STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155568	A. BUILDING -- B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/28/24 Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350 At this Emergency Preparedness survey, Williamsport Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 80 and had a census of 53 at the time of this survey. Quality Review conducted on 06/04/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/28/24 Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350 At this Life Safety Code survey, Williamsport	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sheila Huskey	Executive Director	06/14/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
	Nursing and Rehabilitation 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in all resident rooms. The facility has a capacity of 80 and had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for two detached garage/shed areas that are used for facility storage, which were not sprinklered. Quality Review conducted on 06/04/24			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
	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.			
	Based on observation and interview, the facility failed to ensure 1 of 35 resident room doors to the corridor would close completely and latch into the door frame. NFPA 101, 2012 edition of the Life Safety Code at 19.3.6.3.1 states "Doors protecting corridor openings in other than requited enclosures or vertical openings , exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: 1) 1 ¾ in. (44 mm) thick, solid-bonded core wood. 2) Material that resists fire for a minimum of 20	K 0363	**K – 363 Corridor - Doors** It is the practice of this facility to ensure residents are protected from the passage of smoke through corridor openings. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident in room 101 is safe, the	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
	minutes This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors within the smoke compartment. Findings include: Based on observations made during a tour of the facility on 05/28/24 at 11:55 a.m. with the facility Executive Director and the Maintenance Supervisor, the corridor door to resident room 101 failed to fully close and latch into the door frame when tested. This door would therefore not resist the passage of smoke as required by the code. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the aforementioned door as not fully closing or latching into the doorframe agreed that the door would not resist the passage of smoke. This item was discussed again at the exit conference on 05/28/24 at 1:06 p.m. with the facility Executive Director and the Maintenance Supervisor present. 3.1-19(b)		door has been repaired and resident has not had any issues due to passage of smoke. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. An audit of all residents' corridor doors was completed on 5/30/2024 all are working properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will audit all corridor doors to ensure that they latch properly weekly. They will be inputted into our maintenance program called Tel's. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All resident doors will be monitored weekly. They will be put in our maintenance computer program. The Maintenance Director will turn in audit form to ED/Designee weekly for 4 weeks, then monthly times 4 then quarterly times 2. If 100% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
			achieved an action plan will be submitted. The Maintenance Director will report findings to our QAPI meeting per policy. **By what date the systemic changes will be completed:** 6/28/24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the facilities the monthly fire drill reports entitled "Direct Supply - TELS" forms with the Maintenance Supervisor and the Executive Director on 05/28/24 at 10:10 a.m., there was no documentation for a first shift fire drill completed in the third quarter (July,	K 0712	**K – 712 Fire Drills** It is the practice of this facility to hold 3 fire drills a month one on each shift. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents had the potential to be affected by this practice. No one has been affected. Fire Drill was held on first shift 5/29/2024.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
	August, or September) of 2023. Based on an interview at the time of record review, the Maintenance Supervisor stated that he had only been at this facility for a couple of months and the drill must have been missed by the previous Maintenance Supervisor. This item was discussed again at the exit conference on 05/28/24 at 1:06 p.m. with the facility Executive Director and the Maintenance Supervisor present. 3.1-19(b) 3.1-51(c)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. Fire drills will be held on all three shifts monthly. A new maintenance director has been hired. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** New Maintenance director received education from corporate support on policy of holding fire drills at varied times each shift. ED will follow up monthly to ensure they are completed. ED will assign fire drill duties to HSK/Laund supervisor as needed if Maintenance position becomes open. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Drills will be loaded into our maintenance program upon completion when occur. The Maintenance Director will turn in copy to ED/designee weekly when occur for 4 weeks, then monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155568	A. BUILDING 01 B. WING	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLIAMSPORT NURSING AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993

(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
			times 6 and quarterly times 2. If 100% compliance is not achieved an action plan will be developed. **By what date the systemic changes will be completed:** 6/28/24	