	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345026	B. WING		06/07/2016	
NAME OF PI	ROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, ZIP CODE		
			27	00 ROYAL COMMONS LANE		
RUTAL PA	RK REHAB & HEALTH (м	ATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO	
K 000	INITIAL COMMENTS		K 000			
	at 42CFR 483.70(a); Care section of the LS publications. This bui construction, 1 story, sprinkler system utiliz exit conference all de	e Code of Federal Register using the 2000 New Health SC and its referenced lding is Type V (111) with a complete automatic ting special locking. In the ficiencies noted were wledged with administration.				
K 018 SS=D	are as follows: NFPA 101 LIFE SAFE	rmined during the survey	K 018		6/24/16	
	constructed to resist t Clearance between b covering is not excee impediment to the clo devices that release w pulled are permitted. positive latching hard 18.3.6.3.6 are permitt prohibited. 18.3.6.3 This STANDARD is r Based on observatio approximately 10:00 a deficiencies were not were non-compliant, s	idor openings shall be the passage of smoke. ottom of door and floor ding 1 inch. There is no using of the doors. Hold open when the door is pushed or Doors shall be provided with ware. Dutch doors meeting ted. Roller latches shall be not met as evidenced by: ns, on Tuesday 6/7/2016 at AM onward, the following ed: The corridor doors specific findings include: dor doors did not close latch e frames:		The statements made on this Plan of Correction are not an admission to ar not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w take the actions set forth in this Plan of	nd do vill	

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/31/2016 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ROYAL PARK OF MATTHEWS		
		345026	B. WING		06/07/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 ROYAL COMMONS LANE MATTHEWS, NC 28105		
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
K 018	 a) Corridor doors to b) Corridor door to re c.) Corridor door to s NFPA 101, 19.3.6.3 NFPA 101, 4.6.12.1 M Failure to comply with 	o the lobby. esident room 103 storage room, Service Hall. Maintenance n minimum standards as the risk of death or injury	K 018	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 indicat K018 Corrective Action: The corridor doors to the lobby, the corridor doors to storage room and corridor door to resident room 104 and scheduled to be repaired by Wade Do an outside contractor, on June 23, 20 Systemic changes: The facility has implemented a sched to monitor doors to ensure there are a doors which do not close / latch prope All doors will be checked 1 time per w for 4 weeks, then monthly. Any door found not to be in compliance will be brought to the attention of the Administrator for correction immediat Monitoring: The maintenance department will rep any doors found not to be in correct operation to the Daily Clinical QA teal which meets Monday through Friday. This will be done weekly for one mon until resolved by the main Quality Assessment and Assurance Committ Reports will be presented to the week QA&A Committee by the Administrator	e all por, 116. ule no erly. veek ely. ort m th ee. dy	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/31/20 MAPPROVE D. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ROYAL PARK OF MATTHEWS			(X3) DATE SURVEY COMPLETED		
		345026	B. WING			06/	/07/2016
VAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ROYAL PA	ARK REHAB & HEALTH (CTR OF MATTHEWS			700 ROYAL COMMONS LANE IATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
K 018	Continued From page	e 2	К	018	appropriate. Compliance will be monitored and ongoing auditing progra reviewed at the weekly QA&A Committ The weekly QA&A meeting is attended the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Thera Director, Health Information Manager, Dietary Manager and the Administrator Date of Compliance: June 24, 2016	tee. I by apy	
K 038 SS=D	Exit access is so arra accessible at all times 18.2.1, 19.2.1 This STANDARD is r	ETY CODE STANDARD inged that exits are readily s in accordance with 7.1. not met as evidenced by: ns, on Tuesday 6/7/2016 at	к	038	K038		6/24/16
	approximately 10:00 J deficiencies were not was non-compliant, s 1. The exit door on 5 15 lbs of force to ope 2. Resident room con the bottom and requir to open that door whe NFPA 101: 19.2.1 NFPA 101: 7.2.1.4.5 The forces required to manually in a means	AM onward, the following ed: The means of egress pecific findings include: 600 hall required greater than n the door. rridor door was sticking at red more than 15 lbs of force en closed.			Corrective Action: The exit door on 500 hall and resident room door #512 are both scheduled to repaired by Wade Door, an outside contractor, on June 23, 2016. Systemic changes: The facility has implemented a schedu to monitor doors to ensure there are no doors which do not close / latch proper All doors will be checked 1 time per we for 4 weeks, then monthly. Any door found not to be in compliance will be brought to the attention of the Administrator for correction immediatel	le o rly. eek	
	set the door in motior the door to the minim forces for interior side	n, and 15 lbf (67 N) to open um required width. Opening e-hinged or rs without closers shall not These forces shall be			Monitoring: The maintenance department will repo any doors found not to be in correct operation to the Daily Clinical QA team	rt	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA				FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 02 - ROYAL PARK OF MATTHEWS		COMPLETED		
		345026	B. WING		06	6/07/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS							
ROYAL PA	RK REHAB & HEALTH	CIR OF MATTHEWS		MATTHEWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 038	resident room door. Failure to comply wit	ted one exit door and one th minimum standards as s the risk of death or injury	K 03	which meets Monday through Fric This will be done weekly for one n until resolved by the main Quality Assessment and Assurance Com Reports will be presented to the w QA&A Committee by the Administ ensure corrective action initiated a appropriate. Compliance will be monitored and ongoing auditing p reviewed at the weekly QA&A Con The weekly QA&A meeting is atte the Director of Nursing, Wound Ni MDS Coordinator, Unit Manager, Director, Health Information Mana Dietary Manager and the Adminisi Date of Compliance: June 24, 20	nonth mittee. veekly rator to as rogram mmittee. nded by urse, Therapy iger, trator.		

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