STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395678	A. BLDG: __--_____ B. WING: _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLIAMSPORT HOME, THE STATE LICENSE NUMBER: **491902**	**1900 RAVINE ROAD WILLIAMSPORT, PA 17701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 13, 2025, at The Williamsport Home, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Certified End Page

WILLIAMSPORT HOME, THE

STATE LICENSE NUMBER: 491902

SURVEY EXIT DATE: 02/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLIAMSPORT HOME, THE STATE LICENSE NUMBER: **491902**	**1900 RAVINE ROAD** **WILLIAMSPORT, PA 17701**

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K 0000	INITIAL COMMENT Facility ID# 491902 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on February 13, 2025, it was determined that The Williamsport Home was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two story, Type II (000), unprotected, noncombustible building, that is fully sprinklered.	K 0000		
K 0321 SS=E		K 0321		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395678	A. BLDG: 01 B. WING:	02/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLIAMSPORT HOME, THE STATE LICENSE NUMBER: **491902**	**1900 RAVINE ROAD** **WILLIAMSPORT, PA 17701**

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K 0321 SS=E	Continued from page 1 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. 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)	K 0321	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Williamsport Home agrees with the allegations and citations listed on the statement of deficiencies. The Williamsport Home maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Williamsport Home's written credible allegation of compliance. By submitting this plan of correction, The Williamsport Home does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Williamsport Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or	Completion Date: **04/01/2025** Status: **APPROVED** Date: **02/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 2 This REQUIREMENT is not met as evidenced by:	K 0321	proceeding. 1. The Laundry Room door was addressed immediately so that the door would shut properly on February 13, 2025. 2. A full house audit of doors will be completed to ensure no doors are propped open by February 28, 2025. 3. The Nursing Home Administrator or designee will conduct training/education with all staff regarding the requirement of K321 by March 7, 2025. 4. An audit on doors will be conducted weekly x 2 and then monthly x 2 by the Maintenance Director or designee. The results of the audit will be taken to monthly QA by the Maintenance Director for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures, in one location, affecting one of two floors. Findings include: 1. Observation on February 13, 2025, at 11:34 a.m., revealed the Laundry Room door was held open by unapproved means. Exit interview with the Facility Administrator and the Facilities Manager on February 13, 2025, between 12:10 p.m., and 12:20 p.m., confirmed the hazardous area enclosure deficiency.	K 0321		
K 0353 SS=E		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=E	Continued from page 4 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Williamsport Home agrees with the allegations and citations listed on the statement of deficiencies. The Williamsport Home maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Williamsport Home's written credible allegation of compliance. By submitting this plan of correction, The Williamsport Home does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Williamsport Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or	Completion Date: **04/01/2025** Status: **APPROVED** Date: **02/27/2025**

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K 0353 SS=E	Continued from page 5	K 0353	proceeding. 1. a) The unsealed penetration will be sealed in Activities closet by February 26, 2025. b) The sprinkler head assemblies in the laundry area were cleaned on February 24, 2025. c) The facility cannot reactively correct the sprinkler testing for the second quarter of 2024. d) The facility cannot reactively correct the three-year full flow trip test inspection and data. 2. a) A full house audit will be conducted by the Maintenance Director or designee for any penetrations observed by February 28, 2025. Any penetrations identified will be sealed per Life Safety guidelines. b) A full house audit will be conducted by the Maintenance Director or designee for to ensure sprinkler heads are clear of any lint by February 28, 2025. Any areas	

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K 0353 SS=E	Continued from page 6	K 0353	identified will be cleaned. c) A quarterly schedule will be developed for 2025 to ensure quarterly sprinkler testing is completed. d) The three-year full flow trip test inspection will be scheduled by the end of the first quarter of 2025. 3. The Nursing Home Administrator or designee will conduct training/education with maintenance personnel regarding the requirement of K032 to include monitoring for penetrations, lint free sprinkler heads, quarterly sprinkler testing and three-year trip testing and data by March 7, 2025. 4. a) An audit on penetrations and linen covered sprinkler heads will be conducted weekly x 2 and then monthly x 2 by the Maintenance Director or designee. The results of the audit will be taken to monthly QA by the Maintenance Director for review. b) Maintenance Director or designee	

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K 0353 SS=E	Continued from page 7	K 0353	will complete an audit for any quarterly sprinkler testing quarterly x4. The results of the audit will be taken to monthly QA by the Maintenance Director for review. c) Maintenance Director or designee will complete an audit annually for the completion of the full flow-trip. The results of the audit will be taken to monthly QA by the Maintenance Director for review.	

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K 0353 SS=E	Continued from page 8 Based on observation, interview, and documentation review, it was determined the facility failed to maintain the automatic sprinkler system in four instances, affecting one of two floors. Findings include: 1. Observation on February 13, 2025, between 11:15 a.m., and 12:00 p.m., revealed the following: a. 11:15 a.m., a penetration of the ceiling assembly, located within the first floor, Activities Closet. b. 11:30 a.m., sprinkler head assemblies, located within Laundry, were "loaded" with lint. c. 11:55 a.m., the facility lacked automatic sprinkler system testing and inspection data for the second quarter of calendar year 2024. d. 12:00 p.m., the facility lacked current, three-year, full flow trip test inspection and testing data. Exit interview with the Facility Administrator and the Facilities Manager, on February 13, 2025, between 12:10 p.m., and 12:20 p.m., confirmed the	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=E	Continued from page 9 automatic sprinkler system deficiencies.	K 0353		

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WILLIAMSPORT HOME, THE

STATE LICENSE NUMBER: 491902

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Deputy Secretary for Quality Assurance

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Secretary of Health

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K 0000	INITIAL COMMENT Facility ID# 491902 Component 02 Sunshine Room Based on a Medicare/Medicaid Recertification Survey completed on February 13, 2025, at The Williamsport Home, it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.70(a). This is a one story, Type V (111), protected, wood frame building, that is fully sprinklered.	K 0000		

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

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K 0000	INITIAL COMMENT Facility ID# 491902 Component 03 Ravine Ridge Rehab Unit Based on a Medicare/Medicaid Recertification Survey completed on February 13, 2025, it was determined that The Williamsport Home was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two story, Type II (111), protected, noncombustible building, that is fully sprinklered.	K 0000		
K 0293 SS=E		K 0293		

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

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K 0293 SS=E	Continued from page 1 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.) This REQUIREMENT is not met as evidenced by:	K 0293	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Williamsport Home agrees with the allegations and citations listed on the statement of deficiencies. The Williamsport Home maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Williamsport Home's written credible allegation of compliance. By submitting this plan of correction, The Williamsport Home does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Williamsport Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or	Completion Date: **04/01/2025** Status: **APPROVED** Date: **02/27/2025**

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K 0293 SS=E	Continued from page 2	K 0293	proceeding. 1. The chevron was ordered on February 24, 2025, and will be placed in the corridor located closest to the Resident Room 1 by March 18, 2025. 2. A full house audit will be conducted by maintenance personnel on all exit signs to ensure that the exit access corridors have the proper illuminated exit signage by February 28, 2025. 3. The Nursing Home Administrator or designee will conduct training/education with maintenance personnel regarding the requirement of K0293 by March 7, 2025. 4. An audit on exit signs will be conducted weekly x 2 and then monthly x 2 by the Maintenance Director or designee. The results of the audit will be taken to monthly QA by the Maintenance Director for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395678	A. BLDG: 03 B. WING:	02/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WILLIAMSPORT HOME, THE STATE LICENSE NUMBER: **491902**	**1900 RAVINE ROAD** **WILLIAMSPORT, PA 17701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	(X5) COMPLETE DATE
K 0293 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to maintain exit signage in one location, affecting one of two floors. Findings include: 1. Observation on February 13, 2025, at 10:50 a.m., revealed the portion of the exit access corridor located closest to Resident Room 1 lacked illuminated exit signage. Exit interview with the Facility Administrator and the Facilities Manager on February 13, 2025, between 12:10 p.m., and 12:20 p.m., confirmed the exit signage deficiency.	K 0293		
K 0363 SS=E		K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395678	A. BLDG: 03 B. WING:	02/13/2025

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K 0363 SS=E	Continued from page 4 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 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.	K 0363	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because The Williamsport Home agrees with the allegations and citations listed on the statement of deficiencies. The Williamsport Home maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as The Williamsport Home's written credible allegation of compliance. By submitting this plan of correction, The Williamsport Home does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and The Williamsport Home reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or	Completion Date: **04/01/2025** Status: **APPROVED** Date: **02/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395678	A. BLDG: 03 B. WING:	02/13/2025

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WILLIAMSPORT HOME, THE STATE LICENSE NUMBER: **491902**	**1900 RAVINE ROAD** **WILLIAMSPORT, PA 17701**

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K 0363 SS=E	Continued from page 5 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. This REQUIREMENT is not met as evidenced by:	K 0363	proceeding. 1. The Library Room doors will be fixed to not exceed a one-eighth-inch gap by March 7, 2025. 2. A full house audit will be conducted by maintenance personnel on all corridor doors to ensure door gaps do not exceed a one-eighth inch by February 28, 2025. 3. The Nursing Home Administrator or designee will conduct training/education with maintenance personnel regarding the requirement of K0363 by March 7, 2025. 4. An audit on corridor door openings will be conducted weekly x 2 and then monthly x 2 by the Maintenance Director or designee. The results of the audit will be taken to monthly QA by the Maintenance Director for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0363 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain corridor openings in one location, affecting one of two floors. Findings include: 1. Observation on February 13, 2025, at 11:04 a.m., revealed the distance between the first floor, Library Room doors, exceeded one-eighth-inch. Exit interview with the Facility Administrator and the Facilities Manager on February 13, 2025, between 12:10 p.m., and 12:20 p.m., confirmed the corridor openings deficiency.	K 0363		

Certified End Page

WILLIAMSPORT HOME, THE

STATE LICENSE NUMBER: 491902

SURVEY EXIT DATE: 02/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY