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 03/10/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/6/23 through 3/10/23. Event ID #5GMO11. The following intakes were investigated NCOO192164, NC00194641, NC00197326, NC00198616. 10 of the 10 complaint allegations did not result in deficiency.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family, and staff interviews, the facility failed to utilize a left-hand splint as ordered to maintain or improve range of motion/mobility for 1 of 3 residents (Resident #96) reviewed for range of motion.	F 688	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the	4/3/23

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

Electronically Signed | 04/03/2023

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 03/10/2023

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 688	Continued From page 1 Findings included: Resident #96 was admitted to the facility on 11/17/22 with diagnoses inclusive of dysphagia and aphasia following a stroke, hemiplegia/ hemiparesis, and vascular dementia. A Review of the Treatment Administration Record revealed an order dated 12/5/22 for Resident #96 to wear left hand splint during the day for 6-8 hours, remove daily for skin check and hygiene, in the morning. The Functional Maintenance Program form, with a start date of 12/19/22, identified Resident #96 as dependent for activities of daily living (ADL); Should complete passive range of motion during morning ADL routine for upper extremities; Encourage participation in any exercise groups; Left hand splint to be worn during the day 8 hours to decrease fisting of left hand. Goals included: maintaining skin integrity, proper body alignment, avoiding skin breakdown and leaning in wheelchair. The form had two nursing staff signature entries indicating in-service/ training on how to don and doff the hand splint for the Resident. A quarterly Minimum Data Set (MDS) assessment dated 1/5/23 indicated Resident #96 had severe cognitive impairment and required extensive assistance for bed mobility, transfers, eating and toileting; She required total dependence for dressing, personal hygiene, and bathing. A care plan dated 3/1/23 indicated Resident #96 was on a Functional Maintenance Program, (post therapy discharge directions) for upper and lower	F 688	accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations. For Resident #96, upon discovery and observation and by March 8, 2023, the left-hand splint was applied according to the physician's order. By March 8, 2023, the interdisciplinary team reviewed and confirmed the accuracy of Resident #96's care plan concerning the proper procedures for donning and doffing the left-hand splint and monitoring for compliance and skin integrity. The nurse involved in the resident's care was verbally re-educated on the proper use and application of hand splints and the importance of following orders and care plans. Residents who require a splint for contractures may potentially be affected. By 3/29/2023, the Director of Nursing audited all current residents with contractures by assessing each resident to ensure that splints were applied as ordered. All residents with splint orders were confirmed to be wearing their splints. By 3/29/2023, nurse managers audited all current residents to identify those with	

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 03/10/2023

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 688	Continued From page 2 extremities with the goal to complete upper extremities range of motion with the assistance of staff through the next review period. Interventions included: Observe for pain during performance of range of motion; Occupational therapy consult as needed; Report to nurse if more resistance than usual is met during range of motion exercises. During an observation on 3/6/23 at 3:15 PM, Resident #96 was not wearing left hand splint. The Resident stated she should be wearing it, but staff had not placed it on her and she wanted it on her hand. During an observation and interview on 3/7/23 at 2:40 PM, Resident #96 was not wearing left hand splint. The Resident stated staff "don't put it on" and that she had not declined it. During the observation and interview, the Resident's family member arrived for a visit and stated that she visits frequently and had not seen the resident wearing the left-hand splint in several visits. An interview on 3/7/23 at 2:47 PM with Nurse #3 revealed she worked the day shift 7am-7pm and that she was usually assigned to Resident #96 when she worked. She further revealed the left-hand splint was placed on Resident #96's left hand as tolerated. She could not recall the specifics of the order. She stated nurse aides and nurses were responsible for donning/ doffing hand splints. During an interview on 3/9/23 at 10:25 AM Nurse Aide #4 revealed she worked with Resident #96 on 7am-3pm on 3/8/23 and the previous week. She indicated Resident #96 was able to understand and respond appropriately. She further indicated she had never placed the hand	F 688	physician's orders for supportive devices such as splints, braces, palm guards, or hand rolls. This was achieved by reviewing orders and care plan tasks related to these devices. Once the residents requiring such devices were identified, the nurse managers and MDS nurse verified that the devices were in place, accompanied by physician's orders, CNA tasks, and care plans. By 3/29/23, the facility will provide in-service training to nursing staff on the proper use and application of splints and other assistive devices, inspecting skin per policy for irritation/redness/skin breakdown, and what to do when a splint or assistive device cannot be located or the resident chooses not to participate in the plan of care relating to splints/assistive devices. The facility will integrate the training on splints and other assistive devices into the standard orientation program for all new clinical staff members, ensuring they are knowledgeable about these practices from the start of their employment. Clinical staff members who were unable to attend the in-service training due to absence must receive the training upon their return to work, ensuring all staff members are informed and up-to-date on the proper use and application of splints and assistive devices. The Director of Nursing (DON) or designee will conduct weekly audits of residents with splints or other assistive devices for four weeks, followed by	

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 03/10/2023

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 688	Continued From page 3 splint on the Resident's hand because the nurse usually performed the task and the resident had never asked to apply the splint. She reported the resident had never asked to apply the splint. During an interview on 3/9/23 at 10:03 AM, Nurse #2 indicated she last worked with Resident #96 over the weekend (3/5/23-3/6/23 from 7am-7pm) and that the hand splint was in place during her day shift. She further indicated the nurse aides were responsible for placing the splint on Resident #96's hand. She stated that she provided left hand hygiene and placed the splint to Resident #96's hand on 3/8/23. During an interview on 3/9/23 at 8:54 AM, the Rehabilitation Director revealed a Functional Maintenance Program dated 12/19/23 was completed for Resident #96 when she was discharged from physical therapy services. She reported therapy staff trained nursing staff on donning/ doffing hand splints and photos/ diagrams were usually posted on the inside of resident's closet door. Nursing staff who were trained may or may not have signed the in-service sign-in sheet when they received training. During an interview on 3/9/23 at 9:37 AM, the Occupational Therapist (OT), who was assigned to Resident #96 for a few sessions, revealed nursing staff were trained on donning and doffing the hand splint during the last week that Resident #96 was on the therapy case load. She further revealed nursing staff were supposed to review the Functional Maintenance Program sheets that were located at the nursing station for nursing staff to determine who required range of motion care. The therapy department also provided copies of the Functional Maintenance Program	F 688	monthly audits for three months, to ensure that devices are being used correctly and consistently. The audit sample will include five residents. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly. Any identified issues will be addressed through corrective action and staff re-education as needed. The facility will track and trend audit data, with the goal of achieving and maintaining 100% compliance with the use of splints and other assistive devices. Progress toward this goal will be reviewed quarterly by the QAPI Committee, and adjustments to the plan will be made as necessary to ensure ongoing improvement.	

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 03/10/2023

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 688	Continued From page 4 sheets to the unit manager, medical records and MDS. An interview with the Director of Nursing on 3/9/23 at 3:24 PM revealed she expected staff to follow the order regarding the hand splints and that nurse aides were trained and tasked with donning and doffing hand splints.	F 688		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, and staff interviews, the facility failed to provide meals that were palatable for 5 of 5 sampled residents (Resident # 58, #26, #55, #109, #110). The findings included: a. Resident #58 was admitted to the facility on 1/13/23. An Admission Minimum Data Set (MDS) assessment dated 1/26/23, assessed Resident #58 with clear speech, adequate hearing/ vision, able to understand and be understood, intact cognition and required supervision with eating. On 3/7/23 at 11:16 AM Resident #58 indicated the	F 804	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our	4/3/23

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 03/10/2023

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 804	Continued From page 5 food was usually cold and did not taste good. He further indicated staff had been made aware, but they did nothing. Therefore, his family brings him food. During an observation and interview on 3/8/23 at 1:25 PM, Resident was observed sitting in the dining room with other residents, eating his lunch. He stated the soup was cold and he did not want it reheated. b. Resident #26 was admitted to the facility on 10/31/22. A quarterly MDS assessment dated 12/13/22 indicated Resident #26 was cognitively intact, able to understand and be understood, required extensive one-person assistance with ADLs (Activities of Daily Living) and was independent with eating. On 3/6/23 at 12:49 PM Resident #35 indicated the food was "horrible", had no seasoning, and was always cold. She further indicated she frequently ordered take-out food and could not afford to continue ordering out. c. Resident #55 was admitted to the facility on 11/18/15. A quarterly MDS assessment dated 1/2/23 indicated Resident #55 was cognitively intact and able to understand/be understood. He required extensive assistance with bed mobility, dressing, and toileting; Required supervision with eating and personal hygiene. On 3/6/23 at 10:54 AM Resident #55 revealed the pork and chicken were dry and difficult to cut. He further revealed he had many conversations with staff about the food. d. Resident #109 was admitted to the facility on 4/26/22 with diagnoses inclusive of type 2 diabetes. A quarterly MDS assessment dated 2/3/23 indicated Resident #109 was cognitively intact, had adequate hearing/vision, clear speech,	F 804	residents and maintaining compliance with all applicable federal, state, and local regulations. By 3/31/23, the interdisciplinary team reviewed and updated the dietary needs and preferences of the five sampled residents (Resident #58, #26, #55, #109, #110) to ensure their needs were being met and preferences considered. By 3/31/23, the dietary staff received additional training on food preparation, seasoning, and maintaining appropriate food temperature to improve meal palatability. By 4/3/23, the interdisciplinary team will review the dietary needs and preferences of all interviewable residents in the facility to ensure they are receiving palatable, attractive, and safe food. By 4/3/23, the facility will also examine Resident Council minutes to identify specific areas that may require further attention and address any issues raised regarding food quality and temperature. By 4/3/2023, the facility will establish that the monthly dietary staff meeting includes education on proper food preparation, seasoning, and maintaining food temperatures to enhance meal quality and ensure consistent practices. By 4/3/2023, the facility will establish a monthly Resident Council meeting specifically addressing food quality, providing a platform for residents to express their concerns and offer input on menu planning and improvements.	

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 03/10/2023

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 804	Continued From page 6 and was able to understand and be understood. The Resident required supervision of one staff person with eating after meal set up. During an interview on 3/8/23 at 1:15 PM, Resident #109 received her lunch and stated her grilled cheese sandwich was cold and the broccoli was cold and overcooked. She did not want her lunch reheated and did not want an alternate food item. She further stated she reports her food concerns to staff at times. e. Resident #110 was admitted to the facility on 5/7/22 with diagnoses inclusive of type 2 diabetes, hyperlipidemia, and end stage renal disease. A significant change MDS assessment dated 1/24/23 indicated Resident #110 had moderately impaired cognition, adequate hearing/vision, clear speech, and was able to understand and be understood. The Resident was independent with eating after meal set up. During an interview on 3/8/23 at 1:17 PM, Resident #110 received his lunch took one bite of his grilled cheese sandwich and did not eat his steam zucchini. He revealed the sandwich was cold, disliked zucchini and did not want his sandwich reheated or an alternate food item. A review of Resident Council meeting minutes December 2022 showed residents had concerns about food palatability. A test tray was requested on 3/8/23 at lunch time and left the kitchen at 1:05 PM. The cart arrived on the 200 unit at 1:07 PM. All residents were served, and the test tray was served at 1:27 PM. The steamed zucchini was soft, mushy, and slightly warm not hot. An interview with Nurse Aide #1 on 3/8/23 at	F 804	The facility will conduct weekly audits for five weeks, which will include five test trays, five resident interviews, testing food temperatures in the kitchen, and testing food temperatures upon delivery to the resident. These audits aim to ensure meal temperature and resident satisfaction during the initial phase of implementing the changes. Following this, monthly audits will be conducted for three months. Audit findings will be reported to the Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee monthly. Any identified issues will be addressed through corrective action and staff re-education as needed. The facility will track and trend audit data, with the goal of achieving and maintaining high resident satisfaction with food quality and temperature. Progress toward this goal will be reviewed quarterly by the QAPI Committee, and adjustments to the plan will be made as necessary to ensure ongoing improvement.	

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 03/10/2023

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 804	Continued From page 7 11:26 AM revealed residents had recently complained about the texture (difficulty chewing the food) and temperature of the food. She further revealed she usually offered to reheat cold food and that the Unit Manager was made aware. During an interview on 3/8/23 at 1:30 PM with the Certified Dietary Manager she believed she fixed the issues with the mushy vegetables last summer and was unaware of any current issues regarding food palatability. An interview with the Unit Manager on 3/8/23 at 3:10 PM indicated residents had complained about cold food for a while and it was addressed in department head morning meetings. It was her understanding that the Administrator was handling it. During an interview on 3/9/23 at 3:56 PM the Director of Nursing (DON) revealed she was made aware of resident reports of cold foods and was in discussions with staff about finding a new way of distributing the trays. Her expectation was for staff to distribute meals in a timely manner, have a good taste and for the food not to be cold. An interview with the Administrator on 3/9/23 at 2:28 PM indicated he expected the contract company to provide foods at a palatable temperature. The Administrator further indicated he planned to discuss options for improvement with the contracted food provider.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/3/23

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 03/10/2023

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 812	Continued From page 8 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on 2 of 2 observations, staff interviews and record review, the facility failed to remove dried food stains on a wall, clean the doors and drip pans of two convection ovens, remove debris from coils and the vent of the ice machine and a utensil storage rack in the kitchen. This had the potential to affect food served to residents. The findings included: A continuous observation of the kitchen occurred on 03/06/23 from 12:05 PM - 12:45 PM. During the observation, the following items were observed: a. The wall at the hand sink was observed with multiple dried red, and orange, colored splatters that extended above the hand sink to the baseboard. b. A double convection oven was observed in use. Each of the two doors to each oven was	F 812	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations.	

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 03/10/2023

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 812	Continued From page 9 heavily soiled with black stains with a thick residue of debris. The drip pans of each oven had a thick layer of burned debris. c. The cook's utensil storage rack, positioned over the cook's prep table, and observed in use, was observed with serving utensils (spoons, spoodles and tongs) hanging from the rack. The rack had a thick buildup of debris with a visible layer of dust like debris. d. The coils and air vents of the ice machine were observed with a visible thick layer of dust like debris. Dietary staff were observed preparing tea for the lunch meal directly in front of the coils/air vents of the ice machine. A follow up continuous observation of the kitchen occurred on 03/08/23 from 12:01 PM until 1:05 PM. The soiled items observed on 03/06/23 were observed the same as previously described. The Certified Dietary Manager (CDM) stated in an interview on 03/08/23 at 1:02 PM that she assigned cleaning tasks to the dietary staff as she identified items that needed to be cleaned and followed up to make sure the items were cleaned. She stated that she noticed the red and orange splatters on the wall at the hand sink which she stated occurred when staff discarded trash in the trash can that was next to the wall, but that she had not asked dietary staff to clean the wall. The CDM stated that the double convection ovens were last cleaned 3 weeks ago but that the doors and the bottom of each oven was heavily soiled and needed to be cleaned. She had not asked dietary staff to clean the ovens. The CDM stated that the coils and vents of the ice machine were heavily soiled and that the vendor usually cleaned the ice machine each time it was serviced. She stated she was not sure the last time the	F 812	By 3/31/2023, several cleaning tasks were completed in the kitchen: the wall at the hand sink was cleaned, removing dried food stains; the double convection oven doors and drip pans were thoroughly cleaned, eliminating debris; the cook's utensil storage rack was cleaned, getting rid of debris and dust, and the coils and air vents of the ice machine were cleaned, ensuring dust and debris were removed. By 4/3/2023, the facility will conduct a thorough inspection of the kitchen and food preparation areas to identify any other areas requiring cleaning or maintenance. All residents have the potential to be affected. By 4/3/2023, the facility will implement several actions to improve kitchen cleanliness and maintenance: revising the cleaning schedule to encompass all areas and equipment in the kitchen, including walls, convection ovens, utensil storage racks, and ice machine coils and vents; and providing in-service training to all dietary staff on proper cleaning and maintenance procedures to ensure compliance with food safety requirements. The Certified Dietary Manager (CDM) is responsible for overseeing the implementation and adherence to the cleaning schedule, as well as regularly inspecting the kitchen for cleanliness and proper maintenance. The facility will conduct weekly audits of kitchen cleanliness and equipment maintenance for the first five weeks.	

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 03/10/2023

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 812	Continued From page 10 vents/coils of the ice machine were cleaned, but that it was not due to be serviced until July 2023. The CDM stated she did not have the utensil rack on the cleaning schedule and had not asked dietary staff to clean it. During an interview with the Regional CDM on 3/08/23 at 4:00 PM, he stated that the cleaning schedule should be followed. The Administrator stated in an interview on 03/09/23 at 2:28 PM that the dietary staff should maintain items in the kitchen clean per the cleaning schedule.	F 812	These audits will include visual inspections and verification that the cleaning schedule is being followed. After the initial five-week period, the facility will perform monthly audits for the following three months to ensure sustained compliance with food safety requirements. Audit findings will be reported to the Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee during their monthly meetings. Any identified issues will be addressed through corrective action and staff re-education as needed. The facility will track and trend audit data, with the goal of achieving and maintaining compliance with food safety requirements. Progress toward this goal will be reviewed quarterly by the QAPI Committee, and adjustments to the plan will be made as necessary to ensure ongoing improvement.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		4/3/23

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 03/10/2023

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 867	Continued From page 11	F 867		

are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

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 03/10/2023

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 867	Continued From page 12 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

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 03/10/2023

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 867	Continued From page 13 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Base on observations, staff interviews and record reviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions for Range of Motion/ Mobility, Palatable Foods, Food Procurement, Infection Control which were put in place for the recertification and complaint survey dated 11/19/21, Range of Motion/ Mobility which were put in place for the complaint investigation survey dated 1/24/22, and on the current recertification and complaint survey dated 3/6/23. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referenced to:	F 867	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations.	

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 03/10/2023

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 867	Continued From page 14 F 688: Based on observations, record reviews, resident, family, and staff interviews, the facility failed to utilize a left-hand splint as ordered to maintain or improve range of motion/mobility for 1 of 3 residents (Resident #96) reviewed for range of motion. During the revisit and complaint investigation survey on 1/24/22, the facility failed to apply a hand splint for contracture management as ordered by the physician for 1 of 3 residents reviewed for choices. During the recertification and complaint investigation survey on 11/19/21, the facility failed to apply an arm splint as ordered to a resident following a stroke for 1 of 2 residents reviewed for range of motion. F 804: Based on record review, observations, resident interviews, and staff interviews, the facility failed to provide meals that were palatable and at an appetizing temperature for 5 of 5 sampled residents (Resident # 58, #26, #55, #109, #110). During the recertification and complaint investigation survey on 11/19/21, the facility failed to provide food that was appetizing for 8 of 8 residents reviewed for food palatability. F 812: Based on 2 of 2 observations, staff interviews and record review, the facility failed to remove dried food stains on a wall, clean the doors and drip pans of two convection ovens, remove debris from coils and the vent of the ice machine and utensil storage rack in the kitchen. This had the potential to affect food served to	F 867	By 3/31/23, the Quality Assurance and Assessment (QAA) Committee convened a special meeting to proactively address the identified deficient areas. The Regional Director of Operations and the Regional Quality Assurance Nurse were in attendance to provide guidance, support, and education in the development and implementation of the QAA committee processes. They collaborated with the facility staff to create a comprehensive action plan, focusing on strengthening oversight, monitoring processes, and implementing targeted interventions. Since all residents have the potential to be affected by the cited deficiencies in the facility's QAPI program, the facility will prioritize addressing these issues across the entire resident population. To ensure that the deficient practices do not recur, the facility is committed to strengthening the Quality Assurance and Assessment (QAA) program by focusing on ongoing training and support for QAA committee members. The Regional Director of Operations will provide a targeted in-service training by 4/3/23, with an agenda that covers the roles and responsibilities of QAA committee members, strengthening oversight and monitoring processes, targeted interventions, ongoing education and development, and monitoring performance and ensuring sustainability. This training aims to equip QAA Committee members with the knowledge and tools needed to ensure compliance	

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 03/10/2023

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 867	Continued From page 15 residents. During the recertification and complaint investigation survey on 11/19/21, the facility failed to remove fresh fruit, vegetables and thawed meat stored ready for use with signs of spoilage and undated in 1 of 1 walk-in cooler, 1 of 1 reach-in cooler, and the facility failed to remove expired nutritional supplements stored ready for use from two of two medication storage rooms (100/200 Hall Medication Room and the 300/400 Hall Medication Room). This practice had the potential to affect food and nutritional supplements served to residents. F 880: Based on observations and staff interviews, the Patient Advocate and Nurse Aide #3 failed to assist with or provide hand hygiene for residents prior to meal service for 5 of 5 residents (Resident #78, #84, #226, #71 and #121) and perform hand hygiene between residents while distributing meal trays for 1 of 2 staff (Patient Advocate). During a recertification and complaint investigation survey on 11/19/21, the facility failed to immediately implement Transmission Based Precautions (TBP) for 2 of 2 COVID-19 positive residents, failed to implement COVID-19 screening policy when 2 of 2 employees reported symptoms of COVID-19 (chills, muscle and body aches, headache, sore throat, cough, muscle and body aches) were allowed to work and then tested positive for Covid -19 during their shift, failed to follow CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of substantial to high county transmission rates when 3 of 3 staff members failed to wear eye protection when entering	F 867	and continuous improvement in resident care within the facility. The facility recognizes the importance of fostering a culture of continuous improvement and compliance with best practices. As part of this commitment, the QAA committee will increase the frequency of its meetings to allow for more in-depth analysis, discussion, and collaboration on addressing the identified areas of concern. The QAPI team will meet weekly to closely monitor progress and ensure that the implemented procedures and interventions are consistently maintained across all departments. To ensure that solutions are sustained and the facility continues to provide the highest quality of care, the Regional VP of Operations or Designee will audit the QAA Committee minutes weekly for the first five weeks, followed by monthly audits for the subsequent three months. Audit findings will be reported to the Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee weekly for the five weeks then at the monthly meetings for three months unless the QAPI team determines an extension is needed. Any identified issues will be addressed through corrective action and staff re-education as needed. In addition, the facility will track and trend audit data to ensure ongoing compliance with food safety requirements and other critical aspects of resident care. Progress toward achieving and maintaining compliance will be reviewed quarterly by the QAPI Committee, and adjustments to	

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 03/10/2023

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 867	Continued From page 16 resident rooms; additionally 3 of 3 staff failed to wear the appropriate PPE (gown, gloves and N-95 mask when entering Residents Rooms with Enhance Droplet Precautions (EDP), failed to utilize hand sanitizer or wash their hands when 2 of 2 staff were delivering meal trays for 18 of 18 residents. These practices had the potential to affect all residents who receive care from the facility staff. This failure occurred during a COVID-19 pandemic. During an interview on 3/9/23 at 4:18 PM the Administrator revealed there had not been any changes to the Quality Assurance (QA) policy and that the QA committee meets monthly or at least quarterly. The committee consisted of the Administrator, Director of Nursing, therapy department representative, pharmacy, Medical Director, Business Office Manager, Maintenance Director, nurse managers and Social Worker. The Administrator indicated the repeat deficiency for infection control did not require any adjustment in monitoring and that staff may forget the basics at times. He further indicated that the repeat palatable foods and kitchen deficiency would be addressed with the food provider contract. During a follow-up interview on 3/10/23 at 1:30 PM the Administrator explained that over the last 15 months the QA committee reviewed the QA and monitoring and were aware that the issues related to infection control, splint application, food palatability and kitchen were repeat deficiencies. Those repeated concerns would be addressed, and changes would be made.	F 867	the plan will be made as necessary to ensure ongoing improvement.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/3/23

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 03/10/2023

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 880	Continued From page 17 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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 03/10/2023

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 880	Continued From page 18 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the Patient Advocate and Nurse Aide #3 failed to assist with or provide hand hygiene for residents prior to meal service for 5 of 5 residents (Resident #78, #84, #226, #71 and #121) and perform hand hygiene between residents while distributing meal trays for 1 of 2 staff (Patient Advocate). The findings included: Review of the Hand Hygiene policy, revised	F 880	In accordance with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any	

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 03/10/2023

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 880	Continued From page 19 10/2022, stated in part, "It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infections ...Indications for hand hygiene: ...if hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating ...before eating ...before touching, preparing or serving food ..." a. During a continuous observation on 03/06/23 from 1:20pm to 1:30pm, the Patient Advocate was observed serving the lunch tray to Resident #78. She removed the tray from the meal cart, sat the meal tray on the overbed table. She removed the dome lid from the plate and set it aside. She returned to the meal cart and removed the meal tray for Resident #84. She sat the meal tray on the bedside table in front of the resident. She removed the dome lid from the plate and set it aside. The patient advocate did not ask the residents if someone had already cleaned their hands before serving their lnch tray. She did not assist with or provide hand hygiene to either resident when they were served their lunch tray. She also failed to perform hand hygiene between serving each of the residents. On 3/06/23 at 1:39pm, the Patient Advocate was interviewed. She stated she was not aware she should provide hand hygiene to each resident when serving the meal trays or clean her hands between serving each of the residents. b. During a continuous observation on 3/06/23 at 1:34pm to 1:43pm, Nurse Aide (NA) #3 was observed removing a meal tray from the meal cart, sat the meal tray on the bedside table in front Resident #226. She removed the dome lid from the plate and set it aside. She returned to	F 880	findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations. On March 6th, 2023, a licensed nurse in Infection Control provided hand hygiene for residents #78, #84, #226, #71, and #121. Additionally, the Dietary staff provided hand wipes on the meal trays for these residents. Also on March 6th, 2023, the Director of Nursing provided education for the Patient Advocate and NA #3 regarding hand hygiene protocols while passing trays and assisting residents with hand hygiene prior to meals. All current residents are potentially affected by deficient infection control practices. On March 7th, 2023, the licensed nurse in Infection Control and Unit Managers conducted Infection Control Rounds on all current residents to identify any deficient practices related to hand hygiene, including performing hand hygiene between passing meal trays and providing hand hygiene for at-risk residents prior to meals. No other deficient practices were found. The Director of Nursing initiated a staff-wide education program on hand hygiene, beginning on March 10th, 2023. This education utilized YouTube videos on hand hygiene. In addition, the Director of Nursing and the licensed nurse in	

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 03/10/2023

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 880	Continued From page 20 the meal cart, removed the meal tray for Resident #71 and placed the tray on the bedside table. She removed the dome lid and opened the items on the tray, then assisted Resident #71 to the chair. She returned to the meal cart and removed the meal tray for Resident #121. She sat the meal tray on the bedside table in front of the resident, removed the dome lid and opened the items on the tray. She performed hand hygiene after she delivered each meal tray. She did not ask the residents if someone had already cleaned their hands and she failed to assist with or provide hand hygiene to each resident when they were served their lunch tray. On 3/06/23 at 1:44pm, NA #3 was interviewed. She stated she did not provide hand hygiene to each of the residents when serving their meal tray because there weren't enough hand wipes in the facility to wash each resident's hands before each meal. On 3/6/23 at 5:10pm, the Infection Preventionist was interviewed. He stated staff should clean their hands between each resident and clean the resident's hands when serving their meal tray. He further stated staff could use hand wipes or hand sanitizer to clean the residents' hands and to clean their hands between serving the residents. He stated the patient advocate and the nurse aide had been trained in proper hand hygiene. On 3/9/23 at 2:30pm, the Director of Nursing was interviewed. She stated staff should clean their hands between residents and clean each resident's hands with hand sanitizer or hand wipes when serving the meal trays.	F 880	Infection Control began competency-based education on hand hygiene on the same day. By March 10th, 2023, the Director of Nursing completed a root cause analysis to determine the reason for the failure to perform hand hygiene, revealing that the lack of knowledge, supervision, and monitoring was the root cause for not providing hand hygiene between passing trays and before meals to residents. The Director of Nursing led the root cause analysis process. To address this issue, the Director of Nursing, along with the licensed nurse in Infection Control, began educating all staff on hand hygiene on March 10th, 2023. They used the provided YouTube video, "Clean Hands," and provided in-person education to 100% of staff. This education will also be integrated into the training for all new hires. By March 31st, 2023, education on hand hygiene will be completed for all facility staff, including Registered Nurses, Licensed Practical Nurses, Medication Aides, Nursing Aides, nonclinical staff, department heads, therapy department, environmental services, maintenance, and dietary staff. Any staff member who has not completed the education by the deadline will not be allowed to work until the education has been completed. Beginning on April 3rd, 2023, the Administrator, Director of Nursing, or their designee will observe and monitor hand hygiene for five residents and five staff during tray pass to ensure proper hand	

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 03/10/2023

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 880	Continued From page 21	F 880	hygiene practices are being followed. This audit will be conducted weekly for four weeks and then monthly for three months. The Director of Nursing or their designee will present reports on these audits in the weekly Quality of Life/Quality Assurance meeting. The purpose of the weekly meeting is to ensure that corrective actions for any ongoing concerns or trends are initiated appropriately to comply with regulatory requirements. Attendees at the weekly QA meeting will include the Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, Activities Director, Maintenance Director, Rehab Director, and other designated staff members.	