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

W-1658-001

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 01/20/2017

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 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 LSC revisit to the standard survey conducted on 12/16/16 was conducted on 01/20/17 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.) Corrected deficiencies are noted on the 2567B form.	{K 000}	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.	
{K 300} SS=F	NFPA 101 Protection - Other Protection - Other	{K 300}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Steven H Smith

TITLE: Administrator

(X6) DATE: 1/27/2017

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

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{K 300}	Continued From page 1 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 1/20/17 at approximately 11:35 A.M., it was observed during record review 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) A Time Limited Waiver has been requested for March 20, 2017. The Administrator witnessed this evidence by observation and interview.	{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. 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. Facility desires a Time Limited waiver to expire on 3-20-2017	
{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)	{K 901}		

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APPOMATTOX HEALTH AND REHABILITATON	215 EVERGREEN AVE APPOMATTOX, VA 24522

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{K 901}	Continued From page 2 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 category risk assessment, evidenced as follows This has the potential to affect all residents in the facility. Findings include: On 1/20/17 at approximately 11:40 A.M., it was observed during record review that documentation could be provided for a formal and documented risk assessment. A Time Limited Waiver has been requested for March 20, 2017. The Administrator witnessed this evidence by observation and Interview.	{K 901}	K901 1. Forms created, adding 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 3-20-2017.	
{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	{K 915}		

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{K 915}	Continued From page 3 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 effectlve 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. This has the potential to affect all resldents of the facility. Findings include: On 1/20/17 at approximately 11:50 A.M., it was observed during record review that documentation could not be provided for a calagory documentation provided for essentlal electrical systems. A Time Limited Waiver has been requested for March 20, 2017. The Administrator witnessed this evidence by observatlon and interview.	{K 915}	K915 1. Forms created, added new PMs and facility entering Information to comply with NFPA 99. Essential Electrical 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 notlfied of any Issues for correction to be made S. Facility desires a Time Limited Waiver to expire 3-20-2017	

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POST-CERTIFICATION REVISIT REPORT

W-1658-001

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
495188 Y1	A. Building 01 - MAIN BUILDING 0 t B. Wing Y2	1/20/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	215 EVERGREEN AVE APPOMATTOX, VA 24522

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0325	Correction Completed 01/20/2017	ID Prefix Reg. # NFPA 101 LSC K0711	Correction Completed 01/20/2017	ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 01/20/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) thr	DATE 1/24/17	SIGNATURE OF SURVEYOR [signature]	DATE 1/24/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/16/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			