STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155261	A. BUILDING -- B. WING	10/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSBURG HEALTH CARE	1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/29/18 Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300 At this Emergency Preparedness survey, Williamsburg Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 116 certified beds. At the time of the survey, the census was 45. Quality Review completed on 10/31/18 - DA	E 0000	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.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/29/18 Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300 At this Life Safety Code survey, Williamsburg	K 0000	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

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	Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 45 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/31/18 - DA			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.			

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	Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 7 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect approximately 12 residents, as well as staff and visitors in the compartment containing rooms #5 through #20 and rooms #21, #22, #24, #26, and rooms #28, through #30. Findings include: Based on observations on 10/29/18 during a tour of the facility at 12:40 p.m. with the facility Administrator, room # 27, a room that was a resident room but has been converted to a storage room, failed to self-close and latch into the door frames on multiple attempts. This area measured	K 0321	**K321 Hazardous Areas - Enclosure** I. No residents were affected by the deficient practice. A self closing device was applied to the door of room 27. II. An audit of the building was completed on 11/09/18 for presence of automatic closure devices on hazardous storage rooms, soiled linen rooms, and rooms containing gas fired equipment. All other rooms were found to have appropriate self closing devices that caused the door to close and latch into the frames. III. In an attempt to ensure this deficient practice does not recur, the Administrator or her designee will monitor the building monthly to ensure self closing devices are	11/13/2018

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	approximately 170 square feet and had at least ten large cardboard boxes, hundreds of bedsheets, linens, and plastic supplies and adult diapers located inside. The room containing numerous combustible items was acknowledged by the facility Administrator and she agreed that the room needed a self-closing device as it was hazardous and immediately off the corridor. 3.1-19(b)		appropriately placed and in working order for all hazardous storage areas such as storage rooms. The results will be reported and discussed in the next three quality assurance committee meetings unless compliance is not maintained upon which monitoring will continue for three more quality assurance committee meetings. IV. Documentation of the audit is provided in Attachment A. A photograph of the installed automatic closing device is provided in Attachment B. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K321.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the facility Administrator during a tour of the facility at 12:21 p.m. on 10/29/18, the facility has supervised dry sprinkler systems and had a total of three gauges. The manufacture date of 2012 was listed on the face of one of the three sprinkler system gauges. No recalibration date information was affixed to the sprinkler system gauges either. Based on interview at the time of the observations, the facility Administrator stated she did not believe sprinkler system gauges had been recalibrated within the most recent five year period and acknowledged documentation of sprinkler system gauge replacement or recalibration was not available for review for the out of date sprinkler system gauge which was more than five years old. 3.1-19(b)	K 0353	**K353 Sprinkler System – Maintenance and Testing** I. No residents were affected by the deficient practice. The expired gauge was replaced on 11/13/18. II. An audit of the other sprinkler gauges was performed and none were found to be expired. However, the facility also replaced the other two gauges on 11/13/18. III. In an attempt to ensure this deficient practice does not recur, the Administrator or designee will perform a quarterly visual inspection of the gauges to ensure they are not approaching 5 years post manufacture date. The results will be reported and discussed in the next three quality assurance committee meetings unless compliance is not maintained upon which monitoring will continue for three more quality assurance committee meetings. IV. The work order for replacement of the gauges is provided in Attachment C. Attachment D is a photograph of the replaced gauge. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K353.	11/13/2018
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or 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. 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			

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	Based on observation and interview, the facility failed to ensure 1 of 58 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 15 residents, as well as staff and visitors in the smoke compartment. Findings include: Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility with the facility Administrator, the corridor door to resident room # 40 failed to close and latch into the frame. Based on interview at the time of observations, the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. 3.1-19(b)	K 0363	I. No residents were affected by the deficient practice. Room #40's door wasadjusted to ensure it latched into the frame. II. An audit of the building was completed on 11/09/18 to ensure that all resident room, closet, storage room, and office doors closed completely and latched upon closure. All doors were found to close and latch appropriately. III. In an attempt to ensure this deficient practice does not recur, the Administrator or her designee will do a monthly building check to ensure there are no concerns with improperly closing and latching doors. Any concerns noted will be addressed as appropriate. The results will be reported and discussed in the next three quality assurance committee meetings unless compliance is not maintained upon which monitoring will continue for three more quality assurance committee meetings. IV. The audit of the building for appropriately closing doors is provided in Attachment E. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K363.	11/13/2018