CODE | 1 05/ | 06/2016 | |
| TAPAWIE OF T | NOVIDER OR OUT LIER | | | | , , , | | | |
| ROYAL PA | ARK REHAB & HEALTH | CTR OF MATTHEWS | | | 00 ROYAL COMMONS LANE | | | |
| | | | MA | ATTHEWS, NC 28105 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | : | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 441 | Continued From pag | je 84 | F 4 | 41 | | | | |
| | disease, type II diab | etes and heart disease. | | | the housekeeping department Stanton environmental services. | | | |
| | Data Set (MDS) date | recent quarterly Minimum ed 03/28/16 revealed ognitively intact for daily | | | Identification of potentially affected residents and corrective actions taken: | | | |
| | decision making and | | | | All residents who require isolation | | | |
| | | ene, bathing and toileting. | | | precautions have the potential to be | | | |
| | , , | | | affected by the deficient practice. On | | | | |
| | A review of a physici | | | 5-6-16, the RN Unit Nurse Managers | | | | |
| | indicated TobraDex Suspension 0.3-0.1 % (Tobramycin-Dexamethasone) antibiotic eye drops and instill 1 drop in both eyes four times a | | | | reviewed all patients to ensure that tho | se | | |
| | | | | | who require isolation precautions had | | | |
| | | | | | signs to notify staff. The Housekeeping | g | | |
| | | (redness and drainage of the | | | Supervisor was made aware of this | | | |
| | | The orders also indicated | | | deficient cleaning practice for isolation | | | |
| | contact precautions | for conjunctivitis. | | | room of resident #62. On 5/18/16, all | | | |
| | | | | | Contracted Environmental Service | | | |
| | _ | on on 05/06/16 at 10:08 AM | | | employees were reeducated on the | | | |
| | | #62's room was open and a | | | facilities infection control policy and the | | | |
| | | on the door frame which | | | daily cleaning of precaution rooms, alo | ng | | |
| | | Nurse. A clear plastic storage te floor inside the door which | | | with the procedures on isolation room | | | |
| | contained gowns, glo | | | | cleaning. | | | |
| | | ked a cleaning cart in front of | | | Systemic Changes: | | | |
| | | #62's room and entered the | | | On 5/18/16, all Contracted Environmer | ıtal | | |
| | | loves on and swept the | | | Service employees were reeducated by | | | |
| | | surfaces of the sink and | | | the Housekeeping Supervisor on the | , | | |
| | - | ning rag and mopped the | | | facilities infection control policy and the | <u>د</u> | | |
| | | sekeeper #1 then walked out | | | daily cleaning of precaution rooms, alo | | | |
| | | om and entered another | | | with the procedures on isolation room | 9 | | |
| | resident's room who | | | | cleaning. | | | |
| | precautions with the | same gloves on and used | | | All nurses and the unit managers were | | | |
| | I - | ag to wipe down the sink and | | | also in-serviced by the Director of Nurs | | | |
| | | d the bathroom floor with the | | | that all patients who require isolation m | ıust | | |
| | same mop and mop | water. | | | have signs posted to notify staff of the | | | |
| | | | | | requirement. This education is to be | | | |
| | _ | on 05/06/16 at 10:30 AM | | | completed by June 3, 2016. | | | |
| | - | ted she had only worked in | | | This information has been integrated in | | | |
| | | s. She explained she had | | | the standard orientation training and in | | | |
| | been instructed to w | ipe everything with a cleaning | | | required in-service refresher courses for | r | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345026 | B. WING _ | | | | C / 06/2016 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 700/2010 | |
| | | | | | 700 ROYAL COMMONS LANE | | | |
| ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS | | | | | ATTHEWS, NC 28105 | | | |
| | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | IVI | · | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 441 | Continued From pag | je 85 | F 4 | 41 | | | | |
| | rag, clean the bathro | oom, sweep and mop and | | | all employees and will be reviewed by | the | | |
| | _ | e stated she was unaware of | | | Quality Assurance Process to verify the | | | |
| | | See Nurse that was posted on | | | the change has been sustained. | | | |
| | | nt and stated she had no idea | | | | | | |
| | what the plastic stora | age container inside the door | | | Quality Assurance: | | | |
| | of Resident #62's roo | om was for and had not | | | The director of environmental services | will | | |
| | heard anything abou | it contact precautions. | | | monitor that proper procedure for clear | ning | | |
| | | | | | of isolation room is in compliance daily | | | |
| | During an interview of | | | Additionally the DON will review 5 new | | | | |
| | the long term care Unit Manager/ Assistant | | | | admits and 5 charts with recent lab res | | | |
| | | she explained they posted the | | | to ensure that isolation signs have bee | n | | |
| | _ | ne of Resident #62's room to | | | posted when appropriate. This will be | | | |
| | - | ause they did not want to | | | done weekly for one month then month | | | |
| | | solation was for. She stated | | | for at least three months. Compliance | WIII | | |
| | | re expected to go to the nurse | | | be monitored and ongoing auditing | | | |
| | | ign for instructions regarding | | | program reviewed at the quarterly QA | | | |
| | | lies they should use. She #62 was on contact isolation | | | Meeting to ensure compliance by the director of environmental services. | | | |
| | - | unctivitis and the clear plastic | | | Identified issues will be reported | | | |
| | | Resident #62's door contained | | | immediately to DON or Administrator for | nr. | | |
| | | She further explained staff | | | appropriate action. Compliance will be | | | |
| | | while they were in the | | | monitored and ongoing auditing progra | | | |
| | _ | she was not sure what routine | | | reviewed at the quarterly QA Meeting b | | | |
| | | ould follow when cleaning | | | the director of environmental services. | , | | |
| | Resident #62's room | | | | The quarterly QA Meeting is attended I | Эy | | |
| | | | | | the DON, ADON, Administrator, SDC, | | | |
| | During an interview of | on 05/06/16 at 3:45 PM the | | | MDS, HIM, Dietary Manager and Socia | al | | |
| | Director of Environm | nental Services explained | | | Services. Results of the audits will the | n | | |
| | - | expected to clean resident | | | be shared in the Quarterly QA Meeting | | | |
| | | rm care units of the facility on | | | with the Medical Director with verificati | | | |
| | _ | at should include cleaning of | | | of his attendance along with all member | | | |
| | | ng and mopping. He stated if | | | of the QA Team and Department Head | S | | |
| | | p See Nurse sign on their | | | until resolved. | | | |
| | | I routine for housekeepers to | | | Data of Commissions June 2, 2012 | | | |
| | | he housekeeper should wear | | | Date of Completion: June 3, 2016 | | | |
| | _ | oom. He stated changing of | | | | | | |
| | | d on what the precaution was | | | | | | |
| | | they used disinfectant in the | | | | | | |
| | mop water and that I | kept the room clean. He | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | С | |
| | | 345026 | B. WING | _ | | 05/ | 06/2016 |
| NAME OF PROVIDER OR SUPPLIER ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS | | | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 441 | gloves before they left they should put on cle cleaned the next reside explained Housekeep the facility for 2 days her orientation process housekeeper who wa Housekeeper #1 was experienced houseke received the hands on not received the blood that usually occurred orientation. During an interview on Director of Nursing concharge of the infection 2016 and had been refacility. She explaine nursing staff to inform regarding isolation procedured. She stated infection control procedured infection control procedure trained in infection was her expectation for infection control procedured in infection control procedured in infection control procedured i | eepers should remove their it the resident's room and ean gloves before they dent's room. He further over #1 had only worked in and they had to speed up as because they had a sout of work. He confirmed paired up with an eper on 05/05/16 and a portion of training but had do borne pathogen training over several days in on 05/06/16 at 5:08 PM the confirmed she had taken an control program in January evising the program for the do it was her expectation for a families and visitors eccautions the resident she trained nursing staff in edures but housekeepers on control by the es Director. She stated it for housekeepers to follow edures for cleaning of was her expectation when hished cleaning in a solation precautions they op, change the mop water, graway, change gloves and one they entered the next | F | 441 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | IPLE CONSTRUCTION IG | | ATE SURVEY DMPLETED |
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| | | 345026 | B. WING _ | | | C 05/06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP CO 2700 ROYAL COMMONS LANE 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 OF ((EACH CORRECTIVE ACTIVE) (CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE CROSS-R | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 520 F 520 SS=E | Continued From pag 483.75(o)(1) QAA COMMITTEE-MEME QUARTERLY/PLAN | BERS/MEET | F 5 | | | 6/3/16 |
| | assurance committe nursing services; a p | ain a quality assessment and e consisting of the director of physician designated by the 3 other members of the | | | | |
| | issues with respect t and assurance activ develops and impler | nent and assurance least quarterly to identify to which quality assessment ities are necessary; and ments appropriate plans of ntified quality deficiencies. | | | | |
| | disclosure of the rec | | | | | |
| | | by the committee to identify eficiencies will not be used as | | | | |
| | by: Based on observation record review, the fat and Assurance Commission implemented procedinterventions the cortober, 2015. This which were originally | T is not met as evidenced ons, staff interviews and ucility's Quality Assessment mittee failed to maintain lures and monitor these mmittee put into place in s was for recited deficiencies of cited during a recertification of 10/02/15, a complaint | | F520 Corrective Action for Reside No specific residents were rethe 2567. Corrective Action for Reside Affected: | mentioned in | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | l` ´com | | E SURVEY MPLETED | |
|--------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------|------|----------------------------|--|
| | | | A. BUILDI | NG _ | | Ι, | C | |
| | | 345026 | B. WING | | | | ے 06/2016 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | - | | |
| DOVAL DA | DI DELIAD O LICALTI | LOTE OF MATTUEWS | | 27 | 700 ROYAL COMMONS LANE | | | |
| ROTAL PA | ARK REHAB & HEALII | H CTR OF MATTHEWS | | M | IATTHEWS, NC 28105 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| | | | | | | | | |
| F 520 | Continued From pa | ge 88 | F : | 520 | | | | |
| | investigation survey | completed on 12/03/15 and | | | All residents have the potential to be | | | |
| | on the current recei | rtification survey. The | | | affected by this practice. See other pla | ns | | |
| | deficiencies were in | the areas of choice, accuracy | | | of corrections cited for F242, F278, F3 | ງ9, | | |
| | of the Minimum Dat | ta Set, provision of care and | | | F312, F363, F364, and F371. | | | |
| | services to maintair | n well-being, provision of | | | | | | |
| | assistance with acti | vities of daily living, following | | | Systemic Changes: | | | |
| | menus, food palata | | | On May 31, 2016, the Vice President of | f | | | |
| | continued failure of | | | Liberty Healthcare Clinical Services | | | | |
| | federal survey of re | | | in-serviced the Administrator. Topics | | | | |
| | | acility's inability to sustain an effective Quality | | | included: The need to continue all plan | | | |
| | Assurance Program | 1. | | | correction quality assurance monitors (| | | |
| | | | | | full compliance is sustained for 3 mont | | | |
| | Findings included: | | | | Once sustained for 3 months the surve | • | | |
| | | | | | monitor will be completed quarterly unt | il | | |
| | This tag is cross ref | terred to: | | | after the next survey cycle to ensure | | | |
| | 4 F 040: D | | | | compliance on the next survey. | | | |
| | | n observations, record review, | | | This information has been into material in | | | |
| | | nterviews, the facility failed to | | | This information has been integrated in | | | |
| | | r choice of personal hygiene | | | the standard orientation training and in | | | |
| | | to allow residents to sit | | | required in-service refresher courses for all employees and will be reviewed by | | | |
| | | vered porch or on a patio ts to feel imprisoned and | | | Quality Assurance Process to verify that | | | |
| | _ | facility also failed to honor a | | | the change has been sustained. | 11 | | |
| | - | r the number of showers in a | | | the change has been sustained. | | | |
| | | esident to feel un-clean for 4 | | | Quality Assurance: | | | |
| | | olled for choices (Residents #9, | | | The QA Nurse Consultant will monitor | his | | |
| | #165, #69, and #19 | • | | | issue using the QA Survey Tool. Quali | | | |
| | | , | | | Assurance Audit tools identified in this | , | | |
| | The facility was rec | ited for F 242 regarding failure | | | plan of correction will be reviewed mor | thly | | |
| | _ | egarding frequency of | | | to ensure that audits are completed un | - | | |
| | showers, choice of personal hygiene products compliance is sustained | | compliance is sustained for 3 months. | | | | | |
| | | | Then audits should be completed | ĺ | | | | |
| | 242 was originally of | cited in October 2015 for | | | quarterly to ensure on-going compliand | | | |
| | failure to provide ch | noices in food preferences. | | | until the next annual survey reveals | ĺ | | |
| | | | | | compliance. Any issues will be reporte | :d | | |
| | | n staff interviews, physician's | | | to the Administrator and the Regional | ĺ | | |
| | orders and review of | | | | Operations Manager for corrective | ĺ | | |
| | | ord, the facility failed to assess | | | actions. | | | |
| | the use of nain med | dication when completing a | | | 1 | | 1 | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | | ATE SURVEY OMPLETED | | | | |
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| | | 345026 | B. WING | | | C 05/06/2016 | | | | |
| | ROVIDER OR SUPPLIER | H CTR OF MATTHEWS | | STREET ADDRESS, CITY, STATE, ZIP COL 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 00/00/2010 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | FULL PREFIX (EACH CORRECTIVE ACTION SHOU | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 520 | reviewed for pain (for The facility was recomposed for accuracy in the regarding use of particular | for 1 of 3 sampled residents Resident #87). itted for F 278 regarding failure Minimum Data Set (MDS) in medication. F 278 was ctober 2015 for failure for arding Level II PASSR ition assessment. In staff, nurse practitioner and rviews, the facility failed to illity to use the right arm and assistance with ambulation for to experienced a change in the #47). itted for F 309 regarding failure dent change of condition. For ited in December 2015 for in. In observations, record review of interviews, the facility failed dir for 1 of 6 sampled residents by Living (Resident #258). itted for F 312 regarding failure the with chin hair removal. For ited in October 2015 for in nail care. In observation, staff interviews oved menus, the facility failed portion of mashed potatoes, | F 52 | | | | | | | |
| | The facility was rectorespond to a resist of a resist and staff and family to remove facial harder Activities of Dail The facility was rectored provide assistant and assistant and assistant and assistant and assist with the facility was originally of a failure to assist with the facility of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally of a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was originally or a failure to assist with the facility was rectained to a failure to a | ited for F 309 regarding failure ident change of condition. Fortied in December 2015 for hin. In observations, record review interviews, the facility failed in for 1 of 6 sampled residents by Living (Resident #258). Ited for F 312 regarding failure be with chin hair removal. For hinail care. In observation, staff interviews by the facility failed portion of mashed potatoes, a according to the approved dents observed (Residents 65, #98 and #169) during 1 of | | | | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTI | RUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 345026 | B. WING _ | | | 1 | C 06/2016 |
| | ROVIDER OR SUPPLIER | CTR OF MATTHEWS | | 2700 ROY | DDRESS, CITY, STATE, ZIP CODE YAL COMMONS LANE EWS, NC 28105 | , | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 520 | to follow the menu re mashed potatoes, ve was originally cited in follow the menu rega pudding. 6. F 364: Based on a Meeting Minutes for 4 2016, January 2016 a | ed for F 363 regarding failure garding portion size for getables and rice. F 363 October 2015 for failure to rding portion size for fortified a review of Food Committee 4 months (April 2016, March and December 2015), 4 of 4 | F | 520 | | | |
| | and #54), a test tray, hot foods less than 1 plated for 2 of 2 resid #204 and #49), staff medical records, the to preserve nutritional per resident preferent during 1 of 2 dining e | Residents #9, #345, #329 1 of 1 line observations with 35 degrees Fahrenheit ents observed (Resident nterviews and a review of facility failed to prepare food I value and provide foods ce for taste and temperature xperiences observed. | | | | | |
| | to provide palatable f F 364 was originally of failure to provide pala 7. F 371: Based on o | ood and food temperatures. cited in October 2015 for | | | | | |
| | 1) plate hot foods that Fahrenheit for 2 of 2 (Residents #49 and # hygiene between cleato making direct cont 6 of 6 residents obse #335, #220, #110 and to wear beard restrain for 1 of 1 tray lines of | t were at least 135 degrees residents observed (204), 2) conduct hand an and dirty tasks and prior act with resident 's food for rved (Residents #347, #351, d #136) and 3) 3 staff failed ints during meal preparation | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
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| | | 345026 | B. WING _ | | | C 5/06/2016 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105 | | 3/06/2016 |
| (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 CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 520 | to plate hot food at a Fahrenheit, hand hyg restraints. F 371 was 2015 for failure of tensteam table. Interview with the additional stream in the dietary discorrective plan and wimplementation. The facility monitored pre | minimum of 135 degrees giene and wear beard s originally cited in October inperatures of hot food on the ministrator on 05/06/16 at e facility identified deficient epartment, developed a vas in the process of administrator explained the viously identified deficient v Assurance committee met | F 5 | 20 | | |