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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Rehabilitation & Health Center	2700 Roal 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)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge (Resident #163) and Hospice (Resident #7) for 2 of 29 residents reviewed for accuracy of assessments. The findings included: 1. Resident #163 was admitted to the facility on [DATE]. Review of the discharge MDS assessment dated [DATE] indicated Resident #163 was discharged to home. Review of a nursing progress note dated 9/21/25 indicated Resident #163 was sent to the hospital for evaluation following an episode of sudden confusion and shaking. An interview with the MDS Nurse on 12/4/25 at 1:43 PM was conducted. She stated the discharge MDS for Resident #163 dated 9/21/25 was coded for a discharge to home because Resident #163's Responsible Party (RP) informed the facility that he was sent home from the hospital and would not return to the facility. She stated since Resident #163 ultimately went home, she coded the MDS to reflect his discharge home. An interview with the Director of Nursing (DON) on 12/4/25 at 2:52 PM revealed residents' discharge MDS should accurately reflect their discharge location from the facility. During an interview with the Administrator on 12/4/25 at 3:40 PM she indicated the MDS should be completed accurately. The findings included: 2. Resident #7 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia and rheumatoid arthritis. A Hospice Comprehensive Plan of Care dated 9/11/2025 indicated that Resident #7 was admitted under the care and services of Hospice for end of life on 6/19/2025. Further review of the Hospice Comprehensive Plan of Care for Resident #7 indicated that a recertification of Resident #7's prognosis of 6 months or less was received on 9/11/2025 from the physician. (continued on next page)

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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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #7 was severely cognitively impaired and received Hospice services. Resident #7's prognosis of 6 months or less was coded no. An interview on 12/4/2025 at 1:30 PM with the MDS Coordinator revealed she had completed the quarterly MDS dated [DATE] for Resident #7 and coded it incorrectly for the prognosis of 6 months or less which should have been coded yes. The MDS Coordinator stated the incorrect coding was a mistake and the MDS should have been coded correctly. An interview on 12/4/2025 at 3:56 PM with the Administrator indicated that the MDS assessments should be accurate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and Medical Director, Hospital Urologist, Nurse Practitioner (NP), Resident Representative (RR) and staff interviews, the facility failed to follow hospital discharge orders for a urinary catheter to remain in place for 1 of 5 residents reviewed for urinary catheters (Resident #161). Resident #161 was admitted to the facility from the hospital on 9/18/25 with a urinary catheter due to a diagnosis of hydronephrosis (swelling of the kidneys due to urinary retention). Resident #161's urinary catheter was removed at the facility on 9/19/25 at 6:27 AM and subsequently reinserted at 11:09 PM after the Medical Director reviewed the hospital records which indicated the urinary catheter was to remain in place until follow up with urology. On 9/20/25 Resident #161 was complaining of lower abdominal pain, blood was observed in the catheter tubing, and he was transferred to the emergency department (ED) for further evaluation. The Hospital Urologist noted Resident #161's urinary catheter was not advanced properly, the balloon of the urinary catheter was inflated in the prostate, and during a cystoscopy (insertion of a scope to assist with visual guidance) to insert a 3-way catheter he observed a false passage (tear in the urethral wall). Resident #161 was hospitalized [DATE] through 9/26/25 for CBI (constant bladder irrigation) and antibiotics were administered as a preventative measure. The RR revealed Resident #161 was discharged home on 9/26/25 and was still traumatized by the experience. The findings included:The hospital Discharge summary dated [DATE] at 7:45 PM scanned into the electronic medical record (EMR) revealed Resident #161 was hospitalized [DATE] through 9/18/25 due to a sacral fracture severe bilateral hydronephrosis (swelling of the kidneys due to retention of urine) and was noted to have a history of prostate and bladder cancer, removal of the right lower ureter (tube from the bladder to the kidney) and was tentatively scheduled for surgery to remove a bladder tumor on 10/22/25. The hospital discharge summary further noted that Resident #161's urinary catheter was to remain in place and to schedule a follow up appointment with urology in two weeks.Resident #161 was admitted to the facility on [DATE] and discharged to hospital on 9/20/25. His admitting diagnoses included fracture of the sacrum and malignant neoplasm (cancer) of the prostate and bladder.The nursing admission assessment dated [DATE] completed by Nurse #8 indicated Resident #161 was cognitively intact and had a urinary catheter in place draining clear amber colored urine.Resident #161's physician orders revealed the following orders:9/18/25 remove urinary catheter 9/19/25 for a voiding trial.9/19/25 place a urinary catheter for hydronephrosis. Resident #161's treatment administration record (TAR) indicated the following:9/19/25 removal of the urinary catheter for a voiding trial was documented as completed by Nurse #8 at 6:27 AM.9/19/25 urinary catheter placement was documented as completed by Nurse #8 at 11:09 PM.A nurse's note dated 9/19/25 at 2:32 AM written by Nurse #8 indicated Resident #161 was admitted to the facility for short term rehabilitation due to a sacral fracture and had a history of bladder cancer. Resident #161's urinary catheter was patent and draining clear amber colored urine and per physician's orders a voiding trial was to begin on 9/19/25 at 6:00 AM.A physician's note dated 9/19/25 at 3:32 PM indicated Resident #161 was admitted to the facility following hospitalization due to a sacral fracture and incidentally developed urinary retention which resolved after placement of a urinary catheter. Resident #161's urinary catheter was removed at the facility the morning of 9/19/25, however a review of the hospital records indicated the urinary catheter was to remain in place until a follow up with urology. Nursing staff were notified of new order to reinsert the urinary catheter on 9/19/25. A nurse's note dated 9/19/25 at 5:36 PM written by Nursing Supervisor #1 revealed the Medical Director evaluated Resident #161 and reviewed the hospital records which noted a diagnosis of hydronephrosis and for the urinary catheter to remain in place until a follow up with urology. Resident #161 was informed of new order from the Medical Director to reinsert the urinary catheter to prevent recurrence of hydronephrosis and kidney injury. Resident #161 voiced disappointment due to voiding three times since the catheter was removed this morning but verbalized understanding and agreeable to reinsertion of the urinary catheter. Resident #161 indicated he would notify his RR to schedule a follow up appointment with his urologist. A nurse's note dated 9/20/25 at 7:16 AM written by Nurse #8 revealed Resident #161 tolerated urinary catheter placement with flash of 30 cubic centimeters (ccs) of urine upon insertion, catheter draining clear amber colored urine with total output of 200 ccs by end of shift.A nurse's note dated 9/20/25 at 12:00 PM written by Nurse #9 revealed Resident #161 was observed to have string like blood clots in urinary catheter with complaints of burning and pain. Resident #161 was administered pain medication, the on-call provider was notified, and new orders were received to reposition the urinary catheter and to obtain a urinalysis. When

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to store a syringe used for enteral feedings (also known as tube feeding, is a method of delivering nutrition directly into the gastrointestinal tract) dry and with the plunger separated from the syringe and free from moisture for 1 of 3 residents reviewed for enteral feeding management (Resident #73). This practice had the potential for bacterial growth and contamination.Findngs included: Resident #73 was admitted to the facility on [DATE] with diagnoses of diabetes, stroke, hypertension, hemiplegia, malnutrition, difficulty swallowing, esophageal web, gastrostomy status (indicates the presence of a gastrostomy tube, which is surgically placed to provide direct access to the stomach for nutrition and hydration when oral intake is insufficient or unsafe), dysphagia, and oropharyngeal. Review of Resident #73 order dated 03/16/24 revealed the resident was ordered to receive 250 milliliters of Glucerna (tube feeding formula) 1.5 through bolus every 6 hours and to receive water flush of 100 milliliters before and after each bolus feeding. Bolus feeding is a way to give enteral nutrition (tube feeding). Bolus feedings give large doses of formula several times a day. The formula is poured slowly into a syringe attached to a feeding tube.A significant change Minimum Data Set assessment dated [DATE] indicated Resident #73 received 51% of more of her total calories from enteral feedings and 501 milliliters of fluids per day by enteral feedings.Review of the Resident #73's Medication Administration Record (MAR) revealed Nurse #10 had signed off Resident #73's morning medications on 12/02/2025. During an observation on 12/02/2025 at 10:00 AM Resident #73's syringe used for enteral feedings and medication administration was observed with the plunger inside the syringe which was wet with condensation and stored in a plastic bag on the bedside table. During an observation and interview on 12/02/25 at 12:00 PM, Nurse #10 administered the enteral bolus feeding to Resident #73, followed by the water flush. After the feeding was completed Nurse #10 did not separate the plunger from the syringe and wash it. The Nurse placed the syringe in the bag with the residual feeding formula still in it. Nurse #10 stated she normally did not wash Resident #73's syringe after the resident's feeding due to their not being residue on the syringe after the last flush. Nurse #10 stated she was not aware the syringe was required to be dried before placing the syringe back in the storage bag. Nurse #10 indicated she was aware the plastic syringe and plunger should be washed if residue is left in the syringe but was not aware the plunger should be left out to air dry to prevent any bacterial growth in the syringe. Nurse #10 confirmed she had given Resident #73 his medications through his feeding tube earlier this shift. An interview was conducted with the Director of Nursing on 12/04/25 at 1:40 PM and she stated after an enteral feeding the plastic syringe and plunger should be washed and the plunger left out of the syringe to allow it to air dry to prevent any bacterial growth in the syringe. The DON further revealed nurses had been educated on this protocol and all new hires had been educated during orientation.During an interview with the Administrator on 12/04/25 at 2:05 PM she stated Nurse #10 should have washed the plastic syringe and plunger separately to remove any residue and allowed them to dry completely to prevent any bacterial growth.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, and facility staff, pharmacy staff and Nurse Practitioner (NP) interviews, and record reviews, the facility failed to have effective systems in place for obtaining medications and to ensure they were available to administer to a newly admitted resident in accordance with the physician's orders. This resulted in multiple doses of eleven (11) medications being omitted for 1 of 6 residents (Resident #172) who were reviewed for the availability of their medications.The findings included: Resident #172's resided in the community with a family member prior to her admission to the facility. A physician's Orders Note dated 10/9/24 revealed plans were made to admit Resident #172 to the facility for respite care from 10/18/24 to 10/23/24. Respite care is temporary care given to a person who is unable to care for himself or herself while providing short-term relief for primary caregivers. The Orders Note included a list of the resident's current medications and provider contact information. The resident was admitted to the facility for respite care on 10/18/24. Her diagnoses included end stage renal (kidney) disease with dependence on renal dialysis, glaucoma, gastro-esophageal reflux disease (GERD), and dementia. The resident's admission orders to the facility included the following medications scheduled for administration:--81 milligrams (mg) enteric coated (EC) aspirin to be given as one tablet by mouth one time a day for health maintenance (ordered on 10/18/24 and scheduled for 9:00 AM);--500 mg / 15 milliliters (ml) acetaminophen to be given as 30 ml by mouth two times a day for mild to moderate pain (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--0.2 - 0.5 % brimonidine-timolol solution (an eye drop used to treat glaucoma) to be instilled as one drop in both eyes every 12 hours for glaucoma (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--2% dorzolamide ophthalmic solution (an eye drop medication to treat glaucoma) to be given as one drop instilled in both eyes three times a day for glaucoma (Ordered on 10/18/24 and scheduled for 9:00 AM, 2:00 PM, and 9:00 PM);--0.02 - 0.005% netarsudil - latanoprost solution to be instilled as one drop in both eyes at bedtime for glaucoma (Ordered on 10/18/24 and scheduled for 9:00 PM);--5 mg donepezil (a medication used to treat dementia) to be given as one tablet by mouth at bedtime for dementia (Ordered on 10/18/24 and scheduled for 9:00 PM);--40 mg esomeprazole (a medication used to manage GERD) to be given as one capsule by mouth one time a day for GERD (Ordered on 10/18/24 and scheduled for 9:00 AM);--7.5 mg mirtazapine (an antidepressant) to be given as one tablet by mouth at bedtime (Ordered on 10/18/24 and scheduled for 9:00 PM);--8.6 - 50 mg sennosides - docusate tablet (a combination laxative containing a bowel stimulant and stool softener) to be given as 2 tablets by mouth two times a day for constipation; Hold for diarrhea (Ordered on 10/18/24 and scheduled for 9:00 AM and 5:00 PM);--0.8 grams (g) sevelamer packet (a phosphate binder) to be given as two packets by mouth with meals for chronic renal disease three times daily; mix with 1 - 2 ounces of water (Ordered on 10/18/24);--180 mg diltiazem extended release (ER) capsule (an antihypertensive medication) to be given as one capsule by mouth one time a day for hypertension. (Ordered 10/18/24 and scheduled for 9:00 AM). A Nursing Note dated 10/20/24 at 2:00 PM was authored by Nurse #4. The note reported Nurse #4 contacted a representative of Resident #172's managed care program and made her aware that the resident's medications had not yet been received. The representative reported that their pharmacy (different from the facility's contracted pharmacy) was closed on this date (Sunday) and she would make the pharmacy aware of the situation on Monday morning. Attempts made to contact the managed care program's representative for a telephone interview were unsuccessful. An interview was conducted on 12/3/25 at 2:00 PM with Nurse #4. During the interview, Nurse #4 (a weekend nurse supervisor) stated she did not recall Resident #172. When asked how medications would typically be obtained for a resident admitted for respite care (including participants of the managed care program), the nurse reported that sometimes the resident brought in his/her medications for use at the facility. On 10/21/24 at 4:37 PM, a Nursing Note authored by Nurse #3 indicated both the pharmacy and Nurse Practitioner were notified about the resident's medication status. The note reported that Resident #172 was alert, responsive, and able to make her needs known. Nurse #3 also reported the resident's vital signs were stable and that she denied having pain. Multiple unsuccessful attempts were made to contact Nurse #3 for a telephone interview. A review of Resident #172's Nursing Notes revealed from 10/18/24 to 10/21/24, the resident's vital signs included blood pressure results ranging from 99/71 to 102/76; pulse rate ranging from 72 to 78 beats per minute; respiration rate ranging from 16 to 18 respirations per minute; and, her oxygen saturation rate ranging from 96 - 97% on room air. A Nursing Note dated 10/22/24 at 5:02 PM reported the resident was discharged from the facility and returned home with her family. Resident #172's October 2024 Medication

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.5% for 3 of 5 residents (Resident #24, Resident #53, and Resident #168) observed during the medication administration observation.The findings included: 1. Resident #24 was admitted to the facility on [DATE]. Her cumulative diagnoses included end stage renal disease requiring hemodialysis. On 12/3/25 at 4:50 PM, Nurse #2 was observed as she began to prepare medications for administration to Resident #24. The medications were administered at 5:05 PM and included two tablets of 800 milligrams (mg) sevelamer. Sevelamer is a phosphate binder used to control blood phosphorous levels for patients with chronic kidney disease on dialysis. A review of Resident #24's December 2025 Physician Orders included a current order for 800 mg sevelamer to be given as two tablets by mouth with meals for end stage renal disease. The sevelamer was scheduled for administration at 9:00 AM, 1:00 PM, and 6:00 PM. The manufacturer's prescribing information for sevelamer noted this medication should be taken with meals. The facility's schedule for the delivery of meal trays to each of the residents' hallways was reviewed. The schedule indicated the evening dinner meal trays for Resident #24's hall were scheduled to be delivered at 6:35 PM daily. An interview was conducted with Nurse #2 on 12/3/25 at 5:55 PM. As of the time of the interview, no evening meal trays had been delivered to Resident #24's hallway. Upon request, Nurse #2 reviewed Resident #24's medication order which included instructions to administer sevelamer with meals. The nurse stated she thought those instructions just meant that sevelamer should be given with food and added that she had given Resident #24 juice and crackers approximately 10 minutes before the observation of her medication administration. However, Nurse #2 confirmed the resident would still be receiving her evening meal (not yet delivered). The nurse reported she was not aware the medication was intended to be given with meals. 2. Resident #53 was admitted to the facility on [DATE]. On 12/3/25 at 7:50 AM, Nurse #1 was observed as she prepared eight (8) medications for administration to Resident #53. The medications included two tablets of a single ingredient medication with each tablet containing 8.6 milligrams (mg) sennosides (a stimulant laxative) taken from a stock medication bottle stored on the medication cart. The medication was administered to Resident #53. A review of Resident #53's current physician's orders revealed his medication orders included a combination medication containing 8.6 mg sennosides and 50 mg docusate (a stool softener) to be given as two tablets by mouth two times a day for bowel management. Resident #53 did not have a physician's order for the sennosides to be given as a single ingredient medication. An interview was conducted on 12/3/25 at 10:00 AM with Nurse #1. At that time, Nurse #1 reviewed Resident #53's December 2025 Medication Administration Record (MAR) and confirmed a physician order was written to administer a combination medication containing 8.6 mg sennosides and 50 mg docusate to the resident. The nurse pulled the stock bottle containing 8.6 mg sennosides used for the medication administration observation from the medication cart, reviewed its labeling, and acknowledged it contained sennosides but did not include the second ingredient (docusate). Upon further review of the stock medications available on the medication cart, Nurse #1 identified a bottle containing a combination of the two medications (8.6 mg sennosides and 50 mg docusate) as ordered by the physician. The nurse confirmed she should have administered the combination medication (including docusate) instead of a single ingredient medication containing only sennosides. Nurse #1 stated, I've learned something. 3. Resident #168 was admitted to the facility on [DATE]. On 12/3/25 at 8:55 AM, Medication Aide (Med Aide) #1 was observed as she prepared eight (8) medications for administration to Resident #168. The medications included one tablet of a single ingredient medication with each tablet containing 8.6 milligrams (mg) sennosides (a stimulant laxative) taken from a stock medication bottle stored on the medication cart. The medication was administered to Resident #168. A review of Resident #168's current physician's orders revealed her medication orders included a combination medication containing 8.6 mg sennosides and 50 mg docusate (a stool softener) to be given as one tablet by mouth two times a day for constipation. Resident #168 did not have a physician's order for the sennosides to be given as a single ingredient medication. An interview was conducted on 12/3/25 at 10:43 AM with Med Aide #1. Upon request, the medication aide reviewed Resident #168's December 2025 Medication Administration Record (MAR) and confirmed her medication order was for a combination medication containing both sennosides and docusate. When she pulled the stock bottle

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and resident and staff interviews, the facility failed to serve food at a palatable temperature, hot foods were served lukewarm or cold and a beverage was served partially frozen for 6 of 6 residents reviewed for food palatability (Resident #8, Resident # 37, Resident #54, Resident #14, Resident #110, and Resident #80).The findings Included:a. Resident 8 was admitted to the facility on [DATE]. Resident #8 had a physician's order dated 2/12/2025 for a cardiac diet with regular texture, a thin consistency, and double portions. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact.An observation and interview of Resident #8 was conducted on 12/01/2025 at 2:14 PM during the lunch meal. Lunch trays arrived at the 200 Hall at 1:50 PM on 12/01/2025 and were delivered to all residents at the 200 Hall by 2:10 PM. Resident # 8 was observed removing the lid of the hot beverage on his lunch tray and no steam was visible. Resident #8 complained the lunch meal was also lukewarm and stated he would like his food and coffee served hot. Staff entered and offered to reheat the plated food and beverage. Resident #8 declined to have food reheated. Resident expressed frustration and stated he felt they intentionally always served hot food cold and was hesitant to eat it some days. b. Resident #37 was admitted to the facility on [DATE].The admission MDS assessment dated on 10/13/2025 revealed Resident #37 was cognitively intact. Resident #37 had a physician's order dated 10/28/2025 for a regular diet with regular texture and consistency.Resident #37 was interviewed and observed on 12/2/2025 at 9:12AM. Resident #37 stated his room was at the end of the hallway, so when his tray was served to him the hot foods were not warm when meal trays are served. Resident #37 stated staff needed to reheat at least 50% of the meals.Resident #37 was interviewed and observed on 12/2/2025 at 9:17 AM when staff brought in the breakfast tray and assisted in the set-up. Resident #37 stated to staff the scrambled eggs were lukewarm. Staff offered to reheat the eggs and Resident #37 declined. Resident #37 stated rewarming eggs dried them out and made them too difficult for Resident #37 to chew and swallow. Staff did not offer Resident #37 a replacement or alternative.c. Resident #54 was admitted to the facility on [DATE].Resident #54 had a physician's order dated 9/11/2025 for a regular diet with pureed texture and a thin consistency ordered.The quarterly MDS assessment dated [DATE] revealed Resident #54 was cognitively intact.When Resident #54 was interviewed on 12/1/2025 at 2:36 PM, Resident #54 complained the food was consistently cold when it arrived and staff repeatedly returned to reheat the meals throughout the day. On 12/2/2025 at 9:05 AM Resident #54 was interviewed and observed checking temperature of pureed scrambled eggs and cheese, pureed hot cereal, and pureed moistened biscuit using his index finger and complained the food was lukewarm. When the plate cover was removed there was no steam and the inside of the plate cover was visibly moist with condensation and did not feel warm to touch. At 9:17 AM, staff entered to deliver the roommate's tray and offered to reheat Resident #54's food. The resident agreed, and staff took the plate to reheat it. d. Resident #14 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] specified Resident #14 was cognitively intact. Resident #14 had a physician's order dated 2/26/2025 for a limited concentrated sweets diet with easy to chew texture and a thin consistency. Resident #14 was interviewed on 12/1/2025 at 11:31 AM and complained the food served was very poor in quality and the options weren't appropriate for a diabetic. Resident #14 stated there were not balanced diet options for diabetics, and the hot foods were cold and the cold foods warm. Resident #14 complained the sandwiches and bread were either soggy or dried out. Resident #14 reported raising her concerns repeatedly for the past 4-5 months to Resident Council and the Administrator without improvement. Resident #14 was interviewed and observed again on 12/3/2025 at 9:32 AM. Resident #14 attempted to eat a hardboiled egg from the tray. Resident #14 stated the items on the breakfast tray were not what she had ordered, tray items were not what was on the ticket, and the ham with gravy and bowl of grits were cold. The ticket listed scrambled eggs, ham, hot cereal, orange juice, hot coffee, and toast, but the tray instead contained chunked ham with gravy, grits, a boiled egg, and toast. NA #3 attempted to resolve the situation by offering another egg or reheating the grits. Resident #14 waved the tray away and became emotional, stating NAs tried to make up for ongoing problems with cold food. e. Resident #110 was admitted to the facility on [DATE]. Resident #110 had a physician's order dated 8/7/2023 for a regular diet with easy to chew texture and thin consistency ordered. A quarterly MDS assessment dated [DATE] specified Resident #10 was moderately cognitively impaired. Resident #110 was interviewed and observed on 12/3/2025 at 8:48 AM seated in the 100-200 Unit Dining

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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Rehabilitation & Health Center	2700 Roal 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)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident and staff interviews, the facility failed to honor a resident's food preferences for 1 of 3 residents reviewed for food preferences (Resident #136).Findings included:Resident #136 was admitted to the facility on [DATE].Review of Resident #136's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact.Review of Resident #136's undated preference sheet revealed that she disliked grits and hot cereal (oatmeal) for breakfast.An interview and observation with Resident #136 on 12/03/25 at 9:15 AM revealed she had received hot cereal for breakfast. Resident #136 stated she disliked hot cereal and had informed both dietary and nursing staff on multiple occasions, expressing a preference for yogurt instead.An interview and observation with Resident #136 on 12/04/25 at 9:00 AM revealed she had received grits for breakfast. Resident #136 reiterated that she disliked grits and had communicated this to dietary and nursing staff multiple times, again expressing a preference for yogurt.An interview with Nurse #1 on 12/04/25 at 10:45 AM revealed that Resident #136 had frequently expressed dissatisfaction with receiving food items she did not prefer. Nurse #1 stated she had communicated this to dietary staff but could not recall to whom she had spoken.An interview with the Dietary Manager on 12/04/25 at 9:45 AM indicated ongoing issues with tracking residents' food preferences due to problems with the facility's meal program software. The Dietary Manager acknowledged that multiple residents had received food items they did not prefer and confirmed that Resident #136 had consistently received items she disliked. She stated that a better system was needed to ensure residents received food items they preferred.An interview with the Director of Nursing (DON) on 12/04/25 at 1:20 PM revealed she was unaware that Resident #136 or other residents had received food items they did not prefer. The DON stated she expected residents to receive food items that matched their preferences.An interview with the Administrator on 12/04/25 at 2:00 PM revealed that residents had not voiced concerns about food preferences to her. The Administrator stated she expected residents to receive food items they preferred.

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	345026	A. Building B. Wing	12/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to label and date food items and discard expired items in 2 of 3 nourishment rooms (300/400 hall nourishment room and 500/600 hall nourishment room). These deficient practices had the potential to affect food served to residents. Findings included:1. Observation and interview conducted with the Dietary Manager on 12/1/25 at 10:25 AM revealed Nourishment room [ROOM NUMBER] (300/400 hall) had: an opened container of coffee creamer that was labeled with a name, but no date. a container with noodles labeled with a resident's name but no date. a gallon of iced tea not labeled with the product or resident name and had the best by date of 11/29/25. an opened bottle of prune juice that was not labeled with a resident's name. The Dietary Manager stated during the observation she expected all items to be labeled and expired items discarded. 2. Observation and interview conducted with the Dietary Manager on 12/1/25 at 10:50 AM revealed Nourishment room [ROOM NUMBER] (500/600 hall) had: a container of leftover pudding that was not dated or labeled.The Dietary Manager stated during the observation she expected all items to be labeled. The Dietary Manager revealed kitchen staff checked the nourishments rooms twice a day. The Dietary Manager stated the Assistant Dietary Manager had checked the nourishment rooms on 11/30/25.An interview conducted with the Assistant Dietary Manager on 12/4/25 at 2:25 PM revealed she had worked on 11/30/25 but failed to check the nourishment rooms. It was further revealed she had worked as a dietary aide that day and forgot to check the nourishment rooms. The Assistant Dietary Manager stated she or the Dietary Manager normally checked the nourishment rooms daily. An interview conducted with the Director of Nursing (DON) on 12/4/25 at 1:40 PM revealed all nursing staff had been educated to label and date residents' items in the nourishment rooms. The DON indicated she expected nursing staff to follow those instructions. The DON stated all staff were educated during orientation. An interview conducted with the Administrator on 12/4/25 at 2:00 PM revealed staff were educated to label residents' items when placed in the nourishment rooms. The Administrator further revealed when new staff were hired, they were taught that residents' items were to be labeled during orientation. The Administrator indicated dietary staff checked the nourishment rooms daily as well and were advised to look for items that were unlabeled.