CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-039						
	IDENTIFICATION NUMBER:	A. BUILDING			ATE SURVEY OMPLETED	
	345321			_ 0	C 09/11/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST.			
			1245 PARK AVENUE			
AKE NURSING AND R	EHABILITATION CENTER		HENDERSON, NC 2753	6		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	( (EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
INITIAL COMMENTS		F 0	00			
	DER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE		(X6) DATE 09/14/2015	
	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER AKE NURSING AND R SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT No deficiencies we complaint investiga	RS FOR MEDICARE & MEDICAID SERVICES         T OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345321    PROVIDER OR SUPPLIER  AKE NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    INITIAL COMMENTS  No deficiencies were cited as a result for the complaint investigation Event ID# FP4V11.  Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S  Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S	RS FOR MEDICARE & MEDICAID SERVICES       (X2) MULT         TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         ABULDI       345321       B. WING         PROVIDER OR SUPPLIER       AKE NURSING AND REHABILITATION CENTER       D         VEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         INITIAL COMMENTS       F 0         No deficiencies were cited as a result for the complaint investigation Event ID# FP4V11.       F         VDIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE       Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	RS FOR MEDICARE & MEDICAID SERVICES         I OF DEFICIENCIES       (X1) PROVIDERUSUPPLIENCILA       (X2) MULTIPLE CONSTRUCTION         A BUILDING	RS FOR MEDICARE & MEDICAID SERVICES       OMB N         TOP DEPICIENCES       (X1) PROVIDERSUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) D         PECONECTION       345321       (X2) MULTIPLE CONSTRUCTION       (X3) D         PROVIDER OR SUPPLIER       345321       STREET ADDRESS, CITY, STATE, ZIP CODE       0         PROVIDER OR SUPPLIER       TREET ADDRESS, CITY, STATE, ZIP CODE       1245 PARK AVENUE       1245 PARK AVENUE         MINITIAL COMMENTS       INTITIAL COMMENTS       INTITIAL COMMENTS       PROVIDER PROCEDURE OF PROVIDER PROPRIATE       DEFICIENCY         No deficiencies were cited as a result for the complaint investigation Event ID# FP4V11.       F 000       F000	

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.

DEDADTMENT OF LIEALTH AND LUMANN SEDVICES

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