STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	**600 FULLWOOD 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
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (111) construction, one story, with a complete automatic sprinkler system, and utilizing North Carolina Special Locking Systems. At time of survey the: Total Certified Bed Count =176 Census =148 The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on December 8th 2015 at approximately 9:30 AM onward, the following	K 029	Carrington is committed to providing the highest level of care for our residents. Carrington Place response to this report of survey does not denote agreement with	1/22/15

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

Electronically Signed | 01/21/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	**600 FULLWOOD 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
K 029	Continued From page 1 deficiencies were noted: 1. The facility had unsealed penetrations in the following locations: a. The ceiling of the boiler room above the newly installed unit b. The wall of the boiler room wall near the newly installed unit c. The wall of the laundry at the sprinkler piping penetrates the therapy gym hallway 2. The facility did not have door clonuses installed on the rated doors around the laundry.	K 029	the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. Life and Safety survey was conducted in this facility on December 8, 2015 Corrective Actions that will be accomplished by the facility to correct the deficient practice: Corrective actions that will be accomplished by the facility to correct the deficient practice: 1.The unsealed penetrations were corrected in the following locations: a.The ceiling of the boiler room above the newly installed unit was corrected and completed on 1-9-2015. b.The wall of the boiler room wall near the newly installed unit was corrected and completed on 1-9-2015. c.The wall of the laundry at the sprinkler piping penetrates the therapy gym hallway was corrected and completed on 1-9-2015. 2. The facility door closures on rated doors around the laundry have been installed on 1-9-2015 with re-adjustment completed on 1-19-2015. How will the facility identify other issues having the potential to affect residents by the same deficient practice and the corrective actions that have been or will be taken:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	**600 FULLWOOD 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
K 029	Continued From page 2	K 029	All maintenance staff have been inserviced by EVS Director on identifying and repairing wall penetrations and door enclosures on 1-12-2015. A general facility audit was completed on 1-20-2015 to ensure no other penetrations and door enclosure issues are identified. None was found. Measures and /or systematic changes made or to be made to ensure the alleged deficient practice does not occur: Preventative maintenance log has been developed on 1-20-2015 to audit and for accountability to reflect wall penetrations and fire door closure compliance. How the corrective action will be monitored to ensure that its solution are achieved and sustained and how the plan will be evaluated for effectiveness: Logs will be monitored weekly by Maintenance Supervisor or designee and EVS Director will ensure compliance and monitor logs weekly x 30 days, bi-monthly for 60 days and monthly for 90 days. EVS Director will report compliance to Administrator and Leadership monthly x 90 days and to QAPI x 2 quarter.	