

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

Printed: 04/18/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495375</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/10/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>EMPORIA MANOR LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 WEAVER AVENUE EMPORIA, VA 23847</b>		
(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  Description of structure: The facility is 1 story/stories frame structure with a construction type of V(000)  Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 02/20/2018 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 found not to be in compliance with the Requirements for Participation Medicare and Medicaid.	{K 000}		
{K 291} SS=F	Emergency Lighting CFR(s): NFPA 101  Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based upon observations there are areas that do not have the required emergency lighting.  Findings include  On 02/20/2018 between 9:00 AM and 12:00 PM it is observed that emergency lighting testing of at least 1-1/2 hour duration automatically is not being done.	{K 291}		
{K 363} SS=D	Corridor - Doors CFR(s): NFPA 101  Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	{K 363}		

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

*William J Belmonte*

TITLE

*Administrator*

(X6) DATE

*4-10-18*

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 363}	<p>Continued From page 1</p> <p>hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based upon observations a several damaged corridor doors</p>	{K 363}		

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{K 363}	Continued From page 2 Findings include  On 02/20/2018 between 9:00 AM and 12:00 PM, it was observed several corridor doors throughout the facility damaged with cracks and holes. The above deficiency was observed by the Director of Maintenance.	{K 363}		
{K 374} SS=F	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based upon observations the fire rated smoke barrier walls have penetrations, joints and openings that are not fire stopped and could allow smoke to pass from one side of the smoke barrier to the other side.  Findings include.  On 02/20/2018 between 9:00 AM and 12:00 PM, It was observed open penetrations throughout the facility above the smoke doors. The above deficiency was observed by the Maintenance Supervisor	{K 374}		

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{K 521} {K 521} SS=F	Continued From page 3 HVAC CFR(s): NFPA 101  HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2  This REQUIREMENT is not met as evidenced by: Based upon interviews the facility does not have documentation that the fire dampers have been inspected and tested within the last four years.  Findings include  On 02/20/2018 between 9:00 AM and 12:00 PM it was observed that the facility does not have documentation that the fire dampers have been inspected and tested within the last four years. The above deficiency was observed by the Director of Maintenance.	{K 521} {K 521}		
{K 522} SS=F	HVAC - Any Heating Device CFR(s): NFPA 101  HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from	{K 522}		

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{K 522}	Continued From page 4 occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based upon observations vent/duct returns need to be cleaned.  Findings include  On 02/20/2018 between 9:00 AM and 12:00 PM, a pattern was observed throughout the facility the vent/duct returns need to be cleaned of dust and debris. The above deficiency was observed by the Director of Maintenance.	{K 522}		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 495375	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 4/10/2018	Y3
NAME OF FACILITY EMPORIA MANOR LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEAVER AVENUE EMPORIA, VA 23847		

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 _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	04/10/2018	LSC K0324	04/10/2018	LSC K0345	04/10/2018
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	04/10/2018	LSC K0741	04/10/2018	LSC K0914	04/10/2018
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0919	04/10/2018	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR <i>Rusty Chase / DS</i>	DATE 04/12/18
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE Deputy State Fire Marshal	DATE 04/12/18

FOLLOWUP TO SURVEY COMPLETED ON 2/20/2018

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO