STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 7, 8, 9, 10, and 11, 2023 Facility number: 000136 Provider number: 155231 AIM number: 100275450 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 4 Medicaid: 34 Other: 12 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 18, 2023.	F 0000	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. The creation and submission of this Plan of Correction (POC) 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 this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review on, or after 09/04/2023.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Ahlbrand	Executive Director	09/12/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility staff failed to provide documentation to assure continuity of care for a resident's emergency transfer to an acute care hospital for 2 of 3 residents reviewed for hospitalization. (Resident	F 0622	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #10 and #39's transfer	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	10 and 39) Findings include: 1. Resident 10's clinical record was reviewed on 8/10/23 at 12:13 p.m. Diagnoses included atrial fibrillation, malnutrition, muscle wasting and atrophy, and history of breast cancer. A nurses note, dated 6/30/23 at 1:35 p.m., indicated the nurse went to Resident 10's room in preparation of a port flush and when the dressing was removed from the resident's right chest area, the port area was open and the port was visible. The physician was notified and ordered the resident be sent to the emergency room. The electronic health record (EHR) lacked information being sent with the resident regarding the reason for transfer or health status of the resident. During an interview on 8/11/23 at 2:54 p.m., the DON indicated Resident 10's medical record lacked transfer information for the emergency room visit on 6/30/23. The staff were to send a completed transfer form with the resident when sending out of the facility. 2. Resident 39's clinical record was reviewed on 8/9/23 at 2:54 p.m. Diagnoses included chronic obstructive pulmonary disease, history of stroke, and anxiety disorder. A nurses note, dated 6/30/23 at 7:47 p.m., indicated Resident 39 had complained of chest pain and pain around her waist, and was sent to the emergency room for further evaluation. The EHR lacked information being sent with the		form was completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents being discharged to acute care hospital have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Director of Nursing will educate all nurses on requirements for documentation that must be provided to all residents during a transfer or discharge from the facility to assure continuity of care for a resident's emergency transfer to acute care hospital. How the corrective action will be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will audit electronic health records for residents transferred to acute care hospital to ensure staff provide proper documentation for emergency transfer weekly for 4 weeks, monthly for 3 months and then quarterly until deficient practice no longer occurs. Additionally, the QAPI Committee will monitor/review monthly for a total of six (6) months or until 100% compliance is achieved for three (3) consecutive months. The QAPI Committee will identify any trends or patterns and make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	resident regarding the reason for transfer or health status of resident. During an interview on 8/11/23 at 10:54 a.m., the DON indicated a transfer form for Resident 39 was opened in the EHR, but was not completed and sent with the resident to the emergency room. The transfer form should be completed and sent with the resident when being sent outside the facility. Review of a current policy, dated 4/29/22, titled "Transfer and Discharge Requirements Policy," provided by the DON on 8/11/23 at 12:35 p.m., indicated the following: "...8. The nursing staff, designee will send the following documents with the resident at the time of the transfer and any other pertinent information to perform care of resident...Resident Transfer Form/CCD...Most recent labs/xrays...." 3.1-12(a)(3)		recommendations to revise the plan as indicated.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure a Discharge Minimum Data Set (MDS) assessment was completed following a resident's discharge for 1 of 1 residents reviewed for Resident Assessments. (Residents 50) Finding includes: The record for Resident 50 was reviewed on 8/9/23 at 3:12 p.m. Diagnoses included metobolic encephalopathy, malnutrition, and adult failure to	F 0638	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #50 immediately had discharge MDS assessment completed and transmitted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	thrive. The resident was admitted to the facility on 2/8/23 for a Medicare Part A rehabilitation stay following treatment at an acute care hospital stay. The resident was discharged to the community on 5/21/23. The clinical record lacked a Discharge MDS assessment. During an interview on 8/10/23 at 2:28 p.m., the MDS Coordinator indicated the resident discharged on 5/21/23 and she did her end of care assessment, but she failed to add the Discharge Assessment. She used the Resident Assessment Instrument manual for her policies and procedures. 3.1-31(d)		action will be taken? Residents discharged have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? MDS coordinator was educated on RAI procedures for discharge assessment and end PPS assessments and the difference between the two. How the corrective action will be monitored to ensure the deficient practice will not recur? Director of Nursing or designee will audit discharge MDS assessments weekly for 4 weeks and then monthly ongoing until deficient practice longer occurs. Additionally, the QAPI Committee will monitor/review monthly for a total of six (6) months or until 100% compliance is achieved for three (3) consecutive months. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	Based on observation, interview, and record review, the facility failed to implement a care plan to prevent skin breakdown for 1 of 3 residents reviewed for implementation of skin care care plans (Resident 21). Findings include: Resident 21's clinical record was reviewed on 8/9/23 at 2:17 p.m. Current diagnoses included dementia, diabetes mellitus, and hypertension. The resident had a current physician's order, which originated 5/7/21, to apply knee wedge between bilateral knees daily to prevent redness, even when wearing pants. The resident had a current care plan problem/ need, which originated 5/7/21, regarding the risk for skin break down due to multiple factors including wearing shorts most of the the time and his knees touching and rubbing. This need was reviewed on 8/8/23 and continued as current. Approaches to this problem included apply knee pad daily. During observation on the following dates and times, Resident 21 was seated in his wheel chair without a knee wedge in place: a. On 8/08/23 at 10:43 a.m., the resident was in the dining/activity area in a wheelchair. He was wearing shorts. The wedge was not present. His knees were touching. b. On 8/8/23 at 11:20 a.m., the resident was wheeling in hallway. He was wearing shorts. His legs were bare. There was no knee wedge in place. His knees touched and rubbed against each other as he wheeled him self about. c. On 8/09/23 at 1:57 p.m., the resident was in a	F 0656	Immediate action taken for those residents identified. Resident #21 has been re-evaluated for interventions to prevent skin breakdown. The care plan and resident profile have been updated to reflect these interventions. How the facility identified other residents. Any resident with a potential for alteration in skin integrity has the potential to be affected by the alleged deficient practice. A facility wide audit was conducted for all residents who currently have interventions to prevent skin breakdown. No other findings were identified at this time. Measures put into place/System changes: Direct Care staff were re-educated on ensuring interventions for skin breakdown are followed per the plan of care. How the corrective action will be monitored: The DON or designee will complete a random audit of 5 residents with interventions to prevent skin breakdown to ensure these interventions are implemented 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then 1 day a week x 4 weeks, then once a month for 3 months to ensure substantial compliance. The results of these audits will be reviewed in the Quality Assurance	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	wheelchair in the dining/activity room. He was wearing shorts. His knees were bare. His knees were touching. There was no knee wedge in place. d. On 8/10/23 at 12:25 p.m., the resident was in a wheelchair at the dining room table. There was no knee wedge in place. e. On 8/11/23 at 10:24 a.m., the resident was in his wheelchair in the dining/activity room. He did not have a knee wedge in place. During an interview on 8/11/23 at 10:37 a.m., RN 9 indicated Resident 21 did have a current order for a knee wedge. She did not know why it was not in place. She inspected the resident's room and indicated the device may be in the laundry. She left the unit and returned in approximately 8 minutes with a knee wedge. During an interview on 8/11/23 at 10:48 a.m., CNA 8 indicated staff were aware of resident needs for assistance and devices by looking in the computer or reviewing the "cheat sheet". The CNA then displayed the cheat sheet. The displayed cheat sheet did not indicate Resident 21 used a wedge cushion between his knees. A current, 5/19/21, facility policy titled "Skin Condition Policy", provided by the Director of Nursing on 8/11/23 at 11:24 a.m., indicated the following: "...Potential resident interventions to prevent skin impairment/assist in healing may include: ...Pressure reduction cushion for seating surfaces Individualized repositioning...." 3.1-35(g)(2)		Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
Bldg. 00	On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to act upon a pharmacy recommendation to ensure medication was administered safely for 1 of 5 residents reviewed for unnecessary medications. (Resident 39) Finding includes: Resident 39's record was reviewed on 8/9/23 at 2:07 p.m. Diagnoses included chronic obstructive pulmonary disease, history of stroke, and anxiety disorder. A current health care plan, dated 9/2/22, indicated the resident was at risk for discomfort and impaired mobility related to fibromyalgia, osteoporosis, history of fracture, and osteoarthritis. Interventions included administer medications as ordered and supplements to support bone strength. A pharmacy recommendation, dated 3/7/23, indicated to add special instructions for a physician's order, dated 1/10/23, for alendronate (to treat osteoporosis) 70 mg (milligram) weekly, to drink with at least four ounces of water and to remain upright for 30 minutes after dose to minimize risk of esophageal damage. Review of order in the electronic health record lacked these instructions. During an interview on 8/10/23 at 11:04 a.m., LPN 3 indicated there were no special instructions for the administration of Resident 39's alendronate. He was unaware the resident should remain upright for 30 minutes after administration. He had administered the medications many times to the	F 0756	Immediate action taken for those residents identified. Resident # 39 pharmacy recommendations were updated in the EMR for special instructions related to medication administration. How the facility identified other residents. Any resident with pharmacy recommendations has the potential to be affected by the alleged deficient practice. A facility wide audit was conducted for all residents with pharmacy recommendations for the past 3 months to ensure all were updated in the EMR. No other findings were identified at this time. Measures put into place/System changes: All pharmacy recommendations will be monitored and carried out by DON or designee. How the corrective action will be monitored: The DON or designee will complete a random audit of 5 residents with pharmacy recommendations to ensure these recommendations are completed once a month for 6 months to ensure substantial compliance. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	resident. During an interview on 8/10/23 at 3:53 p.m., the DON indicated the special instructions recommended by the pharmacist were missed and had not been added to the physician's order. Review of a current policy, revised 7/2012, titled, "Pharmacy Services," provided by the DON on 8/11/23 at 11:19 a.m., indicated "Policy: The Consultant Pharmacy works with the facility to establish a system whereby the Consultant Pharmacist observations and recommendations regarding residents medication therapy are communicated to those with authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion." 3.1-25(i)		until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to initiate a gradual dose reduction (GDR) of a psychoactive medication, or evaluate for contraindication of a GDR, for 1 of 5 residents reviewed for unnecessary medications. (Resident 20) Finding includes:	F 0758	1. Immediate action taken for those residents identified. Resident 20 has been reviewed by the MD for the GDR of duloxetine. How the facility identified other residents. Any resident who is prescribed medications which require a gradual dose reduction has the	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	Resident 20's clinical record was reviewed on 8/10/23 at 4:24 p.m. Diagnoses included COVID-19 acute respiratory disease, chronic obstructive pulmonary disease, and other specified depressive episodes. A current medication, dated 8/9/23, included duloxetine (to treat depression) 60 mg (milligrams) delayed release twice daily. A quarterly Minimum Data Set (MDS) assessment, dated 7/31/23, indicated the resident was cognitively intact. She required limited assistance from staff for activities of daily living. She received anti-depressant medications seven out of seven days during the assessment period. A current care plan for other specified depressive episodes, dated 4/1/21, indicated the resident displayed sadness, tiredness, moving slower than normal, and not wanting to do anything. Interventions included the following: document signs/symptoms of depression, approaches used, resident responses, observe for signs/symptoms of depression, and make the provider aware. A Nurse's Note, dated 4/12/23, indicated the interdisciplinary team met and discussed the medication regimen. The Physician was to review the resident for a gradual dose reduction of duloxetine 60 mg daily to 40 mg daily. Review of the pharmacy recommendation "Note To Attending Physician/Prescriber," printed 4/11/23, indicated the duloxetine 60 mg once daily was recommended to be decreased to duloxetine 40 mg once daily. The Prescriber response section of the form was blank. The clinical record lacked a reduction of the		potential to be affected by the alleged deficient practice. A facility wide audit was conducted for all residents who were evaluated for a gradual dose reduction for the past 3 months to ensure all were completed. No other findings were identified at this time. Measures put into place/System changes: All gradual dose reductions will be monitored and carried out by DON or designee. The DON or designee will complete a random audit of 5 residents with gradual dose reductions to ensure these recommendations are completed once a month for 6 months to ensure substantial compliance. How the corrective action will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	duloxetine. During an interview on 8/11/23 at 11:41 a.m., the ADON indicated the pharmacy recommendations for gradual drug reductions were usually placed in the provider's inbox or in the physician folder in the ADON office for the provider to review. She was uncertain of the time frame in which the facility required the gradual dose reductions to be completed. During an interview on 8/11/23 at 11:53 a.m., RN 4 indicated the resident's representative thought it was not a good idea to decrease the antidepressant medication. The Physician did not attempt to decrease the medication. RN 4 indicated the facility was unable to provide a statement of contraindication. The Physician statement of contraindication should have been documented in the resident's clinical record. A current, undated facility policy, titled "MEDICATION MONITORING," provided by the DON on 8/11/23 at 11:55 a.m., indicated the following: "...Policy: Residents who receive psychoactive/psychopharmacological medications are monitored... Every effort is made to ensure that residents receiving these medications obtain the maximum benefit with the minimum of unwanted side effects. Procedure... 7. For deviation from the recommended dosage and dosage reduction criteria, the clinical record contains evidence to support justification for use of a medication not meeting the dosage criteria but considered clinically appropriate. Examples include: a. A medical or psychiatric consultation or evaluation supporting the prescriber's conclusion...." 3.1-48(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to assure an insulin pen, stored in the medication cart, was destroyed in a timely manner for 1 of 3 medication carts observed for medication storage. (100 Front Hall) Finding includes: During a medication cart observation on 8/11/23 at 2:28 p.m., on the 100 Front Hall cart with LPN 5, a Humalog Kwikpen was observed with an open	F 0761	1. Immediate action taken for those residents identified. The outdated insulin pen was disposed of immediately. How the facility identified other residents. Any resident who receives insulin injections has the potential to be affected by the alleged deficient practice. A facility wide audit was	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	date of 6/28/23. During an interview at the time of the observation, LPN 5 indicated the pen should have been replaced after 30 days. Review of a current policy, undated, titled, "Medication Administration," provided by the DON on 8/11/23 at 3:05 p.m., indicated the following: "...Procedure:...10...Expiration dating not specifically referenced in the manufacturer's package insert should not exceed 30 days...." 3.1-25(o)		conducted on all medication carts to ensure all insulin pens were dated and not expired. No other findings were identified at this time. 3. Measures put into place/System changes: Re-education was provided to all licensed staff with emphasis on removing opened insulin pens after expiration date per pharmacy guidelines. Medication carts will be audited 5 times weekly x four weeks, then 3 times a week x four weeks, then one time a week x four weeks, then monthly x 3 months to ensure that all insulin pens are dated and not expired. How the corrective action will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review , the facility failed to serve attractive, palatable food for 1 of 3 residents whose representative was interviewed interviewed (Resident 17), for 2 of 5 residents interviewed during the screening process (residents 4 and 7), for 2 of 2 residents who requested interviews (Residents 15 and 44), and 5 of 5 residents interviewed during meal service (Residents 55, 7, 15 and 44). This deficient practice had the potential to impact the 49 of 49 residents who ate meals prepared in the facility kitchen. Findings include: The 6/15/23 Food Committee Meeting notes indicated the following: a. Eggs were burnt when served. b. Food should be hotter. Food was not hot enough. c. Meat was too tough and couldn't be cut. The 5/21/23 Food Committee Meeting notes indicated the following: a. The residents desired no spicy foods. b. The residents wanted the vegetables to not be mushy. c. The residents would like more food to be made from scratch. During an interview on 8/08/23 at 9:40 a.m., Resident 17's representative indicated the food was not good. The resident didn't eat much because he didn't like the food.	F 0804	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Dietary manager and dietary staff were inserviced on importance of preparing foods with nutritive value, flavor and appearance as well as providing palatable, attractive foods at a safe and appetizing temperature. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Dietician provided education to all dietary staff on importance of providing foods by methods that conserve nutritive value, flavor, and appearance, as well as reviewing required food temperature log. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Executive Director or	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	During an interview on 8/8/23 at 2:39 p.m., Resident 4 indicated the food was not good. It was not flavorful and he frequently did not enjoy the meals. During an interview on 8/8/23 at 2:46 p.m., Resident 7 indicated the food was not good. Often times, she did not like the meals that were served. On 08/09/23 at 11:14 a.m., two residents asked to speak with a surveyor. During an interview at that time, Residents 15 and 44 indicated food tasted bad, meat was either not done, or hard and overcooked. Food was always cold. Staff are aware and the situation had not improved. During dining observation on 8/10/23 at 12:50 p.m., Resident 55 indicated the broccoli was very spicy and overcooked. He was unable to eat it. During dining observation on 8/10/23 at 12:50 p.m., Resident 7 was visibly upset during the observation. She indicated her hamburger was burned and inedible. Her gluten free bread had been served cold when she had requested it to be toasted. The hamburger was observed to be very dark brown, and appeared dry in the center when the resident cut into it with difficulty. During a dining observation on 8/10/23 at 1:03 p.m., Resident 10 was laying in her bed with a tray on her overbed table. The resident had eaten her ice cream. She indicated she was unable to eat her hamburger due to it being burnt and too dry to eat. The broccoli was mushy, and she was not eating the broccoli either. The hamburger was observed to be dark brown in color and dry in appearance. She had eaten her ice cream and a few potatoes. This happened often, and she didn't		designee will audit food appearance and flavor for each diet type one time per day for 30 days, once per week for 4 weeks and then monthly ongoing until substantial compliance. The Executive Director or designee will audit food temperature logs will be audited daily for 30 days, weekly for 4 weeks and then monthly ongoing until deficient practice no longer occurs. Additionally, the QAPI Committee will monitor/review monthly for a total of six (6) months or until 100% compliance is achieved for three (3) consecutive months. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	care for the food. She often only drank her protein drink. During a dining observation on 8/10/23 at 12:22 p.m., two residents were served meal trays while sitting in the common area on the 100 unit. Residents 15 and 44 were trying to determine what the food was on their plates. They indicated they could not identify what the food was. The tray contained tan chopped meat with tan gravy, and pale white and green mushy broccoli. Food temperature logs were reviewed for 7/29/23 through 8/10/23, and the following concerns were identified: a. 7/29/23- no temperatures were recorded for lunch. b. No food temperature logs were completed for 7/30/23, 7/31/23, 8/1/23, 8/2/23, or 8/3/23. c. 8/8/23- no temperatures were recorded for lunch or dinner. d. 8/9/23-no temperatures were recorded for dinner. During a meal service observation on 8/10/23 at 11:52 a.m., foods were being placed on residents plates before all temperatures of every food item had been taken and recorded. During an interview on 8/10/23 at 12:03 p.m., the Dietary Manager indicated he had identified an issue with obtaining and recording food temperatures and had been working with staff to correct this concern. A test tray with a mechanical soft diet was obtained and tasted on 8/10/23 at 12:35 p.m. The following concerns were identified:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	a. The bread was placed on top of the food on the tray, resulting in the bread being wet with the gray juice of the broccoli. b. The chopped fish was covered in a gravy that was very salty and unpleasant to taste. c. The broccoli was pale, light green and white in appearance. It looked very soft. It could be mashed with the back of a spoon and then reassembled to the texture of mashed potatoes. The broccoli was very spicy and tasted as if red pepper flakes had been added. The Administrator and Registered dietitian obtained and tasted a mechanical soft meal tray on 8/10/23 at 12:48 p.m. They both indicated following concerns: a. The gravy, which was topping the fish, was very salty and not enjoyable. b. The broccoli was very spicy and too soft in texture. c. The Administrator was able to smash the broccoli with the back of a spoon. He indicated the texture was not appealing. During and interview on 8/11/23 at 2:00 p.m., the DON indicated 49 of the facilities 50 residents ate food orally. All 49 ate meals that were prepared and served from the facility kitchen on a daily basis. 3.1-21(a)(1)			
F 0847 SS=E Bldg. 00	483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	§483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).			
	Based on interview and record review, the facility failed to ensure residents and/or their representative were not required to sign an agreement for binding arbitration as a requirement for admission to the facility for 3 of 3 residents review for binding arbitration agreements (Resident 25, 14 and 46). This deficient practice had the potential to impact 40 of 40 residents admitted to the facility since 12/02/2022. Findings include: During an interview conducted in conjunction with the entrance conference on 8/7/23 at 10:00 a.m., the Administrator indicated the facility did have "binding arbitration agreements." During an interview on 8/08/23 at 8:43 a.m. the Administrator indicated the arbitration agreements were signed during the admission process and was in section 8 of the admission packet. He indicated the residents/representatives were not provided any additional information regarding the arbitration agreement other than what was in section 8 of the admission packet. 1. Resident 25's, 7/13/22, Admission Agreement indicated section 8.7 addressed an agreement "not to elect a jury trial of any fact trialable by a jury." The form did not indicate signing the binding arbitration agreement was voluntary. The Admission Agreement did not have any section allowing the signer to decline the binding arbitration agreement.	F 0847	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Marketing Director was educated on understanding requirements for residents and or representatives entering into binding arbitration agreements. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents were found to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Changes were made to the facility arbitration agreement to allow residents or representatives to agree or decline entering into a binding arbitration agreement. How the corrective action will be monitored to ensure the deficient practice will not recur? Executive Director or designee will audit new resident arbitration agreements weekly for 4 weeks and then monthly ongoing until deficient practice no longer occurs. Additionally, the QAPI	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	2. Resident 14's, 5/31/22, Admission Agreement indicated section 8.7 addressed an agreement "not to elect a jury trial of any fact trialable by a jury." The form did not indicate signing the binding arbitration agreement was voluntary. The Admission Agreement did not have any section allowing the signer to decline the binding arbitration agreement. 3. Resident 46's, 3/6/23, Admission Agreement indicated section 8.7 addressed an agreement "not to elect a jury trial of any fact trialable by a jury." The form did not indicate signing the binding arbitration agreement was voluntary. The Admission Agreement did not have any section allowing the signer to decline the binding arbitration agreement. During an interview on 8/11/23 at 2:58 p.m., the Admission Coordinator indicated the following: a. Binding arbitration information was included in the facility's admission packet- parties signed at the bottom of page 8. b. There was no option to decline the arbitration agreement. c. During the admission process, section 8.7 of the admission agreement was read to the resident/family to explain binding arbitration. d. He was unaware of any declination form or process. e. "From my understanding based on the Admission Agreement every one must agree to the arbitration agreement." f. He began his employment at the end of November 2022. For every Admission Agreement completed since 12/1/22, he has had the person completing the admission sign the arbitration section of the form.		Committee will monitor/review monthly for a total of six (6) months or until 100% compliance is achieved for three (3) consecutive months. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	During an interview on 8/11/23 at 3:05 p.m., the Administrator indicated the following: a. The facility practiced binding arbitration. b. The Admission Agreement paperwork did not allow the signer to decline. c. He did not know if there was an option to decline. d. No where in the Admission Agreement, or at any time during the admission process, did the facility inform the party that binding arbitration was voluntary. e. Although the facility has had residents/families sign agreements regarding Binding Arbitration, the facility had not entered any action of Binding Arbitration since 9/17/19. A current facility "Admit/Discharge Report: 9/17/19 to 8/31/23", provided by the Business Office Manager on 8/8/23 at 8:58 a.m., indicated 40 residents had been admitted to the facility since 12/1/22. During an interview on 8/11/23 at 4:57 p.m., the Administrator indicated the facility did not have a policy regarding binding arbitration. The facility's current "Admission Agreement", provided as part of the admission packet following the entrance conference on 8/7/23, indicated the following: "...Section 8:7 You agree not to elect a trial by jury of any fact trialable by jury, and you wave any rights to a trial by jury fully to that extent that any such right now or hereafter exists with regards to this Agreement or any matter arising out of the Resident's care at the Community. This waiver of right to trail by jury is given knowingly and voluntarily by you, and is intended to encompass each instance and each			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	issue as to which a trial by jury would otherwise apply. This subsection does not apply to Care Claims...."			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	A. Based on observation, interview, and record review, the facility failed to ensure infection prevention and control strategies were utilized for transmission based precautions to prevent and/or	F 0880	. Immediate action taken for those residents identified. All glucometers were cleaned and disinfected per manufacturer's	09/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	contain the spread of COVID-19 for 3 of 5 residents reviewed for infection control. (Residents 205, 20, and 8) B. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines for glucometer disinfection and failed to implement measures to prevent cross contamination during a random glucometer observation. Findings include: A. During an interview on 8/7/23 at 10:01 a.m., the DON indicated the facility was currently in a COVID-19 outbreak, with three COVID -19 positive residents in transmission based precautions. During an observation on 8/7/23 at 12:35 p.m., the following residents on the 100 unit were in "Red Zone" transmission based precautions: 205, 20, and 8. A sign was on the doors that indicated the following personal protective equipment was required: N95 (respirator facemask), eye protection (faceshield or goggles), gown, gloves, and frequent hand hygiene. Faceshield or goggles must cover the sides and tops and bottoms of eyes with no gaps for all health care providers regardless of vaccination status. A.1. During an observation on 8/7/23 at 12:38 p.m., CNA 13 wore an N95 mask and regular eye glasses. Gaps remained around CNA 13's regular eye glasses. She donned a gown and gloves and entered Resident 205's contact droplet isolation room with the resident's meal tray. CNA 13 delivered the meal to the resident's bedside. CNA 13 did not don a faceshield or goggles to deliver the resident's meal tray.		guidelines immediately. How the facility identified other residents. Any resident who receives blood glucose checks has the potential to be affected by the alleged deficient practice. All residents who receive blood glucose checks have been provided with their own machine. 3. Measures put into place/System changes: All licensed staff have been re-educated on the manufactures guidelines of completing disinfection and prevention of cross contamination. DON or designee will audit 3 residents five times a week x 4 weeks, then 3 residents 3 times a week x 4 weeks, then once a week x 4 weeks, then monthly x 3 months to ensure resident has appropriately assigned glucometer. How the corrective action will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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

Resident 205's clinical record was reviewed on 8/10/23 at 4:57 p.m. Diagnoses included chronic obstructive pulmonary disease, solitary pulmonary nodule, and COVID-19 acute respiratory disease.

A current order, dated 8/2/23, indicated the resident was in contact/droplet isolation for 10 days.

An admission MDS (Minimum Data Set) assessment, dated 8/2/23 indicated the resident was cognitively intact. The resident required extensive assistance from staff for bed mobility, transfers, dressing, and toileting. She required supervision for eating.

A current care plan for active COVID-19 disease, dated 8/2/23, indicated the resident was at risk for significant complications. Interventions included COVID communicate and education to include the resident, resident representative, family members, friends and etc, related to associated risks and complications and droplet precaution isolation in a single room with all meals and services in room.

A Nurse's Note, dated 8/7/23 at 10:28 a.m., indicated Resident 205 was COVID -19 positive and in droplet isolation, with all meals and services provided in the resident's room.

A Nurse's Note, dated 8/8/23 at 12:31 a.m., indicated the resident remained in COVID-19 positive isolation precautions.

A.2. During an observation on 8/7/23 at 12:44 p.m., CNA 13 wore an N95 mask with regular eye glasses on and gaps noted around the top, bottom and sides of the eyes. She donned a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	gown and gloves and entered Resident 20's "Red Zone" isolation room to deliver the resident's meal tray to her in bed. CNA 13 delivered the meal tray without a faceshield or goggles as indicated on the sign affixed to the door. During an observation on 8/10/23 at 12:37 p.m., CNA 14 wore an N95 with only one of the strap secured behind her head. The other strap hung under her chin. She lacked a face shield or goggles. CNA 14 donned a gown and gloves, then entered Resident 20's contact/droplet isolation room to deliver the resident's meal tray. The "Red Zone" isolation sign remained in place on the resident's door. Resident 20's clinical record was reviewed on 8/10/23 at 4:24 p.m. Diagnoses included COVID-19 acute respiratory disease and chronic obstructive pulmonary disease. A current order, dated 7/31/23, indicated Resident 20 was in contact/droplet isolation for ten days. A quarterly MDS assessment, dated 7/31/23, indicated the resident was cognitively intact. She required limited assistance from staff for activities of daily living. A current care plan for active COVID-19 disease, dated 7/31/23, indicated the resident was at risk for significant complications. Interventions included COVID-19 related communication and education to include the resident, resident representative, family members, friends and etc, related to associated risks and complications and droplet precaution isolation in a single room with all meals and services in room. A Nurse's Note, dated 7/31/23 at 3:20 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	indicated Resident 20 was in droplet precautions due to COVID. The resident and staff were aware of restrictions and proper use of personal protective equipment. A.3. During an observation on 8/10/23 at 12:32 p.m., CNA 14 wore an N95 with only one of the strap secured behind her head. The other strap hung under her chin. She lacked a face shield or goggles. CNA 14 donned a gown and gloves, then entered Resident 8's contact/droplet isolation room to deliver the resident's meal tray. The "Red Zone" isolation sign remained in place on the resident's door. Resident 8's clinical record was reviewed on 8/10/23 at 4:46 p.m. Diagnosed included chronic combined systolic and diastolic congestive heart failure and COVID-19 acute respiratory disease. A current order, dated 8/2/23, indicated Resident 8 was in contact/droplet isolation for ten days. A quarterly MDS assessment, dated 7/6/23, indicated the resident was cognitively intact. The resident required extensive assistance from staff for bed mobility, transfers, and toileting. He required supervision for eating. A current care plan for active COVID-19 disease, dated 8/2/23, indicated the resident was at risk for significant complications. Interventions included COVID communicate and education to include the resident, resident representative, family members, friends and etc, related to associated risks and complications and droplet precaution isolation in a single room with all meals and services in room. A Nurse's Note, dated 8/2/23 at 11:59 a.m., indicated the resident tested positive for COVID			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	on 8/2/23. The resident will remain in contact/droplet isolation due to high transmission. A Nurse's Note, dated 8/10/23 at 3:05 p.m., indicated Resident 8 remained in transmission based precautions due to COVID-19. During an interview on 8/10/23 at 12:42 p.m., CNA 14 indicated regular eye glasses did not cover the gaps around one's eyes and were not adequate personal protective equipment. The facility required a faceshield or goggles for eye protection to enter red zone isolation rooms. N95 respirator masks were required with both straps secured prior to entry into a red zone isolation room. She had not secured both N95 straps around her head prior to the delivery of Resident 8 and Resident 20's meal delivery on 8/10/23. During an interview on 8/10/23 at 12:50 p.m., LPN 5 indicated the N95 respirator mask must have both straps secured around the head for it to be worn correctly for personal protective equipment. During an interview on 8/11/23 at 3:40 p.m., RN 4 indicated the facility required the following personal protective equipment prior to entering a COVID positive isolation room: an N95 secured around the head with both straps, faceshield or goggles, gown, and gloves. Regular eye glasses were not approved as eye protection in "Red Zone" isolation. B. During a glucometer observation on 8/10/23 at 12:08 p.m., LPN 5 took the glucometer, test strip vial, and a lancet out of the medication cart. She took them into Resident 30's room and placed all of the items directly on the resident overbed table without a barrier. She donned gloves, obtained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	the resident's blood glucose, doffed gloves, then exited the resident's room after she picked up the items off of the overbed table. Hand hygiene was not performed. She placed the contaminated test strip bottle and glucometer directly onto the medication cart without a barrier. Gloves were donned and the glucometer was picked up, wiped with a Clorox wipe for 30 seconds, then placed back on the contaminated cart for 15 seconds without a barrier. She doffed her gloves and got her keys out of her scrub pocket. Without performing hand hygiene, she picked up the wet glucometer and put it in the top drawer of the medication cart along with the contaminated bottle of test strips and shut the drawer. During an interview, at the time of the observation, LPN 5 indicated each resident did not have their own glucometer. Other residents had their blood glucose tested by the same glucometer. During an interview on 8/11/23 at 3:40 p.m., RN 4 indicated she was the Infection Preventionist. The glucometers were to be cleaned with Clorox wipes with a contact time of two minutes, or until it was dry. She was uncertain if the glucometer needed to remain wet with the disinfectant for the entire two minutes. She stated, "They just wipe them with the Clorox wipes between residents." The glucometer should not be placed back into the medication cart while it remained wet with the disinfectant. Items from the medication cart should not have been placed on a resident's overbed table without a barrier and put back into the medication cart contaminated. Management staff were required to monitor staff for adherence to proper infection prevention and control practices. Two residents had their blood glucose tested with the glucometer used during the glucometer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RANDOLPH NURSING HOME	701 S OAK ST WINCHESTER, IN 47394

(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
	observation and six resident received medications from the medication cart in which the contaminated glucometer was stored. A current facility policy, dated 2/3/22, titled "COVID-19 Infection Control Plan," provided by RN 4 on 8/11/23 at 4:28 p.m., indicated the following: "...Purpose: To prevent and reduce the risk of transmission of the COVID-19 infection... To assist communities with prevention, testing, responses to exposures and positive staff/residents., wearing appropriate personal protective equipment, and visitors. Policy: ...Communities will follow at minimum The Center for Disease Control and Prevention [CDC] recommendations regarding Covid-19 when caring for residents in our communities... Outbreak Plan... Resident will be... placed in Transmission Based Precautions...." A current, undated document, titled "Glucometer Cleaning Instructions," provided by RN 4 on 8/11/23 at 4:28 p.m., indicated the following: "...Cleaning/Disinfecting Equipment... Perform hand hygiene before handling the meter, then don gloves. Use PDI Super Sani-Cloth Germicidal Disposable Wipes to wipe down Glucometer, then allow 2 minute wet time... This will be performed after each use of a glucometer.... 3.1-18(b)(2) 3.1-18(l)			