STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING **02 - ROYAL PARK OF MATTHEWS** B. WING _____	**06/07/2016**

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
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 New Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, 1 story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the: Total Certified Bed Count = 169 Census = 148 The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observations, on Tuesday 6/7/2016 at approximately 10:00 AM onward, the following deficiencies were noted: The corridor doors were non-compliant, specific findings include: 1) The following corridor doors did not close latch and seal tight in there frames:	K 018	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	6/24/16

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

Electronically Signed | 06/21/2016

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K 018	Continued From page 1 a) Corridor doors to the lobby. b) Corridor door to resident room 103 c.) Corridor door to storage room, Service Hall. NFPA 101, 19.3.6.3 NFPA 101, 4.6.12.1 Maintenance Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	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 indicated. K018 Corrective Action: The corridor doors to the lobby, the corridor doors to storage room and corridor door to resident room 104 are all scheduled to be repaired by Wade Door, an outside contractor, on June 23, 2016. Systemic changes: The facility has implemented a schedule to monitor doors to ensure there are no doors which do not close / latch properly. All doors will be checked 1 time per week for 4 weeks, then monthly. Any door found not to be in compliance will be brought to the attention of the Administrator for correction immediately. Monitoring: The maintenance department will report any doors found not to be in correct operation to the Daily Clinical QA team which meets Monday through Friday. This will be done weekly for one month until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as	

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	345026	A. BUILDING **02 - ROYAL PARK OF MATTHEWS** B. WING _____	**06/07/2016**

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K 018	Continued From page 2	K 018	appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: June 24, 2016	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations, on Tuesday 6/7/2016 at approximately 10:00 AM onward, the following deficiencies were noted: The means of egress was non-compliant, specific findings include: 1. The exit door on 500 hall required greater than 15 lbs of force to open the door. 2. Resident room corridor door was sticking at the bottom and required more than 15 lbs of force to open that door when closed. NFPA 101: 19.2.1 NFPA 101: 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile.	K 038	K038 Corrective Action: The exit door on 500 hall and resident room door #512 are both scheduled to be repaired by Wade Door, an outside contractor, on June 23, 2016. Systemic changes: The facility has implemented a schedule to monitor doors to ensure there are no doors which do not close / latch properly. All doors will be checked 1 time per week for 4 weeks, then monthly. Any door found not to be in compliance will be brought to the attention of the Administrator for correction immediately. Monitoring: The maintenance department will report any doors found not to be in correct operation to the Daily Clinical QA team	6/24/16

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K 038	Continued From page 3 This deficiency affected one exit door and one resident room door. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	which meets Monday through Friday. This will be done weekly for one month until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: June 24, 2016	