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 12/03/2015

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and medical record review, the facility failed to evaluate the need for pain medication prior to wound care and assess verbal and non-verbal expressions of pain during wound care for 1 of 4 sampled residents observed for wound care. (Resident #3) The findings included: Review of the facility's policy "General Guidelines for Dressing Procedures", dated August 2005, read in part to include an assessment for pain. Review of the facility's policy "Pain Assessment and Management", dated March 2003, read in part that a pain assessment included location of the pain and intensity of the pain using a pain scale. Resident #3 was re-admitted to the facility on 08/21/15 after surgical amputation of the right great toe and the right second toe. Diagnoses included severe peripheral arterial disease of the right lower extremity, end stage renal disease and diabetes mellitus II.	F 309	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 with 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 be corrected by the date or dates indicated. F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Action: Resident #3: MD was notified of pain during dressing changes on 12/1/15 and the current pain management order was reviewed. Order obtained to continue with current pain management.	12/18/15

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

Electronically Signed | 12/18/2015

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 12/03/2015

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 309	Continued From page 1 A care plan, updated 08/21/15, indicated Resident #3 had surgical wounds which resulted from amputations of her right great toe and right second toe. Interventions included to assess for pain each shift and as needed and to administer pain medication as ordered. A quarterly minimum data set assessment (MDS) dated 10/02/15 assessed Resident #3 with intact cognition, able to be understood, able to understand others, without mood/behavior changes, and requiring extensive staff assistance with bed mobility/transfers/locomotion. The MDS indicated pain medications, as needed, were used in the last 5 days of the assessment period for occasional pain, and rated pain 6 on a scale of 1 to 10. A physician's order dated 10/28/15 ordered acetaminophen (Tylenol) 325 milligrams (mg), 2 tabs every 4 hours as needed for pain. Wound care was observed for Resident #3 on 12/01/15 from 5:43 PM until 5:53 PM. Resident #3's responsible party (RP) was present during the wound care. During the observation, nurse #1 (wound nurse) sprayed the wound bed of the right great toe with wound cleanser and then wiped the wound bed twice with a gauze soaked in an antiseptic solution. Resident #3 grimaced and pulled her foot away with each wipe of the gauze. After the second wipe with the gauze, Resident #3 stated "Don't wipe it, it's tender." Nurse #1 was observed to respond by saying "I have to clean it, I'm almost finished, are you ok?" Resident #3 stated "Yeah." Nurse #1 proceeded to cleanse the second toe wound. The surveyor interrupted and asked Resident #3 if she was having pain and if she wanted pain medication. Resident #3	F 309	Identification of other residents who may have the potential to be affected by this practice: All residents who are determined to who have wound care treatments have the potential to be affected by the alleged practice. On 12/2/15 all residents with wound care treatment were observed by the wound care nurse. Patients were asked prior to the dressing change if they had pain. Pain medications were obtained for patients who described pain. The MD was notified of the predressing pain and orders were obtained to pre-medicate as appropriate. The nurse also observed for nonverbal signs of pain during the dressing change and asked the patient to notify her if they had pain during the treatment. Upon the identification of pain the dressing was stopped and pain medications administered. The MD was notified and predressing pain medications orders were obtained as appropriate. Dressing change would then proceed 30 minutes after pain management or until resident reported no pain or discomfort after assessment of Resident's pain and effectiveness of pain medication was determined. Systemic Changes: On 12/2/15 the wound care nurse was in serviced /educated on pain management before, during and after dressing change by the Director of Nursing. On 12/8/15 – 12/18/15 all nurses RN and LPN (Full time, Part time and PRN) were	

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 12/03/2015

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 309	Continued From page 2 responded "Yes" to both questions. On 12/01/15 at 5:49 PM, nurse #1 asked the RP to advise nurse #2 (primary nurse) that Resident #3 needed something for pain. Nurse #1 then asked Resident #3 if she wanted to stop the wound care and wait for her pain medicine or if she wanted to continue with the wound care. Resident #3 responded by saying it was okay to continue and stated, "I will just have to bear through it." Nurse #1 proceeded with wound care by wiping the wound bed of the right second toe with a gauze soaked in an antiseptic solution; Resident #3 grimaced. Nurse #2 entered the Resident's room on 12/01/15 at 5:51 PM with 2 tabs of acetaminophen 325 mg. Nurse #2 administered pain medication to Resident #3 and stated "I understand you want something for pain, here is your Tylenol." After administering the pain medication to Resident #3, nurse #2 exited the Resident's room. Nurse #2 was not observed to assess the Resident's pain level, location or the effectiveness of the pain medication. Nurse #1 proceeded with wound care by applying an ointment to the wound bed. There was no further assessment of the Resident's pain or the effectiveness of the pain medication. Wound care was completed on 12/01/15 at 12:53 PM. Resident #3 did not verbalize or show signs/symptoms of further pain. Nurse #1 was interviewed on 12/01/15 at 12:57 PM and stated that when she completed wound care for Resident #3, she looked for facial grimacing during the dressing change to determine if the Resident was in pain. Nurse #1 further stated that Resident #3 would tell her if she was in pain. Nurse #1 stated that she did not routinely ask Resident #3 about her pain prior to a dressing change, but rather "I assess by facial	F 309	in serviced on pain management before, during and after dressing change by the Director of Nursing. These in-services /education on pain management were completed on 12/18/15 by the Director of Nursing and/or Designee. The education focused on: Premedicating a patient who has orders prior to dressing changes, asking the patient about pain prior to dressing changes, stopping the wound care process if the patient has pain before or during the process, medicating at verbal and nonverbal signs of pain and notifying the MD if the patient experiences pain during wound care and does not have ordered pain medications Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Pain Assessment Tool before, during and after wound care. Five residents with wound care treatment will be assessed for pain weekly for 4 weeks, and then monthly for three months. The Items reviewed using the QA Pain Assessment (before, during and after wound care) Tool, will include: Did patient report of pain before wound care treatment? If yes, was pain management done? Did patient report of pain during wound care treatment? If yes, was wound care treatment stopped and pain management done? Did patient report of pain after wound care treatment? If yes, was pain management done? Was pain reassessed after pain management? Was pain assessment documented? Was MD	

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 12/03/2015

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 309	Continued From page 3 grimacing during the dressing change and let her tell me if she is having pain." Nurse #1 stated that since Resident #3 stated she was okay with continuing the dressing change and would bear through it, "I continued." An interview was conducted with Resident #3 on 12/01/15 at 6:05 PM. During the interview Resident #3 stated that she was not routinely asked about her pain prior to receiving wound care, but that she would prefer to be asked about her pain in the event she needed pain medication before the wound care was started. An interview with nurse #2 was conducted on 12/01/15 at 6:10 PM. Nurse #2 stated that she worked with Resident #3 in the past, but that she was not the routine nurse for this Resident. Nurse #2 stated she was not familiar with whether or not Resident #3 could verbally rate her pain, so nurse #2 usually assessed her pain by facial grimacing. Nurse #2 stated she had not assessed Resident #3 for pain during the 3 PM - 11 PM shift or prior to the wound care that was just completed because she had not been informed that Resident #3 was going to receive her wound care. Nurse #2 stated had she been made aware, she would have assessed Resident #3's pain before the wound care. Nurse #2 further stated that she should have assessed the Resident's pain by asking her to rate her pain and give the location of her pain before administering pain medication, "but I did not, I just went off what the (family member) said that she was in pain and needed something right away." On 12/02/15 at 10:50 AM the director of nursing (DON) was interviewed. She stated that pain assessments should be routinely done and	F 309	notified for unmanaged pain? Any identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: 12/18/15	

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 12/03/2015

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 309	Continued From page 4	F 309		

should include an assessment of the pain location and level before a nurse administered pain medication and the effectiveness of the pain medication after administration. The DON stated that she expected the primary nurse to assess a resident's pain prior to a dressing change and determine if the resident needed anything for pain before the dressing change was started. The DON then stated that she would stop treatment to a wound if a resident expressed pain during the treatment and offer pain medication and then assess the effectiveness of the pain medication before continuing the wound care. The DON stated she would not expect a nurse to put the responsibility back on a resident to determine whether or not to proceed with wound care after the resident expressed pain and requested pain medication, but would rather expect the nurse to stop the wound care, provide pain medication and assess the effectiveness of the medication before continuing care.

During a follow up interview on 12/03/15 at 10:30 AM, nurse #1 stated that "When I wait a few minutes that seems to be an effective form of pain management for her (Resident #3); she will tell me to stop (wound care) if she wants me to stop." Nurse #1 further stated that in the past when Resident #3 expressed pain during wound care, she did not routinely offer the Resident pain medication, but rather, "I will ask her if she is ok and wait a few minutes before proceeding and let her get herself together and then proceed."