STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING ______ B. WING ______	C 06/02/2022

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**

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F 000	INITIAL COMMENTS An onsite unannounced complaint investigation survey was conducted on 05/31/22. Additional information was obtained through 06/02/22 therefore the exit date was changed to 06/02/22. 1 of the 16 allegations was substantiated. The following intakes were investigated NC00189378, NC00188161, NC00188779 and NC00188384. Event ID# RRFH11.	F 000		
F 580 SS=D	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	F 580		6/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/22/2022

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.

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F 580	Continued From page 1 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 record review, staff, resident, Nurse Practitioner, Medical Director interviews, the facility failed to notify the physician when medications were not administered. This was for 1 of 3 residents reviewed for notification of changes (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/1/21 with a diagnosis of other pulmonary embolism, acute embolism, and thrombosis of unspecified deep veins of lower extremity-bilateral, hypertensive heart disease with heart failure.	F 580	The statements made on this plan of correction do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions outlined in this plan of correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated. F-580 Notify of Changes (Injury/Decline/Room, etc.) Address how corrective action will be	

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F 580

Continued From page 2

The Minimum Data Set (MDS) assessment dated 5/11/22 coded the Resident #1 as being cognitively intact.

A review of the medication administration record (MAR) for April 2022 revealed on 4/25/22 Nurse #2 did not administer Resident #1's 9:00 PM medications and a code of 7 which was a MAR code for sleeping was listed for each medication not given. These medications included the following: Xarelto Tablet 20 MG (Rivaroxaban) Give 1 tablet by mouth at bedtime for pulmonary embolism, Lopressor Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for hypertension, Neurontin Capsule 300 MG (Gabapentin) Give 1 capsule by mouth two times a day for Neuropathy.

A review of electronic health record for 4/25/22 and 4/26/22 revealed there was no documentation in the record pertaining to notification to the physician for Resident #1 not receiving his 9:00 PM medications on April 25, 2022.

A telephone interview on 6/1/22 at 8:06 AM with Nurse #2 who had been responsible for giving Resident #1 his 9:00 PM medications on April 25, 2022. Nurse #2 stated that when she went to give Resident #1 his medications and was not able to wake him and had tried three times and he was sleeping. Nurse #2 stated that she documented on the MAR a #7 which is the code for sleeping and did not make a note in the chart and did not notify the physician. Nurse #2 explained that she should have called the physician and did not report to her supervisor because it was just one time.

F 580

accomplished for those residents found to have been affected by the deficient practice:
On 5/31/2022, the Unit Manager assessed resident #1, and no acute distress was noted. The UM notified the medical provider, and no new orders were given.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
All current residents in the facility have the potential to be affected by the alleged deficient practice. On 6/14/2022, the Director of Nursing completed a 100% audit of all current residents to identify any new condition changes where staff failed to notify the MD. MD notified of any resident noted with a change of condition.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Beginning 6/14/2022, the Director of Nursing educated nursing staff on the following topics: Change of Condition and the importance of ensuring MD is notified. Training was completed on 6/17/2022. Any employee working after 6/17/2022, who did not attend the training, will not work until the training is completed. Education on Change of Condition has been incorporated into new hire and agency orientation.

Indicate how the facility plans to monitor its performance to make sure that

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F 580	Continued From page 3 A telephone interview with the Nurse Practitioner on 6/1/22 at 9:15 AM explained if a Nurse is withholding multiple medications, then she should have notified one of the providers especially because it was multiple medications. A telephone interview on 6/1/22 at 9:54 AM with the Medical Director (MD) stated that for Resident #1 not receiving the 9:00 PM medication especially the Xarelto there could have been serious risks involved as Resident #1 had been diagnosed with a deep vein thrombosis (a medical condition that occurs when a blood clot forms in a deep vein) as well as the Lopressor for his hypertension. The MD stated that it was her expectation that the medications should be administered and notification to the medical provider should have been completed if the medications were not administered. A telephone interview on 6/1/22 at 10:48 PM with the former Director of Nursing (DON) stated he had been familiar with the situation and stated it would be the policy to notify the physician if the medications had been missed. A telephone interview on 6/1/22 at 10:54 AM with the Administrator who stated that it was their policy to notify the doctor if the medication was not followed and it was his expectation that anytime we are not following the doctor's orders we should notify the physician and the Director of Nursing.	F 580	solutions are sustained: Beginning 6/20/2022, the Director of Nursing or designee will monitor compliance utilizing the F-580 Notification of Change of Condition QA monitoring tool. Monitoring will include observations of clinical chart for change of condition and notification of MD for five residents weekly x2 weeks then monthly x3 months. The ongoing auditing program will be reviewed at the weekly Quality Assurance meeting until deemed no longer necessary. The Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager attend the weekly QA Meeting. POC Completion Date: 6/21/2022	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		6/21/22

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F 760	Continued From page 4 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, Medical Director, and Pharmacist interviews, the facility failed to administer 9:00 PM medications which included an anticoagulant (blood thinner) ordered one time a day at bedtime for pulmonary embolism, blood pressure medication ordered one tablet two times a day for hypertension. This was for 1 of 3 residents reviewed for medication errors (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/1/21 with a diagnosis of other pulmonary embolism, acute embolism, and thrombosis of unspecified deep veins of lower extremity-bilateral, hypertensive heart disease with heart failure. The Minimum Data Set (MDS) assessment dated 5/11/22 coded the Resident #1 as being cognitively intact. A review of the medication administration record (MAR) for April 2022 revealed on 4/25/22 Resident #1 did not receive his 9:00 PM medications and a code of 7 which was a MAR code for sleeping was listed for each medication not given. These medications included the following: Xarelto Tablet 20 MG (Rivaroxaban) Give 1 tablet by mouth at bedtime for pulmonary embolism, Lopressor Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for hypertension, Neurontin Capsule 300 MG (Gabapentin) Give 1 capsule by mouth two times a day for Neuropathy.	F 760	The statements made on this plan of correction do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions outlined in this plan of correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated. F-760 Residents are Free of Significant Med Errors Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/31/2022, the Unit Manager assessed resident #1. No acute distress was noted, and the medical director was notified of missed medications with no new orders. On 6/1/2022, Nurse #2 was verbally re-educated on policy related to medication errors/missed medications and change of condition notification. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving medications have the potential to be affected. On 6/14/2022, the Director of Nursing audited 100% of resident medication administration	

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F 760	Continued From page 5	F 760		

F 760 — Summary Statement of Deficiencies (continued):

A review of progress notes for 4/25/22 and 4/26/22 was completed revealed no nursing entries related to Resident #1 not getting his medications on 4/25/22 at 9:00 PM.

An interview on 5/31/22 at 4:39 PM with Resident #1 stated that he did not get his 9:00 PM medications on 4/25/22. He stated that he remembered waking up at around 1:00 AM and told a Nurse's Aide (NA) that he had not gotten his medications and that the NA would tell the nurse. Resident #1 stated that he had fallen back asleep and never received his medications. Resident #1 stated he did let someone know the next day on 4/26/22 but could not remember who.

A telephone interview on 5/31/22 at 7:04 PM with a former Nurse #1 who worked on 4/26/22 during the day. Nurse #1 revealed he recalled Resident #1 mentioning he did not get his evening medications but did recall the second shift evening manager was aware of Resident #1 not receiving his medications.

A telephone interview on 5/31/22 at 7:40 PM with the second shift unit manager (UM) who worked second shift on 4/25/22 stated that he would have remembered if a Nurse came to him to alert him that Resident #1 could not be awaken and did not get his medications. UM explained that if a resident was sleeping and the medication was scheduled, the resident needs to be awakened to give the medication because it was a physician order, and the facility must carry out the physician orders. UM stated that if it was not given the doctor should have been notified and the family as part of the medication may be vital. UM stated in addition, the supervisor on duty should be

F 760 — Provider's Plan of Correction (continued):

records for the past 30 days for missed medication due to resident sleeping. Once it was determined who had missed medications due to sleeping, the MD was notified, and orders were updated to hold if sleeping or medication administration times were updated.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
On 6/13/2022, the Director of Nursing began educating nursing staff on Medication administration. This education included ensuring that medications are provided to residents per physician order and what steps to take if a medication error occurs or if the medication is not administered due to the resident sleeping. The Director of Nursing will ensure that any nurse or medication aide who has not received this training by 6/17/2022 does not work until the training is completed. This information has been integrated into the standard orientation training and the required in-service refresher courses for all staff identified above. Any nurse or medication aide who does not receive scheduled in-service training will not be allowed to work until training has been completed. In addition, any agency nurse utilized by the facility will receive this in-service education before their shift.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Beginning 6/20/2022, the Director of

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F 760	Continued From page 6 notified. A telephone interview on 6/1/22 at 8:06 AM with Nurse #2 who had been responsible for giving Resident #1 his 9:00 PM medications. Nurse #2 stated that when she went to give Resident #1 his medications and was not able to wake him and had tried three times and he was sleeping. Nurse #2 stated that she did remember trying again at 1:00 or 2:00 AM but was not certain what exact time she went into his room and stated that he did not refuse his medications but was just sleeping and stated Resident #1 was not in any distress. Nurse #2 stated that she did not remember any NA telling her that Resident #1 had requested his medications. Nurse #2 stated that she documented on the MAR a #7 which is the code for sleeping and did not make a note in the chart and did not notify anyone. Nurse #2 explained that she should have called the physician but because it was just one time, she did not report it to her supervisor. Nurse #2 stated "I guess it could be detrimental that he did not get his medications but did not want forcibly to wake him up." Nurse #2 stated that she did not know what the policy was for missing a single medication pass but stated she should have charted in the medical record. Nurse #2 stated that if it happened two nights in a row, she would have called the after-hour provider and made a note in the doctor's notebook. A phone call on 6/1/22 at 9:54 AM with the Medical Director (MD) stated that for Resident #1 not receiving the 9:00 PM medication especially the Xarelto there could have been serious risks involved as Resident #1 had been diagnosed with a deep vein thrombosis (a medical condition that occurs when a blood clot forms in a deep vein)	F 760	Nursing or designee will monitor compliance by utilizing the Missed Medication Quality Assurance Tool weekly x2 weeks, then monthly x3 months. The DON will present reports to the weekly Quality Assurance committee to ensure corrective action is initiated as appropriate. The QA Committee will review compliance and the ongoing auditing program at the weekly Quality Assurance Meeting. The Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager attend the weekly QA Meeting. POC Completion Date: 6/21/2022	

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F 760	Continued From page 7 as well as the Lopressor for his hypertension. The MD stated that it was her expectation that the medications should be administered. A telephone call with the Pharmacist on 6/1/22 at 12:10 PM was conducted with a review of the medications Resident #1 had missed. The Pharmacist stated of the medications missed the Xarelto and the Lopressor are significant medications and very important and should not have been missed.	F 760		