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 018
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:

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 Correction.
## Statement of Deficiencies and Plan of Correction

**provider/supplier/CLIA Identification Number:** 345026

**Date Survey Completed:** 06/07/2016

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
</table>
| K018 | 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. | | | | | Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke. |
| K018 | | | | | | | NFPA 101, 19.3.6.3  
   NFPA 101, 4.6.12.1 Maintenance  
   Corrective Action:  
   Systemic changes:  
   Monitoring: |

**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
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING 02 - ROYAL PARK OF MATTHEWS**

**B. WING _____________________________**

**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

**STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 018</td>
<td>Continued From page 2</td>
<td>K 018</td>
<td>appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA&amp;A Committee. The weekly QA&amp;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.</td>
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</tr>
<tr>
<td>K 038</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 038</td>
<td>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.</td>
<td>6/24/16</td>
<td></td>
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</tr>
</tbody>
</table>

**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.
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
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<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 038</td>
<td>Continued From page 3</td>
<td>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.</td>
<td>K 038</td>
<td>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&amp;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&amp;A Committee. The weekly QA&amp;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</td>
</tr>
</tbody>
</table>