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 10/04/2023

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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/03/23 through 10/04/23. Event ID# EQNK11. The following intakes were investigated: NC00201474, NC00203604, NC00205139, and NC00207227. Three of the 10 complaint allegations resulted in deficiency.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		10/11/23

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

Electronically Signed | 10/23/2023

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F 755	Continued From page 1 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, resident interview, Pharmacy Technician, Nurse Practitioner, and Physician interviews, the facility failed to acquire and provide medication to a resident as ordered by the Physician when staff failed reorder and administer an oral anti-diabetic medication for 1 of 3 residents reviewed for pharmaceutical services (Resident #5). This failure resulted in Resident #5 missing a daily dose of an oral anti-diabetic medication for 6 consecutive days. The findings included: Resident #5 was admitted to the facility on 2/1/21 with diagnoses that included diabetes, An annual Minimum Data Set dated 7/2/23 for Resident #5 revealed she was cognitively intact with no behaviors or rejection of care. Physician's orders for Resident #5 revealed Glimepiride Tablet 4 milligrams (mg). Give 1 tablet by mouth one time a day for diabetes. Take with a meal, initiated on 1/5/23. The electronic Medication Administration Record (eMAR) for Resident #5 revealed a medication Glimepiride 4mg was not administered on June 10th,11th,12th,13th,14th or 15th. On June 10th through the14th the administration was coded as #9. #9 chart code read, other/see nurse notes.	F 755	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 dates indicated. F755-PharmacySvcs/Procedures/Pharmacist/Records Corrective action for resident(s) affected by the alleged deficient practice: On 10/3/2023 the Director of Nursing assessed resident # 5, those findings were no harm noted to resident #5. Medication error completed for missed does on 6/10/2023, 6/11/2023, 6/12/2023, 6/13/2023, 6/14/2023, and 6/15/2023. Additionally, the MD was notified of medication error and that medication was on hand and resident had not missed any additional dosed. On 10/3/23, the Director of Nursing verbally reeducated nurses and medication aides related to utilizing	

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F 755	Continued From page 2 On June 15th the administration was coded as #5, #5 chart code read hold/see nurse notes. Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/10/23 at 2:24 PM was documented by Nurse #6, the note did not record a reason for the missed dose. During the investigation multiple unsuccessful attempts were made to contact Nurse #6. Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/11/23 at 1:16 PM was documented by Nurse #5 and read: medication not available. During an interview on 10/3/23 at 4:58 PM Nurse #5 revealed she worked for an agency and had only worked at the facility one time. She recalled caring for Resident #5. She stated the Glimepiride for Resident #5 was not in the cart. She stated she checked the entire cart but could not find the medication. She did not recall ordering the medication or notifying the provider. Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/12/23 at 11:44 AM was documented by Nurse #4 and read: awaiting delivery. During an interview on 10/3/23 at 4:14 PM Nurse #4 revealed she worked for an agency and had only provided care to Resident #5 once or twice. She did not recall a shift when Resident #5 missed her Glimepiride. She further stated she would document "awaiting delivery" if a medication had already been ordered and she was waiting for it to be delivered.	F 755	emergency medication backup system for any medication unavailable on medication cart prior to documenting medication unavailable and notifying the medical director Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 10/10/2023, the Director of Nursing audited 100% of resident medication administration records to identify any medications documented as not administered due to medication unavailable. The results of the audit were no medication noted not administered due to medication unavailable. Additionally, the pharmacy audited the emergency medication backup system to ensure medications in stock. Any medication with low stock or not available was replenished. Measures /Systemic changes to prevent re-occurrence of alleged deficient practice: On 10/9/2023 the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses and medication aides, and agency staff on the following topics: Medication Omission/Medication Error Prevention to assure that medications are provided to residents per medical order and steps to take if a medication error occurs or medication is unavailable. The Director of Nursing will ensure any registered nurse,	

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F 755	Continued From page 3 Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/13/23 at 4:26 PM was documented by Unit Manager (UM) #1 and read: call pharmacy. An interview on 10/3/23 at 2:16 PM with UM #1 revealed she worked on the cart for the hall where Resident #5 resided on a shift in June when there was a call out. She further revealed Resident #5 could voice her concerns. She recalled that Resident #5 did not have a medication card for glimepiride on the cart. Resident #5 told her she had not received the medication for a couple of days, and she had asked the other nurses about it. Resident #5 told UM #1 she was told by another nurse that the medication was already ordered. UM #1 revealed she checked the other carts and could not find the medication; she then called the pharmacy. She was told by the pharmacy; they did not see where the medication had been ordered. UM #1 explained she ordered the medication, but it was not delivered on her shift. Pharmacy deliveries arrived on the evening shift. She stated she reported this to the Director of Nursing (DON) and the Nurse Practitioner. Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/14/23 at 9:47 AM was documented by Medication Aide (MA) #1, the note did not record a reason for the missed dose. During the investigation multiple unsuccessful attempts were made to contact MA #1. Review of an eMAR medication administration note for Resident #5's Glimepiride dated 6/15/23 at 11:45 AM was documented by Nurse #7 and	F 755	licensed practical nurse, or medication aide who has not completed training by 10/10/2023 will not be allowed to work until training is completed. In addition to this, The Director of Nursing will ensure that any newly hired/agency nurse or medication aide who has not completed education by 10/10/2023 will receive education on Medication Omission/Medication Error Prevention related to Plan of Correction during orientation and any agency nurse/medication aide utilized by the facility will receive education on Medication Omission/Medication Error Prevention related to Plan of Correction prior to working their shift. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 10/16/2023, The Director of Nursing or designee will monitor Compliance with the regulatory requirements utilizing F-755 QA Tool for monitoring Medication Availability. Monitoring will include reviewing MAR and observing medications on cart to ensure meds are available to be administered as ordered. The audit is be completed weekly for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager,	

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F 755	Continued From page 4 read: medication on order. During the investigation multiple unsuccessful attempts were made to contact Nurse #7. During an interview on 10/3/23 at 11:54 AM Resident #5 revealed some time back in June of 2023 she missed her diabetic medication called Glimepiride. She stated during that time her regular nurse was out on leave related to a family emergency and the nurses that were working the cart were either agency or nurses that usually worked on other halls. She explained she was familiar with her medications and knew what they looked like. She thought the first day she noticed the Glimepiride was missing was a Saturday. She mentioned it to the nurse and the nurse told her there were none left. Resident #5 did not recall the name of the nurse, she thought she was from an agency. The nurse did not tell her if she ordered the medication or not. Resident #5 stated she mentioned this to each nurse that brought her medications for the 6 days. When she mentioned the missing medication, she was told they could not find it, or she they were waiting for pharmacy to send the medication. She revealed UM #2 told her she had ordered the medication, and it was supposed to be delivered that night. She stated the following day she did not think staff checked the pharmacy delivery because she did not receive her medication on that day either. The following day she received her Glimepiride. An interview on 10/3/23 at 4:56 PM with UM #2 revealed she was the UM for the unit where Resident #5 resided. She did not recall a time when Resident #5 ran out of Glimepiride or calling pharmacy about it. She stated if a	F 755	Health Information Manager, and the Dietary Manager. Date of Compliance: 10/11/2023	

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F 755	Continued From page 5	F 755		

resident was missing a medication in the cart, staff should look through the cart and in other carts, call the pharmacy to order the medication, use their back up pharmacy if needed and call the provider.

During an interview on 10/3/23 at 5:09 PM the Certified Pharmacy Technician from the Pharmacy that serviced the facility revealed there was an order entered into the system for Glimepiride 4mg for Resident #5 on 6/13/23. The medication was delivered to the facility on 6/14/23. She stated she could not see the details of who entered the order.

An interview was conducted on 10/4/23 at 1:30 PM with the Nurse Practitioner (NP). The NP stated one day in June when she was in the facility a nurse told her Resident #5 was out of her Glimepiride. She further stated she thought the resident had already missed two or three doses when she was notified. Staff assured her the medication had been ordered and the resident would receive her next dose. She later learned the resident had missed six doses before receiving the medication. The NP indicated if staff cannot obtain a medication for a resident or if a resident missed a medication dose, they should notify her as soon as possible.

During an interview on 10/3/23 at 5:27 PM the former Medical Director revealed she did not recall Resident #5 not receiving her Glimepiride and she could not say whether she was notified or not. She stated a resident not receiving their Glimepiride for 6 consecutive doses could cause continuous elevated glucose levels and those glucose levels could potentially have significant effects, such as polyuria, and a hyperosmolar

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F 755	Continued From page 6 state (a complication of diabetes that occurs when the blood glucose is elevated for long periods of times leading to dehydration and confusion). She further stated she expected staff to order medication from the pharmacy, use the backup pharmacy if needed. Staff should administer all medications as they are ordered and notify her if they were unable to do so. During an interview on 10/4/23 at 12:30 PM the DON revealed she was not aware of a time when Resident #5 ran out of her medication Glimepiride. She did not recall anyone reporting this to her. The DON further revealed when the nurse removes the medications from the card appropriately there will be a blue strip on the card as a reminder to reorder. She stated if a resident's medication is not in the cart the nurses should ensure the entire cart is checked, they should also check other carts. If the medication was not found, they should reorder the medication from the Pharmacy. They should check to see if the medication could be pulled from their automated medication dispensing machine. If the medication could not be pulled from the pyxis and they were waiting for the medication to be delivered the staff should utilize the backup pharmacy. The DON further stated staff should always notify the provider if the Resident missed a medication.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		10/11/23

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F 760	Continued From page 7 Based on record review and staff, resident, Nurse Practitioner, and Physician interviews, the facility failed to ensure a resident was free from a significant medication error when staff failed to administer an oral anti-diabetic medication for 1 of 3 residents reviewed for significant medication errors (Resident #5). This failure resulted in Resident #5 missing a daily dose of an oral anti-diabetic medication for 6 consecutive days. The findings included: Resident #5 was admitted to the facility on 2/1/21 with diagnoses that included diabetes. An annual Minimum Data Set dated 7/2/23 for Resident #5 revealed she was cognitively intact with no behaviors or rejection of care. A care plan for Resident #5 revised on 7/16/23 revealed the resident was care planned for diabetes with risk for complications. The interventions included diabetes medication as ordered by doctor. Report hypo/hyperglycemic episodes to the MD as needed. Report to the nurse any of the following signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, acetone breath (smells fruity), stupor, or coma. Physician's orders for Resident #5 revealed the following: Glimepiride Tablet 4 milligrams (mg). Give 1 tablet by mouth once a day for diabetes. Take with a meal, initiated on 1/5/23. Finger stick blood sugar three times a day (TID).	F 760	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 dates indicated. F760- Residents Are Free of Significant Med Errors Corrective action for resident(s) affected by the alleged deficient practice: On 10/3/2023 the Director of Nursing assessed resident # 5, those findings were no harm noted to resident #5. Medication error completed for missed does on 6/10/2023, 6/11/2023, 6/12/2023, 6/13/2023, 6/14/2023, and 6/15/2023. Additionally, the MD was notified of medication error and that medication was on hand and resident had not missed any additional dosed. On 10/3/23, the Director of Nursing verbally reeducated nurses and medication aides related to utilizing emergency medication backup system for any medication unavailable on medication cart prior to documenting medication unavailable and notifying the medical director. Corrective action for residents with the potential to be affected by the deficient	

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F 760	Continued From page 8 Call the Nurse Practitioner if the blood sugar is greater than 300 or less than 120, initiated on 12/14/22. Resident #5's blood glucose readings from 6/3/23 through 6/9/23 ranged from 123-309. The electronic Medication Administration Record (eMAR) for Resident #5 revealed a medication Glimepiride 4mg was not administered on June 10th, 11th, 12th, 13th, 14th or 15th. On June 10th through the14th the administration was coded as #9. #9 chart code read, other/see nurse notes. On June 15th the administration was coded as #5. #5 chart code read hold/see nurse notes. An eMAR medication administration note for Resident #5's Glimepiride dated 6/10/23 at 2:24 PM was documented by Nurse #6, the note did not record a reason for the missed dose. Resident #5's blood glucose readings for 6/10/23 revealed blood glucose levels of 155, 221, and 179 on that day. During the investigation multiple unsuccessful attempts were made to contact Nurse #6. An eMAR medication administration note for Resident #5's Glimepiride dated 6/11/23 at 1:16 PM was documented by Nurse #5 and read: medication not available. Resident #5's blood glucose readings for 6/11/23 revealed blood glucose levels of 152 and 189 on that day. During an interview on 10/3/23 at 4:58 PM Nurse	F 760	practice: All resident receiving medications have potential to be affected by the alleged deficient practice. On 10/10/2023, the Director of Nursing audited 100% of resident medication administration records to identify any medications documented as not administered due to medication unavailable. The results of the audit were no medication noted not administered due to medication unavailable. Additionally, the pharmacy audited the emergency medication backup system to ensure medications are in stock. Any medication with low stock or not available was replenished. Measures /Systemic changes to prevent re-occurrence of alleged deficient practice: On 10/9/2023 the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses and medication aides, and agency staff on the following topics: Medication Omission/Medication Error Prevention to assure that medications are provided to residents per medical order and steps to take if a medication error occurs or medication is unavailable. The Director of Nursing will ensure any registered nurse, licensed practical nurse, or medication aide who has not completed training by 10/10/2023 will not be allowed to work until training is completed. In addition to this, The Director of Nursing will ensure that any newly hired/agency nurse or medication aide who has not completed	

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F 760	Continued From page 9 #5 revealed she worked for an agency and had only worked at the facility one time. She recalled caring for Resident #5. She stated the Glimepiride for resident #5 was not in the cart. She stated she checked the entire cart but could not find the medication. She did not recall ordering the medication or notifying the provider. An eMAR medication administration note for Resident #5's Glimepiride dated 6/12/23 at 11:44 AM was documented by Nurse #4 and read: awaiting delivery. Resident #5's blood glucose readings for 6/12/23 revealed blood glucose levels of 173, 292, and 211 on that day. During an interview on 10/3/23 at 4:14 PM Nurse #4 revealed she worked for an agency and had only provided care to Resident #5 once or twice. She did not recall a shift when Resident #5 missed her Glimepiride An eMAR medication administration note for Resident #5's Glimepiride dated 6/13/23 at 4:26 PM was documented by Unit Manager (UM) #1 and read: call pharmacy. Resident #5's blood glucose readings for 6/13/23 revealed a blood glucose levels of 221, 359, and 191 on that day. An interview on 10/3/23 at 2:16 PM with UM #1 revealed she worked on the cart for the hall where Resident #5 resided on a shift in June when there was a call out. She further revealed Resident #5 could voice her concerns. She recalled that Resident #5 did not have a medication card for glimepiride on the cart.	F 760	education by 10/10/2023 will receive education on Medication Omission/Medication Error Prevention related to Plan of Correction during orientation and any agency nurse/medication aide utilized by the facility will receive education on Medication Omission/Medication Error Prevention related to Plan of Correction prior to working their shift. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 10/16/2023, The Director of Nursing or designee will monitor Compliance with the regulatory requirements utilizing F-760 QA Tool for monitoring Missed Medications. Monitoring will include reviewing MAR and observing medications on cart to ensure meds are available to be administered as ordered. The audit is be completed weekly for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/11/2023	

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F 760	Continued From page 10	F 760		

Resident #5 told her she had not received the medication for a couple of days, and she had asked the other nurses about it. Resident #5 told UM #1 she was told by another nurse that the medication was already ordered.

An eMAR medication administration note for Resident #5's Glimepiride dated 6/14/23 at 9:47 AM was documented by Medication Aide (MA) #1, the note did not record a reason for the missed dose.

Resident #5's blood glucose readings for 6/14/23 revealed blood glucose levels of 126, 248, and 192 on that day.

During the investigation multiple unsuccessful attempts were made to contact MA #1.

An eMAR medication administration note for Resident #5's Glimepiride dated 6/15/23 at 11:45 AM was documented by Nurse #7 and read: medication on order.

Resident #5's blood glucose readings for 6/15/23 revealed blood glucose levels of 193, 206, and 149 on that day.

During the investigation multiple unsuccessful attempts were made to contact Nurse #7.

During an interview on 10/3/23 at 11:54 AM Resident #5 revealed some time back in June of 2023 she missed her diabetic medication called Glimepiride. She stated during that time her regular nurse was out on leave related to a family emergency and the nurses that were working the cart were either agency staff or nurses that usually worked on other halls. She explained she

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 10/04/2023

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 760	Continued From page 11	F 760		

was familiar with her medications and knew what they looked like. She thought the first day she noticed the Glimepiride was missing was a Saturday. She mentioned it to the nurse and the nurse told her there was none left on the cart. Resident #5 stated she mentioned her missing Glimepiride to each nurse that brought her medications for the 6 days. Resident #5 revealed during the days she missed her Glimepiride she did not feel sick. She further revealed when she was not receiving her Glimepiride she did not eat any of the carbohydrates on her meal trays. She did not want her blood sugars to become very elevated.

An interview was conducted on 10/4/23 at 1:30 PM with the Nurse Practitioner (NP). The NP stated one day in June when she was in the facility a nurse told her Resident #5 was out of her Glimepiride. She further stated she thought the resident had already missed 2 or three doses when she was notified. Staff assured her the medication had been ordered and the resident would receive her next dose. She later learned the resident had missed six doses before receiving the medication. She did feel Resident #5 had any adverse effects from her missed doses of Glimepiride. The NP indicated if staff cannot obtain a medication for a resident or if a resident missed a medication dose, they should notify her as soon as possible.

During an interview on 10/3/23 at 5:27 PM the former Medical Director revealed she did not recall Resident #5 not receiving her Glimepiride and she could not say whether she was notified or not. She stated although Resident #5 did not experience any adverse effects, a resident not receiving their Glimepiride for 6 consecutive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 760	Continued From page 12 doses could potentially cause continuous elevated glucose levels and those glucose levels could potentially have significant effects, such as polyuria (abnormal production of large amounts of urine > 3 liters a day), and a hyperosmolar state (a complication of diabetes that occurs when the blood glucose is elevated for long periods of times leading to dehydration and confusion). Staff should administer all medications as they are ordered and notify her if they were unable to do so. During an interview on 10/4/23 at 12:30 PM the DON revealed she was not aware of a time when Resident #5 ran out of her medication Glimepiride. The DON further stated staff should always notify the provider if the Resident missed a medication.	F 760		