

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2014
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NAME OF PROVIDER OR SUPPLIER  WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
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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: 10/20/14</p> <p>Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Williamsburg Health Care 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke</p>	K010000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health Care that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health Care.	

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.

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K010029 SS=E	<p>detectors. The facility has the capacity for 116 and had a census of 48 at the time of this survey.</p> <p>All areas where residents have customary access and providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</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 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide working automatic closer's for doors providing access to hazardous areas such as</p>	K010029	<p><b>K029</b></p> <p>1.No residents were affected by the deficient practice.</p> <p>2.Door closers and necessary repairs were made to the doors mentioned in findings a, b, and c</p>	11/14/2014			

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	<p>combustible materials storage rooms larger than 50 square feet, in 1 of 5 smoke compartments. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents on Unit 3.</p> <p>Findings include:</p> <p>a. Based on observation with the human resources director on 10/20/14 between 11:00 a.m. and 2:30 p.m., unoccupied resident rooms: 22, 23, 26, 27, 28, 30, 31, 32, 33, 34, and 35, were being used for the storage of beds, mattresses, upholster recliners, miscellaneous activity supplies and items in cardboard cartons. The doors had no self closer's. Additionally doors to rooms 23 and 27 failed to close when the doors hit impediments in the door frames. The human resources manager acknowledged the storage rooms were larger than 50 square feet, housed combustibles, and did not have self or automatic door closer's.</p> <p>b. Unoccupied resident room 29 was identified by the human resources manager on 10/20/14 at 11:45 a.m., as the construction work room for sawing materials used in the facility renovation</p>		<p>to ensure complete and appropriate closure. An audit of the building's hazardous storage areas was completed to identify other areas of concern regarding completely closing doors. Any concerns identified were addressed.</p> <p>3. In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor hazardous storage areas monthly to verify the presence of properly functioning automatic door closers. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next three quality assurance committee meetings.</p> <p>4. Examples of repairs are provided in Attachment A. Due to the evidence provided Williamsburg Health Care requests paper compliance on Tag K029.</p>				

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K010038 SS=E	<p>project. The room contained electric saws and other tools as well as cans of flammable varnish and other wood finishing materials. There was no self closer. The human resources manager acknowledged the room lacked a self closer.</p> <p>c. On 10/20/14 at 11:55 a.m., the ten by eight foot kitchen supply storage room door failed to self close when tested twice with the human resources manager. Each time the door hit the door frame. The human resources manager acknowledged at the time of observation, the door was in need of repair to ensure it would self close every time.</p> <p>3.1-19(b)</p> <p>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 6 exits was 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 7.1.6.3 requires walking surfaces to be nominally</p>	K010038	<p><b>K038</b> 1.No residents were affected by the deficient practice. 2.The sidewalk identified was repaired. An audit of the building's exit paths/sidewalks was completed to identify other areas of concern regarding safe exit pathways. Any concerns identified were addressed. 3.In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or</p>	11/14/2014			

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K010054 SS=E	<p>level. This deficient practice could affect visitors, staff, and 10 or more residents using the northeast exit.</p> <p>Findings include:</p> <p>Based on observation with the human resources director on 10/20/14 at 1:15 p.m., the surface of the concrete sidewalk exit discharge for the northeast exit had deteriorated and broken away. A patching material had also cracked and broken away leaving an uneven surface across the width of the exit discharge.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on observation and interview, the facility failed to ensure 3 of 43 hardwired smoke connected to the fire alarm system was properly separated from an air supply or return vent. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could</p>	K010054	<p>designee will monitor exit paths/sidewalks monthly to verify a smooth and nominally level surface. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next three quality assurance committee meetings.</p> <p>4.Evidence of the sidewalk repair is provided in Attachment B. Due to the evidence provided Williamsburg Health Care requests paper compliance on Tag K038.</p> <p><b>K054</b></p> <p>1.No residents were affected by the deficient practice. 2. The smoke detectors were moved in the mentioned areas. An audit of the facility's other smoke detectors was completed to identify other areas of concern regarding too close proximity to an air vent. Any concerns identified were addressed. 3.In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or</p>	11/14/2014			

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K010062 SS=F	<p>affect visitors staff and 10 or more residents in the north and east smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the human resources manager on 10/20/14 between 11:00 a.m. and 1:30 p.m., corridor smoke detectors were not properly separated from air flow vents: near the care plan office ( twenty four inches), outside room 58 (four inches), near room 31 (four inches),. Based on interview at the time of observation, the Maintenance Director acknowledged the distance between the vent and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads protecting 5 of 5 exit discharge canopies were free of corrosion and/or rust. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects all occupants.</p>	K010062	<p>designee will monitor smoke detectors monthly to ensure appropriate placement. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next two quality assurance committee meetings.</p> <p>4.Evidence of the movement of the smoke detector is provided in Attachment C and Attachment D. Due to the evidence provided, Williamsburg Health Care requests paper compliance on Tag K054.</p> <p><b>K062 I.</b> No residents were affected by the deficient practice. <b>II.</b> The sprinkler heads identified are being replaced. An audit of the building's sprinkler heads was completed to identify other areas of concern regarding clean not rusty or corroded heads. Any concerns identified were</p>	11/14/2014			

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	<p>Findings include:</p> <p>Based on observation with the human resources manager on 10/20/14 between 11:00 a.m. and 2:00 p.m., one sprinkler head protected each roof overhanging the northeast, southeast, northwest and southwest exit discharge roof canopies. Four sprinkler heads protected the front porch roof canopy. Each of the sprinkler heads were dirty, rusted and/ or getting a green discoloration, usually evidence of corrosion. The human resources director acknowledged the appearance of the sprinkler heads at the time of observations.</p> <p>3.1-19(b)</p>		<p>addressed. III. In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor sprinkler heads monthly to verify the presence of clean sprinkler heads in good repair. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next three quality assurance committee meetings. IV. Evidence of the replacement of the sprinkler head is provided in Attachment D. Due to the evidence provided, Williamsburg Health Care requests paper compliance on TagK062.</p>				
K010073 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure flammable decorations were not used in 1 of 5</p>	K010073	<p><b>K073</b> 1.No residents were affected by the deficient practice.</p>	11/14/2014			

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K010076 SS=E	<p>smoke compartments. This deficient practice could affect visitors, staff and 2 residents in the south smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the human resources manager on 10/20/14 at 11:05 a.m., four wicked candles were located in four wall sconces in the reception lounge. The human resources manager acknowledged at the time of observation the candles were an inherently flammable decoration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in</p>	K010076	<p>2. The candles were disposed of. The facility performed an audit of facility decorations and removed any candles.</p> <p>3. In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor facility decorations monthly to ensure no candles are used. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next two quality assurance committee meetings.</p> <p>4. Evidence of the removal of the candles and sconces is provided in Attachment E. Due to the evidence provided, Williamsburg Health Care requests paper compliance for TagK073.</p> <p><b>K076</b> 1.No residents were affected by the deficient practice.</p>	11/14/2014	

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K010130 SS=D	<p>2 of 2 sprinklered oxygen storage areas, was properly separated from combustibles. NFPA 99, 8-3.1.11.2(c)2 requires the minimal separations from oxygen and combustibles in a sprinklered building be 5 feet. This deficient practice affects staff, visitors and 40 or more residents in the 300 hall and 400 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the human resources manager on 10/20/14 at 11:30 a.m., ten 181 Liter capacity liquid oxygen supply containers were stored in a resident room 33 with combustible stored items such as linens, mattresses and cardboard cartons. The room was filled to capacity which prevented the minimum five feet permitted between combustibles and the stored oxygen containers. The human resources manager acknowledged at the time of observation, combustibles were too close to the oxygen supply containers.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS</p>		<p>2. The completely empty oxygen tanks were removed from the facility. An audit of the facility's other oxygen storage areas was completed to identify other areas of concern regarding being vented to the outside and proximity to combustibles. Any concerns identified were addressed.</p> <p>3. In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor oxygen storage monthly to ensure appropriate placement. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next two quality assurance committee meetings.</p> <p>4. Evidence of the removal of the oxygen tanks is provided in Attachment F. Due to the evidence provided, Williamsburg Health Care requests paper compliance on Tag K076.</p>		

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	<p><b>OTHER LSC DEFICIENCY NOT ON 2786</b></p> <p>Based on observation and interview, the facility failed to ensure the location of 1 of 1 natural gas fuel supply lines was separated from a potential ignition source. LSC 8.4.3.1 requires the storage and handling of flammable gases to be in accordance with (2) NFPA 54, National Gas Code. NFPA 54, Section 1.6.1 (b) describes smoking as a prohibited source of potential ignition for natural gases. This deficient practice could affect any visitor, resident or resident using the smoke hut or exiting via the service corridor.</p> <p>Findings include:</p> <p>Based on observation on 10/20/14 at 12:45 p.m. with the human resources manager, a cigarette butt disposal tower was located beside the emergency generator display access panel. The west side of a smoke hut was secured to a concrete pad located 12 inches from the natural gas fuel supply line at the point it connected to the emergency generator. The gas main was located less than four feet from the smoke hut. The human resources manager acknowledged at the time of observation, the close proximity of the smoke hut and butt disposal tower had the potential to be an ignition source</p>	K010130	<p><b>K130</b></p> <p>1.No residents were affected by the deficient practice.</p> <p>2. The employee smoking area was relocated away from the natural gas line.</p> <p>3.In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor facility smoking areas and butt disposal towers to ensure appropriate location. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next two quality assurance committee meetings.</p> <p>4.Evidence of the movement of the smoking area is provided in Attachment G. Due to the evidence provided, Williamsburg Health Care requests paper compliance on Tag K130.</p>	11/14/2014			

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K010147 SS=F	<p>if there was any leak from or damage to the natural gas fuel line.</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>Based on observation and interview, the facility failed to ensure electrical wiring and equipment was in compliance with NFPA 70, The National Electrical Code for 1 of 1 emergency generators. NFPA 70, Article 348.12(7) requires flexible metal conduit shall not be used where it is subject to physical damage. This deficient practice could affect all occupants in the event the emergency generator was incapacitated due to faulty wiring.</p> <p>Findings include:</p> <p>Based on observation with the human resources manager on 10/20/14 at 12:45 p.m., flexible metal wire conduit ran on the ground from the emergency generator to the facility wall where it was connected to wiring inside the facility.</p>	K010147	<p><b>K147</b></p> <p>1.No residents were affected by the deficient practice. 2. The conduit on the generator was replaced. 3.In an attempt to ensure this deficient practice does not recur, the Maintenance Manager or designee will monitor the generator weekly to ensure all lines to and from are in good repair. Results of the monitoring will be provided to the Administrator. The results will be reported and discussed in the next three quality assurance committee meetings. 4.Evidence of the replacement of the conduit is provided in Attachment H. Due to the evidence provided, Williamsburg Health Care requests paper compliance on Tag K147.</p>	11/14/2014			

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	The conduit was rusted the entire length of the run. Two six inch sections had broken away leaving wires exposed to the elements. The human resources director acknowledged at the time of observation, the conduit was not in good condition.  3.1-19(b)				