

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
---	---

(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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/25/14</p> <p>Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350</p> <p>Surveyor: Bridget Brown, Medical Surveyor, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Williamsport Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The</p>	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review certification of compliance on or after 10-25-2014. James D. Sizemore, HFA Executive Director	

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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			
K010025 SS=F	<p>facility has the capacity for 80 and had a census of 72 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached storage building which was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/02/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure vertical openings in the smoke barrier walls for in 2 of 2 resident sleeping room wings were sealed</p>	K010025	<p>K025 NFPA 101 Life Safety Code Standard Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke</p>	11/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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			
	<p>in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and all residents in the sleeping room corridors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director between 11:30 a.m. and 2:00 p.m., spaces between vertical meeting drywall edges for walls above the laid in ceilings on the 200 foot long C wing and A wing resident room corridors had been sealed with expandable foam rather than drywall tape. The maintenance director acknowledged at the time of observations the drywall seams should have been sealed with drywall tape.</p> <p>3.1-19(b)</p>		<p>barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wires glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p> <p>1.) No Residents was affected by the deficient practice</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>1.) All Residents have the potential to be affected 2.) Work has started on C-Wing to remove spray foam and install fire retardant drywall joint tape; repairs are expected to be completed by November 25, 2014. (Please see picture of work and product information attached)</p> <p>What measures will be put into place or what systemic</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 exits were	K010038	changes will be made to ensure that the deficient practice does not recur? 1.) Maintenance Supervisor was re-educated on approved fire rated sealants by the Executive Director on October 1, 2014. (See attached in-service record) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and 1.) Maintenance Director or designee will conduct facility wide monthly inspections for 6 months then quarterly thereafter ensuring no spray foam has been identified. If spray foam is identified, Maintenance Director or designee will remove spray foam immediately and install approved fire rated sealant. 2.) Findings of the inspections will be submitted to the Continuous Quality Improvement Committee for review. By what date the systemic changes will be completed? 1.) All repairs are to be completed by November 25, 2014	10/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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			
	<p>arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 10 or more residents on the A wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/25/14 at 12:10 p.m., the south exit discharge aggregate concrete surface for the emergency exterior exit from A wing was damaged across the width of the exit discharge surface by pitting, irregular cracks and areas which had broken away which made the surface not level. The maintenance director said at the time of observation, the damage was weather related and the facility planned to replace the concrete.</p> <p>3.1-19(b)</p>		<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p> <p>1.) No Resident was affected by the deficient practice</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>1.) All Residents have the potential to be affected 2.) The surface of the exterior emergency exit is set to be replaced on 10/16/2014</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>1.) Maintenance Director or designee will conduct monthly rounds of the grounds to ensure all emergency exit paths are free from cracks, areas that are broken away and/or missing.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to insure 2 of 5 Physical</p>	K010056	<p><i>i.e., what quality assurance program will be put into place; and</i> 1.) Maintenance Director or designee will conduct monthly rounds indefinitely of the grounds to ensure all emergency exit paths are free from cracks, areas that are broken away and/or missing. 2.) Maintenance Director or designee will submit findings of the rounds to the Continuous Quality Improvement committee for review monthly, any areas identified as broken or missing will be repaired immediately <i>By what date the systemic changes will be completed?</i> 1.) All repairs are to be completed by October 24, 2014</p> <p>K056 NFPA 101 Life Safety Code Standard If there is an</p>	09/30/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
	<p>Therapy room sprinkler heads were installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect staff, visitors and 10 or more residents on A hall.</p> <p>Findings include:</p> <p>Based on an observations on 09/25/14 at 12:00 p.m. with the maintenance director, two heads were located four feet from one another in Physical Therapy. The maintenance director confirmed the separation of sprinkler heads was less than six feet.</p> <p>3.1-19(b)</p>		<p>automatic sprinkler system, it is installed in accordance with NGPA 14, Standard for the installation of sprinkler systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, standard for the inspection, testing, and maintenance of water-based fire protection systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm systems.</p> <p>19.3.5 What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice? 1.) No Residents was affected by the deficient practice How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? 1.) All Residents have the potential to be affected 2.) Facility sprinkler contractor (P.I.P.E) was contacted and removed the sprinkler head on September 30, 2014 (See attached photo) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1.) On September 29, 2014 a facility</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
K010062 SS=E	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 1. Based on observation, the facility failed to ensure sprinkler heads providing protection for 2 of 7 smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents in the A wing. and dining room smoke compartments.	K010062	wide inspection was completed by the Maintenance Director and no other sprinkler heads were identified as being less than 6-feet apart How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and 1.) Maintenance Director or designee will conduct monthly facility wide inspections ensuring all sprinkler heads are at the required space 2.) Inspections will be submitted to the Continuous Quality Improvement committee and any sprinkler head that is found to have less than 6-feet will be repaired immediately By what date the systemic changes will be completed? 1.) All repairs were completed on September 30, 2014 K062 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 What corrective actions will be	09/30/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
	<p>Findings include:</p> <p>Based on observation with the maintenance director on 09/27/14 at 12:00 p.m., sprinkler head escutcheons were missing from a sprinkler protecting the A hall Physical Therapy room and the sprinkler protecting the dietary food storage room. The maintenance director acknowledged at the time of observations, the sprinkler head escutcheons were not in place.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen walk in freezer sprinkler heads was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects 4 or more visitors and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/25/14 at</p>		<p>accomplished for those Residents found to have been affected by the deficient practice?</p> <p>1.) No Residents was affected by the deficient practice</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>1.) All Residents have the potential to be affected</p> <p>2.) Escutcheons that were identified as missing was installed immediately on September 25, 2014 by the Maintenance Director (See attached photo)</p> <p>3.) Items identified being too close to the sprinkler head was removed immediately by the Maintenance Director</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>1.) On September 30, 2014 a facility wide inspection was completed by the Maintenance Director and identified no other areas with missing escutcheons.</p> <p>2.) Dietary staff was re-educated on proper food storage on October 10, 2014 by the Executive Director</p> <p>How the corrective actions will be monitored to ensure the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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			
K010147 SS=E	<p>12:40 p.m., the storage on shelves in the kitchen walk in freezer was located eight inches from the only sprinkler head providing protection for the space. The maintenance director acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical wiring connections in 1 of 7 smoke compartment was maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition,</p>	K010147	<p>deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <p>1.) Maintenance Director or designee will complete facility wide inspections monthly for six months then quarterly thereafter ensuring all escutcheons are present and not missing</p> <p>2.) Dietary Manager or designee will conduct weekly inspections for 4 weeks, bi-weekly for 4 weeks and monthly thereafter for 6 months in the dietary department to ensure all food is stored 18" below the sprinkler head</p> <p>3.) Results of the inspections will be presented during monthly Continuous Quality Improvement meetings and if any escutcheons is identified as missing will be replaced immediately</p> <p>By what date the systemic changes will be completed?</p> <p>1.) All repairs were completed September 30, 2014</p> <p>K147 NFPA Life Safety Code Standard Electrical wiring and equipment is in accordance with NFPA, National Electrical Code. 9.1.2</p>	09/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993			
(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			
	<p>Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 10 or more residents in the south C wing smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 09/25/14 between 11:30 a.m. and 2:00 p.m., a junction box above the laid in ceiling near the C hall dining room smoke barrier was uncovered with wires exposed. The maintenance director said at the time of observation, he was not aware the junction box was uncovered.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to maintain an electrical outlet in 1 of 6 smoke compartments. NFPA 101, 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 1999 edition, Article 410.3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects visitors, staff and 10 or more residents in the south A hall smoke compartment.</p>		<p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p> <p>1.) No Residents was affected by the deficient practice</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>1.) All Residents have the potential to be affected 2.) The junction boxes identified were covered immediately on September 25, 2014 3.) The electric switch in the Executive Directors bath/storage was covered immediately on September 25, 2014</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>1.) The Maintenance Director completed a facility wide inspection of all junction and electrical boxes on September 30, 2014 to ensure all junction boxes were covered 2.) The Maintenance Director covered any junction box that was uncovered immediately</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2014
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993		
(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	
	<p>Findings include:</p> <p>Based on observation with the maintenance director on 09/25/14 at 12:05 p.m., an electric switch in the executive director's bath/storage room had no cover and no switch which left the wiring exposed. The maintenance director agreed the wiring should not have been uncovered.</p> <p>3.1-19(b)</p>		<p><i>i.e., what quality assurance program will be put into place; and</i></p> <p>1.) The Maintenance Director or designee will complete facility wide inspections indefinitely to ensure all junction boxes remain covered and all electrical switches have covers installed</p> <p>2.) The results of the inspections will be turned into the monthly Continuous Quality Improvement committee for review. Any deficient practice will be repaired/replaced immediately upon discovery</p> <p><i>By what date the systemic changes will be completed?</i></p> <p>1.) All repairs were completed on September 30, 2014</p>		