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	04/10/2023

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: 04/10/23 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. Quality Review completed on 04/12/23	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: 04/10/23 Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350 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 483.90(a),	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sheila Huskey	Executive Director	04/24/2023

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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	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 56 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 completed on 04/12/23			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 door to the outside of the facility was not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be	K 0293	K-0293 Court room doors with no (No Exit) sign. **What corrective action(s) will be accomplished for those**	04/21/2023

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	mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect as many as 14 residents, 2 staff and 1 visitor. Findings include: Based on observations made with the Maintenance Director during a tour of the facility at 1:11 p.m. on 04/10/23, the glass door in the main dining room that led outside to the courtyard was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Director agreed that the door to the courtyard was not an exit to the public way, did not have a NO EXIT sign posted, and could be mistaken for a facility exit in the event of an emergency. This finding was reviewed with the Administrator at the exit conference on 04/10/23 at 2:30 p.m. 3.1-19(b)		**residents found to have been affected by the deficient practice:** No residents were directly affected by this deficiency. Paper signs placed on door until ordered signs come in. Signs received and placed on doors 4/21/23. **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. Signs were placed on the doors 4/27/23. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Signs will be placed on any new doors installed in the facility **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:** Maintenance Director/Designee will complete door inspection on all facility doors to ensure signage is up. Will do once a week for 4 weeks and then monthly for 6 months. Results will be monitored in facility QAPI program ongoing until 100% compliance has been achieved. **By what date the systemic changes will be completed: Compliance Date: 4/21/23**	

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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 1 electrical wiring in the facility conference room was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect as many as 6 residents, 8 staff, and 1 visitor. Findings include: Based on observations made on 04/10/23 with the Maintenance Director during a tour of the facility at 12:01 p.m., there was an electrical outlet in the facility conference room with exposed wires at the open end of the outlet where the missing cover plate should have been installed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and stated that they had recently had a water leak that saturated the drywall with water and he was still in the process of making the repair to the area adding that when he was not at work in the area, he would replace the outlet cover for safety. This finding was reviewed with the Administrator at the exit conference on 04/10/23 at 2:30 p.m. 3.1-19(b)	K 0511	**K - 0511 Exposed electrical wires** **It is the practice of this facility to ensure that all wiring in the facility is completely covered.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were directly affected by this deficiency. Missing outlet cover was replaced. **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 within close proximity to a missing outlet cover could have been affected by this deficiency. When any work is being completed in the facility Maintenance Director will ensure that no wires are left exposed at any time. **What measures will be put into place or what systemic changes will be made to**	04/21/2023

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			ensure that the deficient practice does not recur: Maintenance Director will monitor any repairs done at the facility and will check behind any contracted work performed ongoing. **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:** Maintenance Director will audit all electrical outlets weekly times 4 and then monthly for 6 months. Results will be monitored in facility QAPI program ongoing until 100% compliance has been achieved. **By what date the systemic changes will be completed:** **Compliance Date: 4/21/23**	