STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	495188		12/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON	215 EVERGREEN AVE APPOMATTOX, VA 24522

(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	K 000		
	Surveyor: 34730 Construction type: V(111)			
	Description of structure: The facility is a one story building of wood frame construction and concrete floors and is separated from the two story building by a 2- Hour rated fire barrier wall.			
	Sprinkler status: The facility is fully sprinklered with NFPA 13 systems supplied by a 30,000 gallon static tank and a diesel fire pump			
	An unannounced recertification Life Safety Code survey was conducted 12/08/15 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 (Existing) regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.			
	The findings that follow demonstrate non-compliance with Title 42 Code of Regulations. 483.70(a) et seq (Life Safety from Fire.)			
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		
	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X5) DATE
Arthur H Smith	Administrator	12/11/2015

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 018	Continued From page 1 keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities This Standard is not met as evidenced by: Surveyor: 34730 Based on observation and inspection it was determined that the facility failed to maintain corridor doors. This has the ability to affect all occupants in the smoke compartment. Findings include. On 12/08/15 at approximately 10:15 am it was observed that the door to Room 31 is not provided with a functioning means to keep the door closed. The Facility Maintenance Director witnessed this evidence by observation and interview	K 018	1. Maintenance adjusted Room # 31 to latch properly. 2. Maintenance to review selected doors daily by PM system for compliance. 3. All doors reviewed monthly during scheduled fire drills for proper latching. Any issues will be addressed immediately. 4. Process will be reviewed in QA committee for two quarters. 5. 1-7-2016	
K 062 SS=F	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 2 This Standard is not met as evidenced by: Surveyor: 34730 Based on observation and inspection it was determined that the facility failed to maintain the sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 12/08/15 at approximately 10:10 am it was observed that there are sprinklers around the nurse's station which are loaded with dust. On 12/08/15 at approximately 10:22 am it was observed that there are sprinklers in the east wing that are loaded with dust. The Facility Maintenance Director witnessed this evidence by observation and inspection.	K 062	1. Sprinklers around the Nurses' Station and East wing were cleaned and are now free of dust. 2. Maintenance will complete a 100% review of all sprinklers in the facility to ensure that they are free of any dust. Any issues identified will be corrected immediately. 3. Maintenance will complete a quarterly review of all facility sprinklers to ensure compliance. 4. Process will be reviewed in QA committee for two quarters. 5. 1/7/2016	

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Arthur H Smith	Administrator	12/11/2015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

W-1648-002

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER K1 49-5188

1. (B) MEDICAID I.D. NO. K2 49-51883

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Appomattox Health and Rehab Building #2 Rehab Center Admin: Cynthia Smith	A. BUILDING 0202 B. WING C. FLOOR K3	235 Evergreen Ave. Appomattox, VA 24522	A. ✓ Fully Sprinklered (All required areas are sprinklered) B. Partially Sprinklered (Not all required areas are sprinklered) C. None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
✓ MEDICARE ✓ MEDICAID	12/08/2015 K4	06/1988 K6	5. ✓ 2000 EXISTING 6. 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. HOSPITAL 2. ✓ SKILLED/NURSING FACILITY 4. ICF/MR UNDER HEALTH CARE 5. HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ✓ ENTIRE FACILITY 2. DISTINCT PART OF (SPECIFY)

3. IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. YES b. NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID
0		0	0	

7. A. ✓ THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. COMPLIANCE WITH ALL PROVISIONS 2. ✓ ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. FSES 5. PERFORMANCE BASED DESIGN

B. THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
Joseph R. Bono SURVEYOR ID 34730 K10	Assistant Fire Marshal	SFMO - Western	12/08/15
FIRE AUTHORITY OFFICIAL (Signature)	**TITLE**	**OFFICE**	**DATE**
Jerry H Robinson	Fire Marshal Supervisor	SFMO	12/9/15