

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 05/29/2013
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NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
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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: 05/29/13</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	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible allegation of compliance on or after 06-25-2013. James D. Sizemore, HFA Executive Director</p>	
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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>facility has the capacity for 96 and had a census of 73 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K010029 SS=E	<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>1. Based on observation and interview, the facility failed to ensure 1 of 10 self closing doors to hazardous areas, such as the kitchen, latched. Doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 40 or more residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 05/29/13 at 1:30 p.m., the east self closing door between the main dining room and kitchen would not latch. The door could be pushed open without releasing the latch. Upon closer inspection by the executive director at the time of observation, tape was found to have been secured over the latch to prevent it from</p>	K010029	<p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?1.) No Residents were affectedHow other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?1.) Other Residents have the potential to be affected2.) The east self closing door between the main dining room and kitchen was repaired and a new door handle was installed on 6-13-2013.3.) The north C-wing central supply storage had the wall repaired and ceiling tile replaced on 6-12-2013.4.) The south C-wing boiler/electrical room ceiling tile were repaired and replaced on 6-12-2013.5.) The south c-wing boiler/electrical room concrete wall had fire caulking installed around all pipe penetrations, fire brick has been ordered and will</p>	06/25/2013

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	<p>engaging into the door frame. The executive director acknowledged at the time of observation, the tape application was a problem and removed it.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure walls and ceilings to hazardous areas such as the 245 square foot combustible materials storage room and boiler/electrical room in 2 of 6 smoke compartments were complete. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and wall to wall with openings providing fire resistance equal to that of the smoke barrier. This deficient practice could affect staff, visitors and 42 or more residents in C wing smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observations with the executive director and maintenance director on 05/29/13 at 1:45 p.m., the north C wing 245 square foot central supply storage room had a six by fourteen inch cut out of the interior wall leaving the untreated wood studs exposed to the storage room. In addition, one lay in ceiling tile was missing, two other ceiling tiles were damaged leaving openings to</p>		<p>be installed on 6-20-2013 to close the two inch space between the concrete block and metal roof deck. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?1.) Maintenance Supervisor conducted a facility wide walk thru on 6-11-2013 ensuring no other doors were identified; no other doors were identified2.) Maintenance Supervisor conducted a facility wide walk thru on 6-11-2013 ensuring no other ceiling tile was broken or missing and no other other studs were were exposed; no other areas were identified3.) Maintenance Supervisor conducted a facility inspection of all fire walls on 6-11-2013 to identify any other penetrations and no other penetrations were identified How the corrective actions will be monitored to ensure the deficient practice will not recur, (ie what QA program will be put into place?1.) Maintenance supervisor or designee will conduct weekly door inspection for 30 days then bi-weekly for 30 days then monthly thereafter x 6 months. Results of the inspections will be reviewed during monthly continuous quality improvement meetings. Any doors that are not closing and latching will be addressed immediately2.) Maintenance supervisor or designee will complete monthly</p>		

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	<p>the space above, and a half inch hole was unsealed in the corridor wall. The executive director acknowledged at the time of observation, the condition of the walls and ceiling could not provide fire resistance and should have been properly enclosed.</p> <p>b. Based on observations with the executive director and maintenance director on 05/29/13 at 2:25 p.m., the south C wing boiler/electrical switch room lay in ceiling had missing and broken ceiling tiles with bent and damaged metal ceiling covers opening into the space above the ceiling around boiler ducts. The executive director acknowledged at the time of observation, the condition of the ceiling could not provide the fire resistance intended by the original construction.</p> <p>c. Based on observations with the executive director and maintenance director on 05/29/13 at 2:30 p.m., concrete block walls separating the south C wing boiler/electrical switch room from the adjacent resident sleeping room corridor and the pantry had pipe penetrations which left two to four inch unsealed gaps which compromised the integrity of the wall's fire resistance. In addition, the two inch space between the concrete block and metal roof deck between the boiler room and pantry appeared to be unsealed at points along</p>		<p>facility inspections indefinitely looking for broken or missing ceiling tile. Any ceiling tile that is broken or missing will be repaired or replaced immediately. Results of the inspections will be reviewed during monthly continuous quality improvement meetings.</p>		

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	<p>the length of the wall separating the two rooms. The executive director acknowledged at the time of observation, the fire resistance of the wall appeared to be compromised.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 8 locked emergency exits equipped with a magnetic lock unlocked upon activation of the fire alarm system. LSC 7.2.1.6.2(d) allows buildings protected throughout by an approved supervised automatic fire alarm system to have doors equipped with locks which shall automatically unlock the doors in the direction of egress upon activation of the building fire-protective signaling system and the doors shall remain unlocked until manually reset. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 42 residents on C Wing.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 05/29/13 at 2:00 p.m., the north exit door from C Wing was equipped with a magnetic lock designed to unlock upon activation of the fire alarm. At 2:00 p.m. on 05/29/13, the fire alarm was activated and the door lock failed to unlock. The</p>	K010038	<p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?1.) No Residents were were affectedHow other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?1.) Other Residents have the potential to be affected2.) Integrated Electronics of Indiana, Inc. was contacted on 5/29/13 and repaired the north exit door from C-wing allowing it to release upon activation of the fire alarm system on 5/30/13.3.) The fence gate will be relocated creating an exit from C-wing north exit door4.) The fence gate will be relocated eliminating both exits in the main dining room; the courtyard doors have been marked as no exits, signs posted and illuminated exit signs removedWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?1.) Maintenance supervisor during monthly fire drills will check each exit door ensuring they have released, if doors do not release repairs will be made immediatelyHow the corrective actions will be monitored to ensure the deficient</p>	06/25/2013			

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	<p>door was tested twice to confirm the failure. The executive director said at the time of observation and testing, a new fire alarm system had been installed and the contractor may have failed to make necessary changes to this door locking device.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure access to the public way from 3 of 8 emergency exits was readily accessible. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects 42 or more residents on the C wing and main dining room.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 05/29/13 at 1:00 p.m., the fence gate providing access to the public way from the north C wing exit and two exits (identified by illuminated exit signs) was locked. A box mounted on the fence adjacent to the gate designed to hold the lock key was empty. The executive director said at the time of observation,</p>		<p>practice will not recur, (ie what QA program will be put into place?1.) Maintenance supervisor will submit monthly fire drill reports to the continuous quality improvement committee monthly for review; any door found to not release will be repaired immediately.</p>				

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	<p>the mowing contractor may have forgotten to replace the key. On 05/29/13 at 1:20 p.m., the maintenance director reported the key had fallen onto the ground and had been replaced.</p> <p>3.1-19(b)</p>			

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K010147 SS=E	<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 2 of 2 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, 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 30 or more residents in the south A and C wing smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the executive director and maintenance director on 05/29/13 at 12:35 p.m., a junction box providing the electrical connection for the ceiling light fixture in the south A wing linen storage room was uncovered with wires exposed. The maintenance director said at the time of observation, the installation was not done correctly.</p> <p>b. Based on observation with the executive director and maintenance director on 05/29/13 at 2:30 p.m., a junction box above the lay in ceiling of the C wing boiler room was uncovered</p>	K010147	<p>What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?1.) No Residents were affectedHow other Residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?1.) Other Residents have the potential to be affected2.) The light fixture was taken down and junction box cover was installed3.) The junction box above the lay in ceiling on the C-wing boiler room had a junction box cover installed4.) The power strip and multi-tap adapter was removed immediately in the employee break room5.) The power strip was immediately removed in room 212 5/29/136.) The power strip was immediately removed in the Director of Nursing services office 5/29/137.) The conduit and junction box was removed and disposed of on 5/30/13What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?1.) Maintenance supervisor conducted a facility wide walk through ensuring no other junction box was open with exposed wires; no other junction</p>	06/25/2013			

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	<p>leaving wiring exposed. The maintenance director acknowledged at the time of observation, a junction box cover should have been in place.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 7 of 7 flexible cords and/or multi tap adapters were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 40 residents on Wings 2, 9, and 10.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 05/29/13 between 12:15 a.m. and 2:35 p.m., a power strip piggybacked to a multi tap adapter were used to provide power for a refrigerator and microwave in the employee break room. A power strip was located under the head of a resident bed in room 110. A power strip was used to provide power to a refrigerator in room 212. A microwave and refrigerator were plugged into a power strip in the director of nurses office. The maintenance</p>		<p>boxes were identified2.) Maintenance Supervisor, Housekeeping Supervisor and Executive Director conducted a facility wide search for power strips and removed any that were located on 5/30/133.) Executive Director notified all families and Residents on 6/3/13 that power strips of any kind were prohibited and that the facility was installing numerous outlets in all rooms of the facilityHow the corrective actions will be monitored to ensure the deficient practice will not recur, (ie what QA program will be put into place?1.) Maintenance Supervisor or designee will conduct weekly room inspections for 30 days, then bi-weekly for 30-days, then monthly thereafter indefinitely of all Resident rooms and offices to ensue no power strips are found. If power strips are found they will be removed immediately. Inspections will be reviewed during monthly continuous quality improvments.</p>				

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	<p>director said at the time of observation, he didn't know the power strips and adapters were being used in this manner. The executive director agreed at the time of observations and had the power strips removed.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure electrical wiring and equipment was in compliance with NFPA 70, National Electrical Code, in 1 of 6 smoke compartments, . NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect staff, visitors and 20 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 05/29/13 at 12:20 p.m., conduit in the laundry room was run from a junction box through a partition behind the commercial dryers to a receptacle box four feet above the floor without support. The box could be seen vibrating while the dryers were in operation. The executive director and maintenance director acknowledged at the</p>			

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	time of observation the installation had not been secured correctly. 3.1-19(b)				