STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING **01, 02** B. WING _____	R **01/26/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	**235 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}		

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 12/21/2017 was conducted on 01/26/2018 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 in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING **01, 02** B. WING _____	R **01/26/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	**235 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}	Continued From page 1 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 12/21/2017 was conducted on 01/26/2018 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 in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.	{K 000}		