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| 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 07/11/2013 |
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| NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH & REHAB | 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: 07/11/13</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 & Rehab 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 and Rehab that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health and Rehab. | |
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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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| | <p>detectors. The facility has the capacity for 116 and had a census of 59 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> | | | | |

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| K010025 SS=E | <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 2 of 2 openings in smoke partitions, such as a wall and ceiling, were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect 10 or more visitors, staff or residents accessing the north exit.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 07/11/13 at 11:45 a.m., a two by two inch wall cutout and one annular gap in the ceiling were unsealed in the vestibule of the north exit. The administrator acknowledged at the time of observations, the openings should have been sealed to maintain the integrity of the smoke partitions.</p> <p>3.1-19(b)</p> | K010025 | <p>K025 I. No residents were affected by the deficient practice. II. The openings in the ceiling and in the wall were sealed. Evidence of repair to the ceiling and to the wall is provided in Attachments A and B respectively. III. The administrator or designee will monitor the building monthly to ensure no other openings in the walls or ceilings are present. Evidence of an audit performed for other areas of concern is provided in Attachment C. The results of the monitoring will be reported in the next two quality assurance committee meetings. IV. Due to the evidence provided, Williamsburg Health and Rehab is requesting paper compliance for tag K025.</p> | 07/25/2013 | | | |

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| K010064 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 4 or more staff, visitors and any residents using the corridor located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 07/11/13 at</p> | K010064 | <p>K064 I. No residents were affected by the deficient practice.II. A K Class Placard was placed on the wall over the fire extinguisher. Evidence of placement of the placard is provided in Attachment D.III. In an attempt to ensure this deficient practice does not recur, the administrator or designee will monitor each year for the presence of the K Class Placard.IV. Due to the evidence provided, Williamsburg Health & Rehab requests paper compliance on tag K064.</p> | 07/25/2013 | | | |

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| | <p>11:30 a.m. with the administrator, a placard was not posted near the K-class fire extinguisher in the kitchen. The administrator acknowledged at the time of observation, there was no placard.</p> <p>3.1-19(b)</p> | | | |

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| K010076 SS=E | <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>1. Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage areas was properly separated from combustibles. NFPA 99, Health Standards for Health Care Facilities, 8-3.1.11.2(c) requires the minimal separation from oxygen and combustibles in a sprinklered building be 5 feet or an enclosed cabinet of noncombustible construction having a minimum fire protection rating of one half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. This deficient practice affects staff, visitors and 28 residents on the Desk 2 wing.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 07/11/13 at 11:50 a.m., the oxygen supply storage room was used</p> | K010076 | <p>K076 I. 1-2. No residents were affected by the deficient practice.II. 1. The combustibles were removed from the oxygen storage room. Evidence of removal of the combustible items is provided in Attachment E. 2. The automatic closer was adjusted to ensure complete closure of the door. Evidence of the fully closed door is provided in Attachment F.III. 1. In an attempt to ensure this deficient practice does not recur, the administrator or designee will monitor monthly to ensure no combustible materials are stored within 5 feet of oxygen tanks. Evidence of an audit for other areas of concern regarding oxygen storage and combustibles is provided in Attachment G. The results of the monitoring will be reported in the next two quality assurance committee meetings.2. In an attempt to ensure this deficient practice does not recur, the administrator or designee will</p> | 07/25/2013 | |

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| | <p>for the storage of plastic, paper and cardboard wrapped respiratory supplies on shelves located immediately adjacent to and above five liquid oxygen supply storage containers in the room. The administrator acknowledged at the time of observation, the minimum separation between stored items and the oxygen had not been maintained.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered oxygen supply storage rooms was separated by construction with a one hour fire-resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. Furthermore, sprinklered hazardous areas such as the oxygen storage room are required to be equipped with self closing doors and the door is required to latch. This deficient practice affects staff, visitors and 28 residents on the Desk 2 unit.</p> <p>Findings include:</p> <p>Based on observation with the</p> | | <p>monitor monthly to ensure that applicable areas are equipped with fully functioning door closures and that the doors fully close. Evidence of an audit for other areas of concern regarding improperly functioning automatic closure devices is provided in Attachment H. The results of the monitoring will be reported in the next two quality assurance committee meetings. IV. Due to the evidence provided, Williamsburg Health & Rehab requests paper compliance on tag K076.</p> | | |

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| | <p>administrator on 07/11/13 at 1:50 a.m., five liquid oxygen containers were stored in the oxygen storage supply room. The self closing door did not work and the door gapped one inch along the latch side of the door. The administrator acknowledged at the time of observation the door could not close due to recent work on the floor.</p> <p>3.1-19(b)</p> | | | | |