STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	**179 COMBS STREET** **SPARTA, NC 28675**

(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(211) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. At time of survey the: Total Certified Bed Count = 112 beds = 90 NF + 22 AC Census = 76 NF The deficiencies determined during the survey are as follows:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/21/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: Non-passage hardware on exit access door from 400 hall nurse's station. Positive latching	K 038	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Alleghany Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right	5/7/15

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

Electronically Signed | 05/07/2015

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	345261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/21/2015**

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K 038	Continued From page 1 hardware is equipped with a locking mechanism that requires special knowledge to release from inside the room - greater than a single motion is required to release latching mechanism. This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiencies. The doorknob at the 400-Hall Nurse□s Station was replaced on 4/28/2015 by the Maintenance Director. All other doorknobs were checked in the facility to ensure they did not require greater than a single motion to release the locking mechanism. The Maintenance Director was re-educated by the Administrator on May 4, 2015 related to the use of doorknobs that require a single motion to release the latching mechanism. The Maintenance Director will perform random checks of doorknobs on inside doors to ensure doorknobs are working correctly 2xmonthly x1 month then 1 x monthly x 2 months. Results will be submitted to the Performance Improvement Committee monthly x 3 months for review and follow up as needed.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		5/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/21/2015**

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 4/21/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. sprinkler coverage is incomplete in 400 hall medical records storage room - a corner of floor area is not covered by existing sprinkler arrangement. 2. there is drywall putty on sidewall sprinkler in 200 hall central shower room across from room 201. These deficiencies affected one of two smoke compartments in each referenced space. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	Representatives of K&S Sprinkler Company arrived on April 30, 2015. While inspecting the medical records storage area for placement of a new sprinkler a sidewall sprinkler was found to already be in place. The sidewall sprinkler is in good working order. On April 30, 2015 K & S Sprinkler Company, Inc. was contracted to replace one sidewall mounted sprinkler in the 200-Hall shower room. The sprinkler head was replaced on May 5, 2015. All other sprinklers have been visually inspected for debris by the Maintenance Director and were corrected at the time if issues were noted. The Maintenance Director was re-educated by the Administrator May 4, 2015 on the maintenance of the sprinkler heads. The Maintenance Director will perform random checks of the sprinkler heads to ensure they are free of debris 2 x monthly then 1 x monthly x 2 months after replacement of sidewall sprinkler is completed. Results will be submitted to the Performance Improvement Committee monthly x3 months for review and follow up as needed.	