

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 12/08/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	<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: 12/08/15</p> <p>Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450</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 sprinkled except the receptionist office closet. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of</p>	K 0000	<p>The creation and submission of this plan does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review of certification of compliance on or after 1/7/16.</p>	

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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K 0025 SS=E Bldg. 01	<p>69 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three detached wooden storage buildings which were not sprinkled.</p> <p>Quality Review completed 12/10/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure penetrations caused by the passage of wire and/or conduit through 1 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or</p>	K 0025	All referenced unsealed penetrations have been repaired. Maintenance Director or Designee will monitor areas for any new unsealed areas monthly for 6 months. Date of completion will be 12/23/15.	12/23/2015

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	<p>wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 38 residents in 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 12/08/15 between 12:00 p.m. and 12:40 p.m., the 200 hall smoke barrier wall had the following unsealed penetrations.</p> <p>a) a ten inch by ten inch hole containing conduit located in the attic of the smoke barrier wall.</p> <p>b) an one inch by two inch hole containing wires located in the attic of the smoke barrier wall.</p> <p>c.) a three inch by half inch hole containing conduit located in the attic of the smoke barrier wall.</p> <p>d.) there where two half inch holes containing wires in the electrical room door frame which was located in the smoke barrier wall.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the penetrations and provided the measurements.</p>			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 45 residents in 3 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 11/30/15 at 10:11 a.m., following ceiling smoke barriers contained unsealed penetrations.</p> <p>a. in the ceiling of lobby electrical room there was an unsealed half inch penetration around a wire.</p> <p>b. in the ceiling of the closet in room 310 there were two unsealed half inch penetration around a wires and the sprinkler head.</p> <p>c. in the ceiling of the mechanical/electrical room on 300 hall there were three unsealed half inch penetration around pipes and in a pipe sleeve.</p> <p>d. in the ceiling of the sprinkler riser room there was an unsealed one inch</p>			

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K 0027 SS=E Bldg. 01	<p>penetration around the main sprinkler line.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 7 smoke barrier doors were providing a fire resistance of at least 20 minutes, and 1 of 7 smoke barrier doors were self closing. This deficient practice could affects up to 38 residents in 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 12/08/15 between 11:50 a.m. and 1:00</p>	K 0027	<p>The labels on the fire doors in the 200 hall smoke barrier door to the lobby have been cleaned and fire rating information is visible.</p> <p>The smoke barrier door to the lobby electrical will be replaced with a proper fire rated door that has a self closure device. These will be monitored monthly to ensure that the labels are visible and the self closure fire door is functioning properly by the maintenance director or designee. Date of completion</p>	01/07/2016

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K 0029 SS=E Bldg. 01	<p>p.m., the following was noted:</p> <p>a. the double set of smoke barrier doors in the 200 hall smoke barrier wall had labels that were painted over and the fire rating could not be determined.</p> <p>b. the smoke barrier door to the lobby electrical room which was located in the 200 hall smoke barrier wall did not have a label showing the fire rating of the door.</p> <p>c. the smoke barrier door to the lobby electrical room which was located in the 200 hall smoke barrier wall was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of a self closer, and could not provide documentation of the smoke doors fire rating.</p> <p>3.1-19(b)</p> <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>		will be 1/7/16		

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	<p>Based on observation and interview, the facility failed to ensure 2 of 2 corridor doors to the laundry room and 1 of 2 doors to the kitchen were provided with self closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect up to 50 residents in the main dining room, and all staff in the service hall, kitchen, and laundry room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 12/08/15 between 10:39 a.m. and 10:50 a.m., the following was noted:</p> <p>a. the clean laundry door to the laundry room did self close but failed to latch into the frame.</p> <p>b. the soiled laundry door to the laundry room was not equipped with a self closing device.</p> <p>c. the kitchen door from the dining room did self close but was only equipped with a manual dead bolt causing the door not to automatically latch into the frame.</p> <p>All of the aforementioned doors were open to the corridor. Based on interview, this was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>	K 0029	<p>The door to the laundry room has been repaired to latch into the frame.</p> <p>The door to the soiled laundry room has been equipped with a self closure.</p> <p>The kitchen door lock has been replaced and allows the door to latch into the frame. These doors will be monitored 5 times a week for 4 weeks and then monthly for 5 months to ensure they are closing properly by the maintenance director of designee. Date of completion will be 12/23/15.</p>	12/23/2015

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K 0038 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks in the facility was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by</p>	K 0038	<p>The door to the laundry room has been repaired to latch into the frame. The door to the soiled laundry room has been equipped with a self closure. The kitchen door lock has been replaced and allows the door to latch into the frame. These doors will be monitored 5 times a week for 4 weeks and then monthly for 5 months to ensure they are closing properly by the maintenance director of designee. Date of completion will be 12/23/15.</p>	01/07/2016

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K 0066 SS=D Bldg. 01	<p>manual means only. This deficient practice could affect up to 20 residents, staff and visitors in using the lobby exit in an emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 12/08/15 at 12:00 p.m., the exit door located in the lobby leading to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force four separate times. Based on interview at the time of observation, the Maintenance Director acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force four separate times.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p>			

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	<p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted for staff was maintained, and the metal container with a self-closing cover was used for an ashtray. This deficient practice was not in a resident care area but could affect all staff in the smoking area and using the employee exit.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 12/08/15 at 12:10 p.m., in the outside designated staff smoking area that was provided with a "smokers oasis" which is a metal container with a long neck used</p>	K 0066	Staff was educated on 12/14/15 that discarded smoking materials can only be disposed of in the provided appropriate container and never in a trash receptacle. This area will be monitored 5 times a week for 8 weeks, 3 times a week for 8 weeks then monthly for 2 months. Date of completion will be 12/23/15.	12/23/2015			

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K 0076 SS=E Bldg. 01	<p>for cigarette butts the following was observed:</p> <p>a. there was a trash can containing at lease 30 cigarette butts with combustible material such as empty cigarette packs and other paper trash.</p> <p>b. there was a open ash tray stand containing at least 30 cigarette butts.</p> <p>c. at least ten cigarette butts were observed on the ground in the smoking area.</p> <p>Based on interview at the time of observation, this was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure the electrical fixtures in 1 of 1 oxygen storage rooms were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for</p>	K 0076	<p>The cited electrical fixture has been raised to the appropriate height. The maintenance director or designee will monitor this monthly</p>	12/23/2015

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K 0143 SS=E Bldg. 01	<p>nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect 29 residents in the 300 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 12/08/15 at 11:30 p.m., the oxygen storage room on the 300 hall which contained large liquid oxygen storage tanks had one electrical switch on the wall 49 inches above the floor. Based on interview, this was acknowledged and measurements were given by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated,</p>		for 6 months. Date of completion will be 12/26/15.				

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K 0147 SS=D	<p>sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 21 residents in the 300 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 12/08/15 at 11:30 a.m., there were over 40 unsealed quarter inch holes in the walls of the oxygen storage/transferring room on the 300 hall which contained large liquid oxygen storage tanks. Based on interview at the time of observation, the Maintenance Director acknowledged the holes and proved the measurements.</p> <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 0143	The unsealed quarter inch holes located in the oxygen storage/transferring room on the 300 hall have been repaired. The maintenance director or designee will monitor for new holes weekly for 4 weeks then monthly for 5 months. Date of completion will be 12/23/15.	12/23/2015	

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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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
Bldg. 01	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents near the 300 hall nourishment room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 12/08/15 at 11:45 a.m., a regular light weight extension cord was plugged in and providing power for a microwave in the 300 hall nourishment room. Based on interview, this was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>	K 0147	<p>The regular light weight extension cord has been removed in the 300 Hall nourishment room. The maintenance director or designee will monitor 5 times a week for 4 weeks, weekly for 4 weeks then monthly for 4 months. Date of completion will be 12/23/15.</p>	12/23/2015			