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	12/19/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 12/19/17 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 46. Quality Review completed on 12/27/17 - 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	K 0000	Submission of this plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/19/17 Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300 At this Life Safety Code survey, Williamsburg Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 51 at the time of this survey. All areas where the residents have		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.	

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	customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/27/17 - DA			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation 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			

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	(over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) Based on observation and interview, the facility failed to ensure the corridor door to 1 of 10 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 22 residents, as well as staff and visitors on the Desk 1 / Desk 3 hall area. Findings include: Based on observation on 12/19/17 at 11:47 a.m., during a tour of the facility with the Administrator and the Human Resource Manager, the Mechanical Storage room on the Desk 1 / Desk 3 hall, which was directly off the corridor, contained a fuel fired furnace and was not provided with a self-closing device on the door. The Administrator and the Human Resource Manager acknowledged that the Mechanical Storage room on the Desk 1 / Desk 3 hall, which was directly off the corridor contained a fuel fired furnace and did not have a self-closing device on the corridor door at the time of the observation.	K 0321	**K321** I. No residents were affected by the deficient practice. A self closing device was applied to the door to the furnace room on the Desk 1/Desk 3 hallway. II. An audit of the building was completed on 1/04/18 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 Maintenance Manager or designee will monitor the building monthly to ensure self closing devices are appropriately placed and in working order for all hazardous storage areas such as furnace rooms, soiled linen rooms, and combustible storage rooms. 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 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	01/08/2018

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	3.1-19(b)		photograph of the installed automatic closing device is provided in Attachment B. Attachment Z provides documentation of discussion of expectations with the maintenance manager and a form for submission of monthly building rounds. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K321.	
K 0351 SS=B Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling	K 0351	**K351** I. No residents were affected by the deficient practice. The loose	01/08/2018

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	construction in 1 of 1 kitchen walk-in freezer in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 4 staff in the kitchen. Findings include: Based on observation on 12/19/17 at 11:25 a.m. during a tour of the facility with the Administrator and the Human Resource Manager, the walk-in kitchen had an escutcheon that was hanging down approximately one inch from the ceiling. Based on interview at the time of observation, the Administrator acknowledged the loose escutcheon in the walk-in freezer. 3.1-19(b)		escutcheon was repaired on 1/04/18. II. To ensure that no other escutcheons are loose or offset, an audit of the building was performed on 1/05/18. Any concerns identified were addressed. III. In an attempt to ensure this deficient practice does not recur, the Maintenance Supervisor or designee will do a monthly building check to ensure there are no concerns with loose or offset escutcheons. 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 unless compliance is not maintained upon which monitoring will continue for three more quality assurance committee meetings. IV. The work order for repair of the escutcheon is provided in Attachment C. Documentation of the building review is provided in Attachment A. Attachment Z provides documentation of discussion of expectations with the maintenance manager and a form for submission of monthly building rounds. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K351.	
K 0353 SS=C	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13.	K 0353	**K353** I. No residents were affected by the deficient practice. II. A log has been created to record weekly gauge checks and monthly valve checks. III. In an attempt to ensure this deficient practice does not recur, the Administrator or designee will perform a monthly log review to confirm all checks had been performed and will initial on the log to confirm review of said log. 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 log is provided in	01/08/2018

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	Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on review of Superior Systems and Supply's "Sprinkler System Inspection Form" documentation for the most recent twelve month period on 12/19/17 at 11:00 a.m., with the Administrator and the Human Resource Manager, weekly dry sprinkler system gauge inspection documentation for 52 weeks of the most recent 52 week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Administrator acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not		Attachment D. Attachment Z provides documentation of discussion of expectations with the maintenance manager. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K353.	

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	available for review. 3.1-19(b)			
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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			

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	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. Based on observation and interview, the facility failed to ensure 1 of 56 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 12 residents, as well as staff and visitors on the Desk 2 hall. Findings include: Based on observation on 12/19/17 at 11:11 a.m., during a tour of the facility with the Administrator and the Human Resource Manager, the corridor door to resident room # 2 on the Desk 200 hall failed to close and latch into the frame. Based on interview at the time of observations, the Administrator and the Human Resource Manager acknowledged the aforementioned resident room door not latching into the door frame. The door was later fixed and rechecked prior to my exiting the facility. 3.1-19(b)	K 0363	**K363** I. No residents were affected by the deficient practice. As stated in the 2567 the door was repaired prior to the end of the visit. II. An audit of the building was completed on 1/04/18 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 Maintenance Supervisor or designee will do a monthly building check to ensure there are no concerns with improperly closing and latching doors. 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 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 A. Attachment Z provides	01/08/2018

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			documentation of discussion of expectations with the maintenance manager and a form for submission of monthly building rounds. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K363.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 100 electrical lights were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect up to 18 residents, as well as staff and visitors on the Desk 1 hall. Findings include: Based on observation on 12/19/17 at 12:10	K 0511	**K511** I. No residents were affected by the deficient practice. II. To ensure that no other junction boxes are without covers, an audit of the building was performed on 1/05/18. Any concerns identified were addressed. III. In an attempt to ensure this deficient practice does not recur, the Maintenance Supervisor or designee will do a monthly building check to ensure there are no concerns with open junction boxes. 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 unless compliance is not maintained upon which	01/08/2018

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	p.m., during a tour of the facility with the Administrator and the Human Resource Manager, the smoke barrier wall on the Desk 1 hall near the Care Planning Office had an open junction box with exposed wiring. The Administrator acknowledged the open junction box above the ceiling on the Desk 1 hall at the time of the observation. 3.1-19(b)		monitoring will continue for three more quality assurance committee meetings. IV. A photograph of the replaced junction box cover is provided in Attachment E. Documentation of the building review is provided in Attachment A. Attachment Z provides documentation of discussion of expectations with the maintenance manager and a form for submission of monthly building rounds. Due to the evidence provided, Williamsburg Health Care requests desk review for tag K511.	