

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/18/2012
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NAME OF PROVIDER OR SUPPLIER  RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/18/12</p> <p>Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Randolph Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. There were no smoke detectors in resident sleeping rooms.</p>	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The provider respectfully request that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 7/16/12.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>The facility has a capacity of 88 and had a census of 69 at the time of this visit.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80 for 1 of 12 hazardous areas. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient</p>	K0029	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The provider respectfully request that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 7/16/12. Based on the addendame we will close off the roll up fire door area to the kitchen, and install a new fire rated door with a magnetic hold open device for the entrance door from the dinning room. The food storage room door will be replaced by a contractor by 7/16/12.	07/16/2012	

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	<p>practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 06/18/12 at 10:15 a.m. with the administrator and maintenance supervisor, the rolling fire door protecting the opening from the kitchen to the main dining room lacked an attached inspection tag. The main dining room was open to the corridor. Based on interview on 06/18/12 and subsequent Fire Safety record review at 9:00 a.m. with the administrator and maintenance supervisor, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the kitchen's vertical rolling fire door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 17 hazardous areas, such as a combustible storage room over 50 square feet and a soiled linen room, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 38 residents who reside on the 100 Hall.</p>						

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	<p>Findings include:</p> <p>Based on observations on 06/18/12 during a tour of the facility from 9:00 a.m. to 12:50 p.m. with the administrator and maintenance supervisor, the food storage room, which measured 220 square feet and stored combustible cardboard boxes of paper supplies and cardboard boxes of food supplies, had a metal one hour fire rated door broken in the center of the door and the door failed to self close in the door frame leaving a two inch gap along the latching side of the door from the door knob to the bottom of the door in the closed position. Furthermore, the 100 Hall soiled linen room door had a one inch gap along the latching side of the door from the door knob to the bottom of the door with the door in the closed position. This was verified by the administrator and maintenance supervisor at the time of observations.</p> <p>3.1-19(b)</p>				

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 1 of 4 first shift fire drills, 1 of 4 second shift fire drills and 2 of 4 third shift fire drills were held quarterly on each shift over the past year to protect 69 of 69 residents. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on a review of the "Fire Drill Reports" with the administrator and maintenance supervisor on 06/18/12 at 9:00 a.m., there was no record of a fire drill conducted on the third shift for the fourth quarter of the year 2011 or the first shift, second shift and third shift for the fourth quarter of the year 2011. Based on an interview with the administrator on 06/18/12 at 9:35 a.m., it was stated the previous maintenance supervisor may have destroyed some of the facility's</p>	K0050	A new comprehensive program is in place to ensure all fire drills are completed and meet code requirements. We are now using a computerized maintenance management system to assist in scheduling, tracking and reporting fire drill compliance.	07/16/2012			

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	<p>documentation for fire drills and there was no documentation to indicate a fire drill was conducted for the third shift, third quarter 2011 or the first, second and third shift for the fourth quarter 2011. The missed fire drills were acknowledged by the administrator at the time of record review.</p> <p>3.1-19(b)</p>				

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observations and interview, the facility failed to ensure 4 of 84 rooms were provided with sprinkler heads free of paint. LSC 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 38 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/18/12 during a tour of the 100 Hall with the administrator and maintenance supervisor from 11:20 a.m. to 12:10 p.m., two sprinklers in resident rooms 110, 114, 115 and 113 were all covered with white paint. This was verified by the administrator and maintenance supervisor at the time of observations.</p> <p>3.1-19(b)</p>	K0062	The automatic sprinkler heads that needed to be free of corrosion, foreign materials, paint and physical damage have all been replaced to meet code.	07/16/2012