

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Royal Park Rehab & Health Ctr of Matthews		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Royal Commons Lane Matthews, NC 28105	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000</p> <p>Based on observations, record reviews and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 out of 1 sampled resident observed with medications left at bedside (Resident #42).</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on [DATE].</p> <p>The annual Minimum Data Set (MDS) dated [DATE] showed that Resident #42 was cognitively intact.</p> <p>Review of Resident #42's care plan dated 7/29/24 revealed there was no focus area for self-administering medications.</p> <p>Upon review of Resident #42's medical record, there was no Self Administration assessment for any prescribed medications.</p> <p>Resident #42's Medication Administration Record (MAR) revealed that Medication Aide #1 signed off administering the following medications to Resident #42 on 8/5/24 and 8/7/24 at 9:00 AM. Medication Aide #1 administered aspirin 81mg (milligrams), Flomax 0.4mg, loratadine 10mg, potassium chloride, vitamin C 5000mg, vitamin D3 2000 units, zinc 25mg, docusate sodium 100mg, Eliquis 5mg, furosemide 20mg and chlormadinone.</p> <p>On 8/05/24 at 10:41 AM an interview and observation were made of Resident #42. Resident #42 was in his bed, and he had a clear medication cup sitting on his bedside table full of pills. During the conversation Resident #42 picked up the cup and took his pills. Resident #42 stated that sometimes he was not ready to take his medication when the nurse brought them. Resident #42 stated that the nurse left the medicine for him to take. Resident #42 stated he always takes his medication and doesn't throw any out. Resident #42 stated he knows what medicine he takes and when. Resident #42 stated he has lived at the facility for a long time and doesn't remember being assessed to take his medications without supervision.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/06/24 at 2:35 PM an interview was conducted with Medication Aide #1. Medication Aide #1 stated that if a resident would like to be independent with medications they would need to get a physician's order from the doctor and would need to be assessed. If the resident refused to take medications the staff would mark refusal in computer. Medication Aide #1 stated that if Resident #42 refused or was not ready to take his medications she would need to hold the medications for a few minutes and then reapproach and offer the medications again. Medication Aide #1 stated that Resident #42 has told her in the past he was not ready for medications, this usually occurred in the morning when he was not awake all the way. When this happened staff would take his medications and hold them and then reapproach. Medication Aide #1 had not left medications with Resident #42 without supervision. Medication Aide #1 stated that currently she has no residents that take medications independently.</p> <p>On 8/07/24 at 9:30 AM a second observation and interview was made with Resident #42. Resident #42 again had a clear pill cup with pills. The cup was in Resident #42's hand. Resident #42 was observed taking his pills. No nurse or medication aide was present in or around the room.</p> <p>On 8/07/24 at 9:36 AM a second interview was conducted with Medication Aide #1. The Medication Aide stated that she remembered Resident #42 bringing the cup up to his mouth and she thought he had taken all his medicine. Medication Aide #1 stated that Resident #42 does need to be observed when taking his medications. Medication Aide #1 stated she should have stayed to make sure Resident #42 took all his medications.</p> <p>On 8/07/24 at 11:01 AM an interview was conducted with the Director of Nursing (DON). The DON stated that for a resident to be able to take medication independently a self-assessment would be completed to see if they can self-administer. The nurses would do the teaching, and the resident would demonstrate. If deemed able to self-administer the nurse staff would keep the medicine on the medication cart. Resident #42 had not been assessed to take his own medications and should be supervised. The staff should not walk away when administering medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41069</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on record review, observations and staff interviews, the facility failed to implement their infection control policy when Nurse #1 did not perform hand hygiene after removing soiled dressings with drainage and before donning new gloves to cleanse the wound for 3 of 3 wound care observations on 1 of 2 residents reviewed (Resident #25).</p> <p>The findings included:</p> <p>The facility's policy entitled Hand Hygiene last revised on 10/2022 indicated the following:</p> <p>Specific indications for hand hygiene included after contact with body fluids or excretions, non-intact skin, wound dressings, and after removing gloves.</p> <p>Gloves - If gloves are worn for a procedure, hand hygiene is to be completed before putting on gloves and after removal and deposit of gloves in appropriate container. The use of gloves does not replace hand hygiene.</p> <p>A continuous observation of wound care on 8/7/24 from 9:08 AM through 9:40 AM revealed Nurse #1 applying hand sanitizer to both hands, and putting on gloves and a gown before entering Resident #25's room. She removed the old dressing on Resident #25's wound to her left upper back. The old dressing had a large amount of drainage that was colored green and had a foul odor. Nurse #1 discarded the old dressing and removed her gloves. Without doing hand hygiene, she proceeded to put on a new pair of gloves, and cleaned the wound with a gauze soaked with wound cleanser. Nurse #1 removed her gloves and without doing hand hygiene, she put on a new pair of gloves to both hands. Nurse #1 packed the wound with a medicated packing strip, removed her gloves and put on new gloves. She then applied zinc oxide to the surrounding skin, removed her gloves and put on new gloves. She covered the wound with a dry gauze and a dry bordered dressing. Nurse #1 removed both gloves and without doing hand hygiene, put on a new pair of gloves to both hands. At 9:25 AM, Nurse #1 was observed to clean Resident #25's deep tissue injury to the right heel with a gauze that had been soaked with wound cleanser. She removed her gloves and without performing hand hygiene, she put new gloves on and applied skin prep to Resident #25's right heel. She discarded her gloves and put new gloves on. Nurse #1 proceeded to remove Resident #25's old dressing on her right upper back wound. The old dressing was moderately soaked with serosanguineous drainage (clear serous fluid and blood mixture). Nurse #1 removed her gloves and without doing hand hygiene, put on new gloves. She cleaned the wound with a gauze that had been moistened with wound cleanser and then wiped it with a dry gauze. She removed her gloves and put new gloves on. She packed the wound with a medicated packing strip, removed her gloves and put new gloves on. Nurse #1 applied zinc oxide to the surrounding skin, covered the wound with a dry gauze and a bordered dressing. She discarded any unused supplies including her gown and gloves, and washed her hands.</p> <p>An interview with Nurse #1 on 8/7/24 at 11:48 AM revealed she had been educated to wash her hands before getting started with wound care, and during wound care after changing her gloves. Nurse #1 stated that she knew that she was supposed to sanitize her hands after removing gloves and that she tried to carry a hand sanitizer with her, but she forgot to do so during the wound care observation on Resident #25.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview with the Infection Preventionist (IP) on 8/7/24 at 12:12 PM revealed staff was supposed to wash hands before doing wound care, when removing dressings and after changing gloves. The IP stated that hand hygiene was supposed to be done after each glove change. The IP shared that in-services regarding infection control especially hand hygiene was a continuous process, and he last did an education with all staff on July 2024 wherein he covered topics such as the use of Personal Protective Equipment and handwashing. The IP further shared that he had not observed Nurse #1 perform wound care because she usually did the dressing changes in the early mornings when he was not in the facility, but he had not heard of any issues regarding wound care. He also stated that he had done an education with Nurse #1 on wound care and hand hygiene, but he could not remember the date when he did it. The IP further stated that it was a problem that Nurse #1 did not do hand hygiene in between changing gloves, and that she might have forgotten to do it during the observation. He also stated that if a resident had multiple wounds, he would advise to start with the least infected wound going to the most infected wound to prevent possible cross-contamination.</p> <p>An interview with the Director of Nursing (DON) on 8/7/24 at 11:55 AM revealed staff was supposed to wash their hands or perform hand hygiene every time gloves were removed. The DON stated that they often did education with all their staff regarding infection control and hand hygiene procedures.</p>		