STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345026	A. BUILDING: _____ B. WING _____	1/3/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 580	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family member interview, staff interviews and record review, the facility failed to notify the resident representative after resident falls for 1 of 3 sampled residents who required resident representative notification (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/14/17 with diagnoses which included cerebral infarction and orthostatic hypotension. The face sheet listed Resident #1 as the responsible person with family members listed as emergency contacts. Review of admission nursing note dated 12/14/17 revealed Resident #1 was alert with the ability to make needs known.

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

The above isolated deficiencies pose no actual harm to the residents

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F 580	Continued From Page 1

Review of a fall investigation dated 12/15/17, written by Nurse #1, revealed Resident #1 slid off the bed and fell onto the floor with no injuries. The report indicated Resident #1 was confused. The report indicated Resident #1 and the physician received notification.

Review of a fall investigation dated 12/19/17, written by Nurse #1, revealed Resident #1 fell during an attempted independent transfer to a chair with no injury. The report indicated Resident #1 was confused. The report indicated a family member and physician received notification.

Review of a nursing note, written by Nurse #3, dated 12/19/17 revealed Resident #1 complained of back pain at 4:00 PM. Nurse #3 documented the nurse practitioner received notification and ordered Resident #1 to receive a pain medication with monitoring.

Review of a nursing note, written by Nurse #3, dated 12/19/17 revealed Resident #1 complained of new pain with breathing at 7:00 PM. Resident #1's respiratory rate was 20 with an oxygen saturation rate of 97% on room air. Nurse #3 documented physician notification and an order to transport to the hospital for evaluation. Nurse #3 documented Resident #1's family member accompanied Resident #1.

Telephone interview with Resident #1's family member on 01/02/18 at 9:50 AM revealed the family member received notification of the 12/19/17 fall when the family member visited Resident #1 during an occupational therapy session and asked why Resident #1's complained of back pain. Resident #1's family member explained she wanted to be informed of all incidents regarding Resident #1 and did not know the 12/15/17 fall occurred.

Interview with the occupational therapist (OT) on 01/02/18 at 10:39 AM revealed Resident #1 followed simple verbal cues and was confused. The OT reported Resident #1 complained of back pain and was very confused during the 12/19/17 session. The OT reported she informed Resident #1's family member and nursing staff.

Interview with Nurse #1 on 01/03/18 at 8:32 AM revealed Resident #1 was confused. Nurse #1 explained she did not notify Resident #1's family member since Resident #1 was listed as the responsible person on the face sheet. Nurse #1 reported she informed Resident #1's family member of the 12/19/17 fall since the family member was physically present in the facility.

Interview with the Director of Nursing (DON) on 01/03/18 at 10:54 AM revealed Nurse #1 followed the correct procedure when the family member did not receive notification of the falls. The DON explained staff notified Resident #1 since he was listed as the responsible person on the face sheet. The DON explained the facility's admission coordinator determined who received notification during the initial admission process.

Interview with the Admissions Coordinator on 01/03/18 at 11:04 AM revealed she listed Resident #1 as responsible person in error.

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	345026	A. BUILDING _____ B. WING _____	C 01/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff, nurse practitioner and physician interviews, and record review, the facility failed to conduct a complete physical assessment after a resident fell for 1 of 3 sampled residents who fell (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/14/17 with diagnoses which included cerebral infarction and orthostatic hypotension. Review of Resident #1's admission physician's orders dated 12/14/17 revealed medications included Lovenox 40 micrograms subcutaneous daily and Plavix 75 milligrams by mouth daily. (Both medications are used to thin blood and prevent blood clots.) Review of admission nursing note dated 12/14/17 revealed Resident #1 was alert and able to make needs known. Review of Resident #1's initial care plan dated 12/14/17 revealed interventions for daily use of an anticoagulant (blood thinning) medications	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance will all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F-684. Plan for correcting specific deficiency and the process that led to the deficiency cited: The facility failed to conduct a complete physical assessment after resident #1 fell in the facility. Correction for involved resident: on 12/19/2017 Resident #1 was sent to emergency room for evaluation for increase complaints of pain to back and left side after a fall. The resident did not return to facility after treatment in acute	2/2/18

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

Electronically Signed | 01/26/2018

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F 684	Continued From page 1 included precaution to avoid falls and observe for signs of bleeding such as bruising. The care plan indicated Resident #1 required the physical assistance of one person with transfers. Review of a fall investigation dated 12/19/17, written by Nurse #1, revealed Resident #1 fell during an attempted independent transfer to a chair with no injury. The report indicated Resident #1 was confused, had full range of motion and normal vital signs. The report indicated a family member and physician received notification. Review of a nursing note, written by Nurse #3, dated 12/19/17 revealed Resident #1 complained of back pain at 4:00 PM. Nurse #3 documented the nurse practitioner received notification and ordered Resident #1 to receive a pain medication with monitoring. Review of a nursing note, written by Nurse #3, dated 12/19/17 revealed Resident #1 complained of new pain with breathing at 7:00 PM. Resident #1's respiratory rate was 20 with an oxygen saturation rate of 97% on room air. Nurse #3 documented physician notification and an order to transport to the hospital for evaluation. Review of Resident #1's emergency room admission physical examination dated 12/19/17 revealed the physician documented Resident #1 was alert and in no apparent distress but complaining of pain upon breathing with an oxygen saturation rate of 99% on room air. The physician documented Resident #1 had two rib fractures with a hemothorax on the left side. The emergency room physician documented Resident #1's left chest wall was tender with ecchymosis	F 684	care. The procedure for implementing an acceptable plan of correction for the specific deficiency sited: All residents that have had a falls in the facility have the potential to be affected by the deficient practice. On 1-19-2018 the Director of Nursing and QA nurse consultant completed 100% audit of all residents having falls in the past 14 days and the completion of a physical assessment post fall. Those findings were that 18 falls had occurred and of those 18, 2 falls did not have a post fall documented. One of those residents had been discharged. On 1/19/2018 the DON/Unit Manager completed full body audits on those residents falls in the past 14 days. One of those residents had discharged and were unable to be assessed further. Of those residents remaining in the facility, all body audits findings were negative for redness, swelling, bruising, or bleeding. On 01/9/2018 the DON/Designee began in servicing all FT-PT-PRN RNs and LPNs on post fall monitoring. This education included: Post Fall Documentation. 1. Resident that are being charted on for falls follow up for injury should be assessed every shift with complete vital signs for a minimal of 72 hours. In order to meet the requirements for post fall assessment documentation, you must indicate this in the notes. This can be accomplished several ways. State post fall	

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F 684	Continued From page 2 (bruising) posteriorly. Resident #1 was admitted to the hospital. Interview with Nurse #1 on 01/02/18 at 11:30 AM revealed Resident #1 required frequent supervision due to confusion and attempts to independently transfer. Nurse #1 explained Resident #1 sat in a wheel chair in the facility's common area near the nursing station so staff could provide frequent monitoring. Nurse #1 reported she heard another resident's family member shout that Resident #1 was falling at approximately 2:40 PM on 12/19/17. Nurse #1 reported she and Nurse #2 came immediately to the common area and observed Resident #1 seated on the floor in front of a chair. Nurse #1 reported she and Nurse #2 conducted an assessment which included vital signs and full range of motion. Nurse #1 reported Resident #1 had no injury. Interview with Nurse #2, the unit manager, on 01/02/18 at 1:02 PM revealed she heard someone call out that Resident #1 fell at approximately 2:40 PM on 12/19/17. Nurse #2 explained Nurse #1 and herself immediately responded and conducted a physical assessment. Nurse #2 explained Resident #1 received vital sign measurement and a range of motion. Nurse #2 reported a full body assessment was not conducted although she had to tuck Resident #1's shirt back into pants and did not see anything abnormal on Resident #1's lower back. Nurse #2 reported she did not check Resident #1's legs, arm, or chest for redness, swelling, bleeding or bruising. A second interview with Nurse #1 on 01/02/18 at 2:23 PM revealed Resident #1 did not receive a	F 684	assessment completed, no injury or pain identified. Patient assessed for injury and pain post fall, none noted. S/P falls assessment, no complaints or injuries noted. No effects noted with post falls assessment. You must state this in the nurse's note / fall follow up note in order to show that you completed the assessment. When a resident has a fall, the person discovering the resident reassures the resident and immediately alerts the primary nurse. The nurse assesses the resident for injuries. With suspected fractures of limbs, the limb in question are immobilized and an order to send to the ER is obtained. When other fractures are suspected of limbs, the limbs in questions are immobilized and an order to send to the ER is obtained. The attending physician is notified immediately. The attending physician is notified immediately of the fall if injury is apparent. If no injury is apparent the physician is notified. Notify the family or resident representative. Any RN, LPN staff not completing fall education with post fall documentation after 01/24/2018 will not be allowed to work until in-service has been completed. On 01/24/2018. This training has been incorporated into the general orientation for RNs and LPNs. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and or/or in compliance with the regulatory requirement: To ensure compliance on 01/29/2018 the Director of	

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F 684	Continued From page 3 full body assessment. Nurse #1 reported Resident #1 received the assessment in the common area. Nurse #1 reported she did not check Resident #1's legs, arms, back or chest for redness, swelling, bleeding or bruising. Nurse #1 reported the assessment was conducted in the common area. Interview with Nurse #3 on 01/02/18 at 3:23 PM revealed Resident #1 complained of back pain at 4:00 PM. Nurse #3 reported she notified the nurse practitioner and medicated Resident #1 for pain. Nurse #3 explained she called the on-call physician when Resident #1 complained of pain when breathing. Nurse #3 reported she measured Resident #1's vital signs and oxygen saturation rate but did not conduct a body assessment. Interview with the nurse practitioner (NP) on 01/03/18 at 8:56 AM revealed she expected staff to conduct a full body assessment after a fall. The NP explained Resident #1 was at a higher risk for bleeding due to blood thinners but bruising might not immediately occur. Interview with the Director of Nursing (DON) on 01/03/18 at 10:54 AM revealed she expected staff to conduct a complete assessment after a fall. The DON reported staff should have checked Resident #1 for signs of redness, swelling, bleeding and bruising. Telephone interview with Resident #1's physician on 01/03/18 at 12:38 PM revealed he expected staff to conduct a full assessment after a fall which included observation for redness, swelling, bleeding and bruising.	F 684	Nursing designee completed quality assurance audits of residents with falls review for a complete physical assessment after a fall. These audits will be completed 1 times a week for 4 weeks, then 2 time a month for 3 months on 5 residents having falls. The audit will include identification of any redness, swelling, bleeding after a fall. Audits findings will be presented in the weekly QA/QOL meeting for review by the Administrator/Director of Nursing and Quality Assurance team. The Quality Assurance Meeting is attended by the Director of Nursing, Assistance DON, Unit managers, Minimum Data Set Coordinator, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for implementing the plan of correction is the Administrator and/or Director of Nursing.	