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		12/16/2016

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: 21761 Construction Type: V(111) Number of stories: One Story Building description: The facility is a one-story building of wood frame construction with concrete floors, and is separated from the two-story building by a 2-hour rated barrier wall. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by a 30,000 gallon static water tank and a diesel fire pump. An unannounced standard recertification Life Safety Code survey was conducted 12/16/16 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 2012 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.)		Appomattox Health & Rehabilitation Center's Fire Marshall POC. The facility desires that the Plan of Correction be considered the facility's allegation of compliance. The statements made in this POC are not an admission and do not constitute agreement with the alleged deficiencies here in.	
	NFPA 101 Protection - Other		K 300	
K 300 SS=F	Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are	K 300	1. A PM will be created for annual audit/test of fire rated doors. All units are in process of survey and test.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward H. Smith	Administrator	12/29/2016

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 300	Continued From page 1 deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doors, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 1:35 P.M., it was observed that documentation could not be provided for rated door periodic testing and inspection. (Sections 7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4) The Administrator witnessed this evidence by observation and interview.	K 300	2. Maintenance Director to review PMs and when due have survey/tests completed and documented on MFA forms. 3. Corporate will add PMs to Maintenance system for review and follow-up as necessary. 4. Facility will have Maintenance Director report any occurrences of door issues to the Safety/QA committee for review and actions needed to ensure compliance. 5. Facility desires a Time Limited waiver to expire on 3-20-17	
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater	K 325	K 325 1. HK Director implemented an Alcohol Based Hand Rub Dispenser Testing Log on 12/21/2016 2. HK Director or designee to review the log daily M-F for compliance.	

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 325	Continued From page 2 than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to perform ABHR testing, evidenced as follows; Findings include: On 12/16/16, upon review of documentation at approximately 11:45 am, it was observed during inspection that documentation for the Alcohol Based Hand Rub automatic dispensers testing was not available. Automatic dispensers are located throughout the facility in sleeping area corridors. The Administrator witnessed this evidence by observation and interview.	K 325	3. All ABHR dispensers and documentation reviewed monthly by the HK Director and any issues will be addressed immediately. 4. Process will be reviewed in QA committee for two quarters. 5. 12/21/2016	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff	K 711	K 711 1. 12-23-2016 Updated the Departmental Fire Plan instructions to include the removal of wheeled equipment stored in the corridors. (HK, Nurses, and CNAs)	

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K 711	Continued From page 3 per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide complete emergency procedures, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 12:20 P.M., it was observed the written emergency procedures did not include the removal of wheeled equipment stored in corridors. The Administrator witnessed this evidence by observation and interview.	K 711	2. Fire Plan to be reviewed monthly by the Maintenance Director and Administrator to ensure all wheeled equipment are identified for removal and where to store. 3. Maintenance Director to monitor monthly during unannounced fire drills for compliance. 4. Process will be reviewed by QA committee for 2 quarters. 5. 12-23-2016	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide a formal and documented catagory risk assessment,	K 901	K 901 1. Forms created, added new PM and facility entering information to comply with NFPA 99- Chapter 4. 2. Update annually to ensure any occurrences are not missed. 3. Maintenance Director will monitor PMs and complete when due. 4. Safety/QA committee to be notified of any issues for corrections to be made.	

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K 901	Continued From page 4 evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed that no documentation could be provided for a formal and documented risk assessment. The Administrator witnessed this evidence by observation and interview.	K 901	5. Facility desires a Time Limited waiver to expire 3-20-17 (correction date)	
K 915 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide electrical systems documentation, evidenced as follows;	K 915	K 915 1. Forms created, added new PMs and facility entering information to comply with NFPA 99. Essential Electric System Categories. 2. Update annually to ensure any occurrences are not missed. 3. Maintenance Director will monitor PMs and complete when due. 4. Safety/QA committee to review the process and be notified of any issues for correction to be made. 5. Facility desires a Time Limited waiver to expire 3-20-17 (Correction Date).	

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K 915	Continued From page 5 Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed there was no catagory documentation provided for essential electrical systems. The Administrator witnessed this evidence by observation and interview.	K 915		
K 923 SS=F	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923	K923 1. (2) signs ordered 12/20/2016 to include Caution: Oxidizing Gases stored within, No Smoking. (Locations: Oxygen room and Occupational Therapy storage room) 2. Maintenance Director to review selected doors daily for compliance. 3. All doors will be reviewed monthly during scheduled fire drills for proper wording on all oxygen storage rooms. 4. Process and proper signage will be reviewed in QA committee for two quarters. 5. 01-13-2017	

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K 923	Continued From page 6 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly mark medical gas storage, evidenced as follows; Findings include: On 12/16/16 at various times it was observed during inspection the Occupational Therapy room storage closet, and oxygen storage rooms signage throughout the facility did not include the wording "'CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING", at a minimum. The Administrator witnessed this evidence by observation and interview.	K 923		

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W-1658-002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02 B WING	(X3) DATE SURVEY COMPLETED
	495188		12/16/2016

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APPOMATTOX HEALTH AND REHABILITATON	215 EVERGREEN AVE APPOMATTOX, VA 24522

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K 000	INITIAL COMMENTS	K 000		
	Surveyor: 21761 Construction Type: II(111) Number of stories: Two Stories Building description: The facility is a two-story building separated from the one-story main building by a 2-hour rated barrier wall. The first floor contains the dining area, kitchen, and Physical Therapy Gym. The basement contains the mechanical room and laundry facility. There are no sleeping areas in this building. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by a 30,000 gallon static water tank and a diesel fire pump. An unannounced standard recertification Life Safety Code survey was conducted 12/16/16 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 2012 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 161 SS=D	NFPA 101 Building Construction Type and Height Building Construction Type and Height	K 161		

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

Administrator 12/29/2016

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 161	Continued From page 1 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This Standard is not met as evidenced by: Surveyor: 21761	K 161	K 161 1. Fire rated ceiling to be repaired at the corridor beside Physical Therapy. 2. Maintenance Director to review this area weekly to ensure there is not a breach in the membrane. 3. Maintenance Director to review monthly during scheduled fire drills to ensure that the 1 hour fire rated ceiling construction is intact. 4. Process will be reviewed in QA committee for two quarters. 5. 1-20-2016	

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K 161	Continued From page 2 Based on observation and interview, it was revealed the facility failed to maintain rated construction, evidenced as follows; Findings include: On 12/16/16 at approximately 2:50 P.M., it was observed there was a breach in the membrane of the 1-hour rated ceiling construction in the corridor at Physical Therapy. The Administrator witnessed this evidence by observation and interview.	K 161		
K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler	K 222	K 222 1. A. 12-19-2016 (Amped) adjusted the stairwell delayed locking device from 30 seconds to 15 seconds as marked. B. 12-16-2016 Basement rear exit door disabled and then was adjusted to provide egress to the outside by depressing the delayed locking device, releasing within 15 seconds. (Henderson Electric) On 12-19-2016 (Amped) added lock tight to the thumb screw for ensure compliance.	

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K 222	Continued From page 3 system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain delayed egress exits. This violation potentially affects 2 of 2 smoke compartments, evidenced as follows;	K 222	2. Maintenance Director to review daily to ensure both the stairwell and basement rear exit doors are functioning as indicated. 3. Maintenance to review selected doors by PM system for compliance. 4. Process will be reviewed by QA committee for two quarters. 5. 12-19-2016	

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K 222	Continued From page 4 Findings include: 1. On 12/16/16 at approximately 2:54 P.M., it was observed during inspection that the stairwell delayed locking device on the egress door to the basement was releasing after 30 seconds instead of 15 seconds as marked. 2. On 12/16/16 at approximately 2:55 P.M., it was observed during inspection that the delayed locking on the rear egress door to the outside from the basement failed to release, preventing exiting without a swipe card. The delayed locking device has been disabled until it can be repaired. The Administrator witnessed this evidence by observation and interview.	K 222		
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doors, evidenced as follows; Findings include: On 12/16/16 upon records review, at	K 300	K 300 1. A PM will be created for annual audit/test of fire rated doors. All units are in process of survey and test. 2. Maintenance Director to review PMs and when due have survey/tests completed and documented on MFA forms. 3. Corporate will add PMs to Maintenance system for review and follow-up as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	495188		12/16/2016

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

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K 300	Continued From page 5 approximately 1:35 P.M., it was observed that documentation could not be provided for rated door periodic testing and inspection. (Sections 7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4) The Administrator witnessed this evidence by observation and interview.	K 300	4. Facility will have Maintenance Director report any occurrences of door issues to the Safety/QA committee for review and actions needed to ensure compliance. 5. Facility desires a Time Limited waiver to expire on 3-20-17	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide complete emergency procedures, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 12:20 P.M., it was observed the written emergency procedures did not include procedures to include the removal of wheeled equipment stored in corridors. The Administrator witnessed this evidence by observation and interview.	K 711	K 711 1. 12-23-2016 Updated the Departmental Fire Plan instructions to include the removal of wheeled equipment stored in the corridors. (HK, Nurses, and CNAs) 2. Fire Plan to be reviewed monthly by the Maintenance Director and Administrator to ensure all wheeled equipment are identified for removal and where to store. 3. Maintenance Director to monitor monthly during unannounced fire drills for compliance. 4. Process will be reviewed by QA committee for 2 quarters. 5. 12-23-2016	

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

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K 901 K 901 SS=F	Continued From page 6 NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide a formal and documented catagory risk assessment, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed that no documentation could be provided for a formal and documented risk assessment. The Administrator witnessed this evidence by observation and interview.	K 901 K 901	K 901 1. Forms created, added new PM and facility entering information to comply with NFPA 99- Chapter 4. 2. Update annually to ensure any occurrences are not missed. 3. Maintenance Director will monitor PMs and complete when due. 4. Safety/QA committee to be notified of any issues for corrections to be made. 5. Facility desires a Time Limited waiver to expire 3-20-17 (correction date)	
K 912 SS=D	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.	K 912	K 912 1. Kitchen electrical receptacle ordered 12-16-2016 to replace broken receptacle. (Henderson Electrical)	

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K 912	Continued From page 7 If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain electrical equipment, evidenced as follows; Findings include: On 12/16/16 at approximately 2:43 P.M., it was observed during inspection there is a broken electrical receptacle in the kitchen. The Administrator witnessed this evidence by observation and interview.	K 912	2. Maintenance Director to review weekly kitchen receptacles to ensure all receptacles are intact. 3. Maintenance Director to review receptacles monthly to ensure compliance. 4. Process will be reviewed in QA committee for two quarters. 5. 1-20-2017	
K 915 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	K 915	K 915 1. Forms created, added new PMs and facility entering information to comply with NFPA 99. Essential Electric System Categories. 2. Update annually to ensure any occurrences are not missed. 3. Maintenance Director will monitor PMs and complete when due. 4. Safety/QA committee to review the process and be notified of any issues for correction to be made.	

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K 915	Continued From page 8 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide electrical systems documentation, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed there was no category documentation provided for essential electrical systems. The Administrator witnessed this evidence by observation and interview.	K 915	5. Facility desires a Time Limited waiver to expire 3-2019 (Correction Date).	