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 08/02/2019

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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E 000	Initial Comments A recertification survey was conducted from 07/30/19 to 08/02/2019. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID J33L11.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint investigation was conducted on 08/02/19. One of the one allegation was substantiated and cited. Event ID: J33L11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		8/26/19

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

Electronically Signed | 08/23/2019

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and medical record review, the facility failed to provide a dignified dining experience by not providing a resident with meal assistance to allow him to eat his meal at the same time his tablemates ate. This occurred for 1 of 15 sampled residents observed during dining for dignity (Resident #21). The findings included: Resident #21 was admitted to the facility 1/26/18. Diagnoses included dementia. A quarterly Minimum Data Set assessment dated 4/30/19 assessed Resident #21 with impaired cognition and required extensive physical assistance of 1 staff person with eating. A care plan, revised April 2019, identified Resident #21 had an activities of daily living self-care performance deficit due in part to his dementia. Staff interventions included, in part, to	F 550	- 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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/2/2019 the Director of Nursing assigned 2 staff members at resident #21 table and changed meal time delivery to	

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F 550	Continued From page 2 anticipate his needs and provide staff assistance while promoting his dignity. Resident #21 was observed continuously on 07/30/19 from 12:20 PM until 1:17 PM seated in his geriatric chair at the dining table in the dining area of the 100 unit. His lunch meal remained covered and on the table while two tablemates received staff assistance with eating their lunch meal. Resident #21 watched as his tablemates ate their lunch. On 07/30/19 at 1:15 PM, Nurse Aide #2 (NA #2) entered the dining area, picked up the resident's lunch tray and warmed his food. Resident #21 received assistance with eating his lunch meal on 07/30/19 at 1:17 PM. During this observation, Resident #21 stated "Yes" when asked if he was ready to eat. He ate 100% of his lunch meal with staff assistance. A family interview occurred on 07/31/19 at 02:19 PM and revealed that Resident #21 enjoyed socializing during meals and that he would have found it "undignified" to be at a table waiting to eat while others around him ate. The family member also stated that when she visited the facility she often saw staff feeding other residents at the same table while Resident #21 waited to be fed. The family member further stated that when this happened, she would find his meal tray and feed him. An interview with NA #2 occurred on 07/31/19 at 03:06 PM and revealed that she noticed on 07/30/19 Resident #21 had his lunch tray on the table "for a long time without being fed." She went on to explain that he waited because she and her co-worker were feeding other residents and "sometimes residents have to wait to be fed." NA #2 confirmed that she did not ask another	F 550	that table and tables where residents that needed assistance were seated in order to provide a dignified dining experience. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 8/21/2019 the Administrator and Director of Nursing evaluated 100% of other residents eating at tables in the dining area for lunch and dinner meals. All residents needing assistance with meals and sitting at the same table were served and assisted with their meals at the same time during the meal service period. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/23/2019 the Director of Nursing completed in-services for 100% of facility registered nurses, licensed practical nurses, and certified nursing assistants on Resident Rights, Meals service and assistance to all residents sitting together at the same table are provided meal and assisted with their meal at the same time in a dignified manner. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 8/27/2019 the Director of Nursing/designee will begin quality	

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F 550	Continued From page 3 staff member to help so that Resident #21 could eat while his tablemates ate. An interview with NA #1 on 07/31/19 at 03:09 PM revealed she worked with Resident #21 routinely and described that he required staff assistance with meals. NA #1 stated that on 07/30/19 during lunch she was assigned to assist residents who ate in their rooms. NA #1 stated after she completed her assignment, she entered the dining room and noticed that Resident #21 had not been fed his lunch. NA #1 further stated she saw that "his lunch tray was just sitting there", so she took his tray to heat it up and then fed him. NA #1 also stated that sometimes it took a while to get all the residents fed who needed assistance on the unit. A continuous observation of the lunch meal occurred on 08/01/19 from 12:08 PM until 12:26 PM on the 100 unit. During this observation, Resident #21 was seated in his geriatric chair with his lunch meal covered on the table in front of him. On 08/01/19 from 12:15 PM to 12:26 PM a staff member assisted another resident with eating lunch at the same table while Resident #21 watched and his meal remained on the table covered. Resident #21 received staff assistance with his lunch meal on 08/01/19 at 12:26 PM by NA #1 and ate 100% of his meal. An interview with Nurse #2 occurred on 08/01/19 at 03:44 PM and revealed that she would not expect residents to wait 57 minutes to receive assistance with their meal. Nurse #2 stated she was not informed, but that the Nurse Aides should let her know if help was needed to feed residents so that all residents seated at the same table ate at the same time.	F 550	assurance auditing meal service in dining area is coordinated so that all residents sitting together at the same table and consuming their meal are assisted at the same time. Monitoring to include lunch meal observations in dining area of 5 residents weekly x4 then monthly x 3 and will be reviewed the facility QA meeting weekly. The QA meeting attended by the Administrator, Director of Nursing, Unit mangers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager. Date of compliance will be 8/26/2019	

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F 550	Continued From page 4 An interview with nurse #3 occurred on 08/01/19 at 04:39 PM and revealed she was unaware that residents were waiting during meals to be fed and stated "That shouldn't be." Nurse #3 also stated that at least two additional staff were available to assist with meals so that residents were not waiting to eat at the same table while others were being fed. Nurse #3 further stated that she had previously informed nurse aides that if residents were waiting to be fed, to call for help and stated "57 minutes was too long to wait." The Director of Nursing (DON) was interviewed on 08/01/19 at 05:38 PM and stated that two nurse aides who comprised the shower team were always available since showers were not given during meals and she expected nurse aides to alert the nurse or call for help so that staff could be sent to the units to help with meals. The DON further stated that additional staff were available to assist with dining so that residents did not have to wait for an extended period of time to get help with their meals and residents who were seated together ate at the same time.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code the discharge location for 1 of 2 residents (Resident #145) reviewed for hospitalizations.	F 641	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	8/26/19

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F 641	Continued From page 5 Findings included: Resident #145 admitted to the facility on 6/18/2019 and discharged from the facility to home on 7/5/2019. A Physician's order dated 7/3/2019 read in part: "Ok to discharge home on 7/5/2019". A Social Service progress note dated 7/4/2019 read in part: "resident to discharge home alone on 7/5/2019, has supportive family member". The discharge Minimum Data Set (MDS) dated 7/5/2019 revealed Resident #145 was cognitively intact and had active discharge planning in process to return to the community. Review of Section A2100 (Discharge Status) indicated Resident #145 was discharged to an acute hospital. An interview was completed with the Social Worker/ Discharge Planner on 8/1/2019 at 2:31 PM. She stated Resident #145 established a goal to return home. The Social Worker/ Discharge Planner arranged for Resident #145 to have home health services and additional community resources when she returned home. She explained Resident #145 did not discharge to the hospital, but discharged from the facility to home with family support. The Social Worker/ Discharge Planner verbalized she did not code Section A2100 on the MDS. An interview was completed with the MDS Coordinator on 8/1/2019 at 2:43 PM. The MDS Coordinator explained she recalled Resident #145 and remembered she discharged from the facility to home. The MDS Coordinator stated	F 641	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. F641 Accuracy of Assessments Corrective Action: Resident #145: Resident Minimum Data Set (MDS) assessment (Discharge return Not Anticipated) with Assessment /Reference Date (ARD) [7/5/2019] was modified with a Corrective Attestation Date of 8/1/2019. The assessment was submitted to the state QIES system on 8/2/2019 and was accepted on 8/2/2019 Submission ID: 17208195 Identification of other residents who may be involved with this practice: All current residents with Discharge return Not Anticipated Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 8/19/2019 through 8/23/2019 an audit was completed by the MDS Nurse Consultant to reviewed all Discharge return Not Anticipated Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who were discharged to the community has section A2100(Discharge Status) coded accurately. All of Discharge return not anticipated MDS assessments completed in the last 6 months have been coded accurately. This was completed on 8/23/2019. Systemic Changes: On 8/23/2019 The Registered Nurse (RN)	

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F 641	Continued From page 6 she used nursing notes to code the discharge section on the MDS. The MDS Coordinator expressed she coded the discharge location as acute hospital in error and would correct the assessment immediately to reflect the accurate discharge location. An interview was completed with the Administrator on 8/2/2019 at 9:21 AM. He stated he expected the MDS department to code the MDS assessments as accurately as possible.	F 641	Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section A2100: OBRA discharge status coding instructions are Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. " Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds. " Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons. " Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents. " Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in	

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F 641	Continued From page 7	F 641	providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals. " Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities. " Code 07, hospice: if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient hospice programs. " Code 08, deceased: if resident is deceased. " Code 09, long term care hospital (LTCH): if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under ¿1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days. " Code 99, other: if discharge location is none of the above. This in service was completed by 8/23/2019. Any The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other	

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F 641	Continued From page 8	F 641	Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments that is Discharge return not anticipated or Discharge return anticipated to ensure that section A2100:OBRA Discharge Status is coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information	

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F 641	Continued From page 9	F 641	Management), Dietary Manager, Wound Nurse. Date of Compliance: 8/26/2019	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, and physician interview the facility failed to determine a pain level and administer an as needed pain medication as ordered in response to a resident's complaint of pain for 1 of 5 residents reviewed for pain management (Resident #393). Findings included: Resident #393 was readmitted to the facility on 7/7/18 with medical diagnoses inclusive of chronic pain syndrome and peripheral vascular disease. Resident #393's last quarterly Minimum Data Set (MDS) dated 7/16/19 revealed she was cognitively intact, she had clear speech and could make her needs understood and understood others. The MDS also specified the resident received as needed pain medication for frequent pain. Resident #393's care plan updated with the last	F 697	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. - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 7/30/2019 Resident #393's received 5mg of Oxycodone at 6:29 pm, pain level 6. On 8/1/2019 new orders were received assess pain ever shift and assessed daily from 8/1/2019. On 8/12/2019 resident #	8/26/19

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F 697	Continued From page 10 quarterly MDS on 7/16/19 indicated a focus area for pain medication therapy related to chronic pain. The interventions included administer medications as ordered and review at intervals for pain medication efficacy by assessing whether pain intensity acceptable to resident and controlled adequately by therapeutic regimen. A review of the Resident #393's physician orders included an order written on 2/11/19 for Oxycodone Hydrochloride (narcotic analgesic) 5mg every four hours for moderate to severe pain. Resident #393's medication administration record (MAR) for 07/30/19 revealed she received 5mg of Oxycodone at 1:19 pm for pain level 5. The medication was signed off as given by Nurse #1. On 7/30/19 at 5:14 PM, an observation of medication administration completed by Nurse #1 revealed Resident #393 requested her pain pill and Nurse #1 informed Resident #393 that she had 45 minutes before her next dose could be administered. Nurse #1 informed Resident #393 that she would return with the pain medication in 45 minutes. Nurse #1 did not ask the resident the location of her pain or what pain level she was experiencing. Resident #393 displayed grimacing during this observation. Resident #393's MAR for 07/30/19 specified she received 5mg of Oxycodone at 6:29 pm, pain level 6. The medication was signed off as given by Nurse #1. On 7/31/19 at 4:34 PM during an interview with Resident #393, she reported her pain medication was given later in the evening on 7/30/19.	F 697	393 was reassessed by the physician and pain assessment was reviewed with and her Gabapentin was increased. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 8/21/2019 the Director of Nursing evaluated 100% of facility residents for pain medications, completion of pain assessments to include medication administration for pain management. On 8/23/2019 all residents have orders for pain assessments for daily monitoring and medications provided as needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/23/2019 the Director of Nursing completed in-services for 100% of facility registered nurses, licensed practical nurses, and certified nursing assistants on pain management policy and pain assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 8/27/2019 the Director of Nursing/designee will complete Quality assurance auditing of pain medication administration and pain assessment of 5 residents for pain assessments and pain	

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F 697	Continued From page 11 Resident #393 reported she had lower back pain when she made the request to Nurse #1 to receive her pain medication at 5:14 PM on 7/30/19. Resident #393 could not recall what her pain level was at the time she was given the pain medication by Nurse #1 during the evening of 7/30/19. Resident #393 reported she had to wait until the time she could receive her pain medication and no alternative methods for pain relief were offered. Resident #393 stated her pain level sometimes reached a level of 8 on a scale of 1-10 with ten being the worse when she had to wait for her next dose of pain medication. On 7/31/19 at 4:49 PM during a phone interview, Nurse #1 revealed she informed Resident #393 on 7/30/19 during the medication pass in the afternoon that she would have 30 or 45 minutes before the next dose of her pain medication could be administered. Nurse #1 stated she was not sure if the time was 30 minutes or 40 minutes. Nurse #1 stated she had not asked the resident to rate her pain or the location of her pain because she had administered pain medication to her in the past and was knowledgeable of Resident #393 complaining of lower back pain. During an interview with Nurse #1 on 8/1/19 at 3:23 PM, she reported when Resident #393 requested her pain medication on 07/30/19 at 5:14 PM and she informed the resident she had to wait 30 to 45 minutes before she could receive her next dose, she must have incorrectly calculated the time when the resident's next dose could be administered. Nurse #1 confirmed she signed off on the resident's MAR that she administered pain medication to Resident #393 on 07/30/19 at 1:19 PM which meant the resident's next dose of Oxycodone Hydrochloride	F 697	medications administration as needed .Audits will be completed weekly x4 then monthly x 3 and will be reviewed the facility QA meeting weekly. The QA meeting attended by the Administrator, Director of Nursing, Unit mangers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager.	

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 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 12	F 697		

5mg every four hours for pain could have been administered on 07/30/19 at 5:19 PM.

On 7/31/19 at 5:20 PM during an interview with the Director of Nursing (DON), she stated her expectations were for nurses to assess residents' pain by asking them to rate their pain on a scale of 1-10 with 10 being the worse experienced pain, ask residents the location of their pain, identify medication ordered for pain, determine last time residents received their pain medication, and administer as ordered. The DON stated the facility had a policy that medications could be given an hour before and an hour after the medication scheduled time for administration and the facility had standing orders for pain medication. The DON also stated nurses should provide residents with alternative medications when available, notify one of the facility's provider of residents' request for pain medication outside of their scheduled times, and provide nonpharmacological alternatives for pain relief. The DON stated she expected nurses to use their judgement and best practice to provide pain relief for residents who had expressed pain either verbally or nonverbally.

On 8/1/19 at 9:24 AM during an interview with the Medical Director, she reported Resident #393's pain was controlled on her current medication regimen and that she had not displayed drug seeking behaviors. The Medical Director stated she expected residents to receive their pain medication if within the time range of the order and nurses were to use their discretion to give pain medication as well as contact the medical providers if there was a concern. The Medical Director indicated that if Resident #393 had requested pain medication within minutes of the

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F 697	Continued From page 13 order for next dose, then the nurse should have assessed for pain level, location and administered the medication based on nurse assessment.	F 697		