PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING		COMPLETED		
	155261		B. WI	B. WING		10/29/2018	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				AFAYETTE RD		
WILLIAMSBURG HEALTH CARE					ORDSVILLE, IN 47933		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Diag.	An Emergency Prer	paredness Survey was	E 00	000	Submission of this plan of		
		diana State Department of		700	correction shall not constitute	or	
		te with 42 CFR 483.73.			be construed as an admission		
					Williamsburg Health Care that	-	
	Survey Date: 10/29)/18			allegations contained in this		
	•				survey report are accurate or		
	Facility Number: 0	00162			reflect accurately the provision	of	
	Provider Number:	155261			service to the residents of		
	AIM Number: 1002	284300			Williamsburg Health Care.		
	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 con	npleted on 10/31/18 - DA					
K 0000							'
Bldg. 01							
. 3	Licensure Survey w State Department of CFR 483.90(a). Survey Date: 10/29/ Facility Number: 0 Provider Number: 1002	00162 155261	K 00	000	Submission of this plan of correction shall not constitute of be construed as an admission Williamsburg Health Care that allegations contained in this survey report are accurate or reflect accurately the provision service to the residents of Williamsburg Health Care.	by the	

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155261		JILDING	nstruction 01	(X3) DATE COMPL 10/29/	ETED	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE		1609 LA	DDRESS, CITY, STATE, ZIP COD FAYETTE RD FORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0321	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					
SS=E Bldg. 01	Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-he (with 3/4 hour fire automatic fire extiraccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> C			COMPLETED	
	155261		B. WI	NG		10/29	/2018	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					AFAYETTE RD			
\/\/II \(\D \) \/	ISBURG HEALTH (^ARE			FORDSVILLE, IN 47933			
VVILLIAIV				CINAVI	ONDOVILLE, IN 47 955			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	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						
		N/A						
		l-Fired Heater Rooms						
	, ,	er than 100 square feet)						
		nance, and Paint Shops						
		ooms (exceeding 64						
	gallons)	_						
	e. Trash Collectio							
	(exceeding 64 ga	15						
		orage Rooms/Spaces						
	(over 50 square for	•						
	-	classified as Severe						
	Hazard - see K32	•	17.00	21			11/12/2010	
		on and interview, the facility	K 03	321	K321 Hazardous Areas -		11/13/2018	
		corridor door to 1 of 7			Enclosure	L		
		ich as combustible storage			I. No residents were affected	ЭУ		
	-	are feet, soiled linen rooms, and			the deficient practice. A self	41		
		provided with self-closing ld cause the doors to			closing device was applied to door of room 27.	trie		
		e and latch into the door frames				_		
					II. An audit of the building was	j		
	_	noke resistant partitions. This ould affect approximately 12			completed on 11/09/18 for	,		
	_	s staff and visitors in the			presence of automatic closure			
		s starr and visitors in the tining rooms #5 through #20			devices on hazardous storage			
					rooms, soiled linen rooms, and rooms containing gas fired	u		
	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				equipment. All other rooms w	oro.		
					found to have appropriate self		1	
					closing devices that caused the			
					door to close and latch into the			
					frames.			
					III. In an attempt to ensure this	s		
					deficient practice does not rec			
					the Administrator or her desig			
		C-close and latch into the door			will monitor the building month		1	
					ensure self closing devices ar	-		
	frames on multiple attempts. This area measured		ı		1 See See See See See See See See See Se	-	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155261		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/29/2018	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE		1609 L	ADDRESS, CITY, STATE, ZIP COD AFAYETTE RD FORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE
K 0353 SS=F Bldg. 01	large cardboard box linens, and plastic s located inside. The combustible items v facility Administrat room needed a self-hazardous and imm 3.1-19(b) NFPA 101 Sprinkler System - Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system - Provide in REMAF	supply source RKS information on non-required or partial		appropriately placed and in working order for all hazard storage areas such as stor rooms. The results will be reported and discussed in three quality assurance conmeetings unless compliant not maintained upon which monitoring will continue for more quality assurance conmeetings. IV. Documentation of the aprovided in Attachment A. photograph of the installed automatic closing device is provided in Attachment B. the evidence provided, Williamsburg Health Care requests desk review for tare	dous age the next mmittee e is three mmittee udit is A Due to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/29/2018 155261 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1609 LAFAYETTE RD WILLIAMSBURG HEALTH CARE CRAWFORDSVILLE, IN 47933 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility K 0353 K353 Sprinkler System -11/13/2018 failed to ensure 1 of 3 sprinkler system gauges Maintenance and Testing were replaced every 5 years or documented as I. No residents were affected by tested every 5 years by comparison with a the deficient practice. The expired calibrated gauge. NFPA 25, Standard for the gauge was replaced on 11/13/18. Inspection, Testing, and Maintenance of II. An audit of the other sprinkler Water-Based Fire Protection Systems, 2011 gauges was performed and none Edition, Section 5.3.2.1 states gauges shall be were found to be expired. replaced every 5 years or tested every 5 years by However, the facility also replaced comparison with a calibrated gauge. Gauges not the other two gauges on 11/13/18. accurate to within 3 percent of the full scale shall III. In an attempt to ensure this be recalibrated or replaced. This deficient practice deficient practice does not recur, could affect all residents, staff, and visitors in the the Administrator or designee will facility. perform a quarterly visual inspection of the gauges to ensure Findings include: they are not approaching 5 years post manufacture date. The Based on observations with the facility results will be reported and Administrator during a tour of the facility at 12:21 discussed in the next three quality p.m. on 10/29/18, the facility has supervised dry assurance committee meetings sprinkler systems and had a total of three gauges. unless compliance is not The manufacture date of 2012 was listed on the maintained upon which monitoring face of one of the three sprinkler system gauges. will continue for three more quality No recalibration date information was affixed to assurance committee meetings. the sprinkler system gauges either. Based on IV. The work order for replacement interview at the time of the observations, the of the gauges is provided in facility Administrator stated she did not believe Attachment C. Attachment D is a sprinkler system gauges had been recalibrated photograph of the replaced gauge. within the most recent five year period and Due to the evidence provided, acknowledged documentation of sprinkler system Williamsburg Health Care gauge replacement or recalibration was not requests desk review for tag K353. available for review for the out of date sprinkler

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3.1-19(b)

NFPA 101

Corridor - Doors

Corridor - Doors

K 0363

SS=E

Bldg. 01

system gauge which was more than five years old.

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155261	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/29/2018	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				1609 LA	NDDRESS, CITY, STATE, ZIP COD NFAYETTE RD FORDSVILLE, IN 47933		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE
	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary standard the door complying with the door closed with a control of the door closed with a control of the door release when the permitted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lad other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restricts resistance of glass assemblies.	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,					
		(S details of doors such as ngs, automatics closing					

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AND PLAN OF CORRECTION 155261 NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION doors to the corridor would close completely and latch into the dorn 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 acknowledged that the corridor door to resident room #40 failed to close and latch into the form. 3.1-19(b) Administrator, the corridor door to resident room #40 failed to close and latch into the frame. 3.1-19(b) Administrator, the recording door to resident room #40 failed to close and latch into the frame. Based on observation on #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility with the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. Based on observation on #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility with the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a four of the facility with the facility administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a facility administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a facility administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. Based on observation on 10/29/18 at 12:27 p.m., during a f	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
MAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 #4 of 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) STREET ADDRESS, CITY, STATE, ZIP COD 1809 LAFAYETTE RD CRAWFORDSVILLE, IN 47933 ID PROVIDER RAJAC CORRECTION DATE TO SHAPPEN AND CORRECTION DATE TO SHAPPEN AND SHA	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED		
MAME OF PROVIDER OR SUPPLIER 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933	155261			B. WING 10/29/2			/2018	
PREFIX TAG RECULATORY OR LSC IDENTITYING INFORMATION TAG Based on observation and interview, the facility administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation and interview the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator, the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. 3.1-19(b) Based on observation on #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room #40 failed to close and latch into the firame. Based on observation on 10/29/18 at 12:27 p.m., during a tour of the facility Administrator acknowledged that the corridor door to resident room during the facility appropriately. III. In an attempt to ensure this deficient practice. COMPLETION. 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018 1/1/13/2018				1609 L	AFAYETTE RD			
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) ### Of alied to close and latch into the frame acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. ##### Of alied to close and latch into the frame acknowledged that the corridor door to resident room #40 failed to close and latch into the frame. ##### Of alied to close and latch into the frame acknowledged 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. ###################################	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
Williamsburg Health Care requests desk review for tag K363.	IAU	Based on observati failed to ensure 1 or doors to the corridor latch into the door could affect approximately staff and visitors in Findings include: Based on observati during a tour of the Administrator, the # 40 failed to close on interview at the facility Administration corridor door to resum and latch into the finding a tour of the facility Administration corridor door to resum and latch into the finding to the facility Administration that the facility Administration that the facility and the facility Administration that the facility administration t	on and interview, the facility of 58 sets of resident room or would close completely and frame. This deficient practice simately 15 residents, as well as a the smoke compartment. on on 10/29/18 at 12:27 p.m., a facility with the facility corridor door to resident room and latch into the frame. Based time of observations, the tor acknowledged that the sident room #40 failed to close	K 0		I. No residents were affected the deficient practice. Room #40's door wasadjusted to ensit latched into the frame. II. An audit of the building was completed on 11/09/18 to ensithat 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 recite Administrator or her design will do a monthly building cheensure there are no concerns improperly closing and latchin doors. Any concerns noted waddressed as appropriate. The results will be reported and discussed in the next three quassurance committee meeting unless compliance is not maintained upon which monitor will continue for three more quassurance committee meeting IV. The audit of the building for appropriately closing doors is provided in Attachment E. Dut the evidence provided, Williamsburg Health Care	sure sure sure sure sure sure sur, neee ck to with g ill be ne ality us pring uality us r	

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