STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	**405 SOUTH GREENE STREET** **WADESBORO, NC 28170**

(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 III (111) construction, one story, with a complete automatic sprinkler system. At time of survey the: Total Certified Bed Count = 95 Census = 83 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 Thursday, January 15, 2015 at approximately 8:00 AM onward, the following deficiencies were noted:	K 029	Anson Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is January 29, 2015. Preparation and/or execution of this	1/30/15

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

Electronically Signed | 01/27/2015

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.

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K 029	Continued From page 1 1) The corridor door to the clean storage room/oxygen room located next to room 52 did not have have positive latching. 2) There is a hole in the wall behind the door in the soiled linen room in the service corridor that will need to be repaired in order to maintain the required fire resistance rating of the room. 3) In the mechanical room on the service corridor the wall located next to the chiller water pumps have mold on the walls and are not maintained in good condition.	K 029	plan of correction does not constitute admission to, nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. Tag 0029 Corrective Action The clean storage rooms (next to room 52) latching mechanism has been adjusted by the maintenance director,so the door latches. The hole in the dirty utility room has been repaired by the maintenance director. The area of discolored drywall in the mechanical room has been cleaned and repainted by the maintenance director. Corrective Action for Others All doors have been inspected on January 19, 2015, by the Maintenance Director to ensure that they properly latch. All storage rooms have been inspected by the Maintenance Director to ensure no other holes were identified. All areas were reviewed by the Maintenance Director for any mold or discoloration. Any areas of concern identified were corrected as necessary. The Director of Maintenance has placed on his monthly rounds sheet (example attached) to review all doors for positive latching, all penetrations that may occur during ancillary work in the facility, and all areas of possible discoloration or	

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K 029	Continued From page 2	K 029	mold that may occur. Systemic Changes The Director of Maintenance has placed on his quarterly rounds sheet to review all doors for proper positive latching, all firewalls for possible penetration and all walls for possible mold contamination. Monitoring The Maintenance Director will review all doors for latching, all areas that could be compromised by penetrations, and all areas that could be contaminated by mold, monthly for 3 months and then quarterly thereafter. The maintenance director will report his audit findings to the monthly Quality Assurance and Performance Improvement (QAPI) committee for three months, for any further recommendations. The Maintenance Director will be responsible to follow-up on any recommendations made.	