STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/29/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/23 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 At this Emergency Preparedness survey, Randolph Nursing Home was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 82 certified beds. At the time of the survey, the census was 49. Quality Review completed on 08/31/23	E 0000	It is the practice of this provider to ensure federal participation requirements for nursing homes participating in Medicare and/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 any violation of regulation(s). This provider respectfully requests 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 (PSR) on, or after 09/22/2023.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Ahlbrand	Executive Director	09/15/2023

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain	E 0025	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Mutual Aid Agreement with other	09/22/2023

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	the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Executive Director and Director of Facilities Maintenance on 08/29/23 between 10:30 a.m. and 1:07 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the agreements were more than 3 years old. Based on an interview during records review, the Executive Director stated he was unsure if the agreements were still in force and he would make sure to revisit the mutual aid and transfer agreements the facility currently has. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present.		LTC facilities and other providers were immediately reviewed and updated. **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?** Executive Director will review emergency preparedness policies and procedures are reviewed annually to ensure arrangements with LTC facilities and other providers to receive residents in the event of limitations or cessation of operation to maintain the continuity of services to LTC residents. **How the corrective action will be monitored to ensure the deficient practice will not recur?** Executive Director of designee will audit emergency preparedness policies and procedures on an annual basis to ensure the alleged deficient practice no longer occurs. Audit results will be reviewed during monthly Safety/QAPI meetings for compliance or need for additional actions taken.	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/23 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 At this Life Safety Code survey, Randolph Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinkled. 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 82 and had a census of 49 at the time of this visit. 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. Quality Review completed on 08/31/23	K 0000	It is the practice of this provider to ensure federal participation requirements for nursing homes participating in Medicare and/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 any violation of regulation(s). This provider respectfully requests 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 (PSR) on, or after 09/22/2023.	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 4 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 15 residents in the facility. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., in the corridor near Resident Room # 116, a Personal Protective Equipment (PPE) cart was in use but not equipped	K 0211	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The PPE cart that was near Resident Room #116 was immediately removed from the hallway. **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 on the 100 hall 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?** All PPE carts have been replaced with carts that have wheels to ensure they can be moved in the event of an emergency. **How the corrective action will be monitored to ensure the deficient practice will not recur?**	09/22/2023

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	with wheels to allow the cart to be moved out of the halls during an emergency. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 3.1-19(b)		Director of Nursing or designee will audit the alleged deficiency on a weekly basis for four (4) weeks and then monthly ongoing or until substantial compliance is reached. The results of the audit will be reviewed monthly during Safety/QAPI meetings to ensure compliance or the need for changes.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the			

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	building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through the Main Entrance exit was readily accessible for residents without a clinical diagnosis requiring	K 0222	**What corrective action will be accomplished for those residents found to have been affected by the deficient**	09/22/2023

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	specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25, staff and visitors if needing to exit the facility. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the Main Entrance exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was concealed behind a "flapper" and required special knowledge of how to figure out where the code was being hidden. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 3.1-19(b)		**practice?** The door code protocol at the Main Entrance was immediately changed to a clear code for exit of the facility. **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?** Main Entrance door code has been made readily accessible for residents without a clinical diagnosis requiring specialized security measures. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Executive Director or designee will audit the alleged deficiency on a daily basis for seven (7) days, a weekly basis for three (3) weeks and then monthly ongoing or until substantial compliance is reached. The results of the audit will be reviewed monthly during Safety/QAPI meetings to ensure compliance or the need for changes.	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

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Bldg. 01	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper. This deficient practice could affect staff and up to 20 residents' staff and visitors. Findings include:	K 0321	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The popcorn machine found in the Activity room was immediately	09/22/2023

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	Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., a hot oil popcorn popper was being stored in the activity area. When asked where the machine was used the Director of Facilities Maintenance stated it was used "right here." The aforementioned area is open to the corridor and did not have a door with a self-closing device installed. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 2. Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 2 staff in the activities room. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the Activities Room, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, decorations and cardboard boxes. The corridor door to this area was did not self-close and latch into the door frame. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present.		placed in a proper location with limited access and a door with a self-closing device. **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 inside the Activity room 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?** The popcorn machine will be stored in a proper location with limited access and a door with a self-closing device. Additionally, the popcorn machine will be operated outdoors to avoid any potentially-combustible items. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Executive Director or designee will audit the storage and use of the popcorn machineon a weekly basis for four weeks and then monthly until substantial compliance is reached. The results of the audit will be reviewed monthly during safety/QAPI meetings to ensure compliance or the need for changes.	

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K 0353 SS=E Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 3 staff.	K 0353	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The sprinkler head behind the dryers was immediately cleared of dust and debris. **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 do not have access to this area. **What measures will be put into**	09/22/2023

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	Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the sprinkler head behind the dryers was covered in dust or showed signs of loading. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 3.1-19(b)		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director will inspect all sprinkler heads in addition to required fire prevention systems inspections from outside vendors. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Maintenance Director or designee will audit The alleged deficiency will be audited on a weekly basis for four weeks and then monthly until substantial compliance is reached. The results of the audit will be reviewed monthly during safety/QAPI meetings to ensure compliance or the need for changes.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not			

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	155231	A. BUILDING 01 B. WING	08/29/2023

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

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 2 residents. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the (1) corridor door to the shower room on the 300 hall failed to	K 0363	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 300-hall shower room door was immediately adjusted to self-close and latch and the kitchen room storage door was removed of the bungee cord and floor mat that was obstructing the door to self-close and latch. **How other residents having the**	09/22/2023

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	155231	A. BUILDING 01 B. WING	08/29/2023

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	self-close and latch positively into the door frame. Based on interview at the time of the observations, the Director of Facilities Maintenance agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. And (2) the kitchen storage room door, leading into the kitchen area was being held open with a bungee cord and was obstructed with a thick floor mat and not allowing the door to self-close and latch into the door frame. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** No additional resident 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?** The Maintenance Director in-serviced staff on the fire safety protocols and importance of not obstructing or impeding doors from self-closing and latching. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Maintenance Director or designee will audit corridor doors to ensure they self-close and latch and no doors are obstructed from closing. The alleged deficiency will be audited on a weekly basis for four weeks and then monthly until substantial compliance is reached. The results of the audit will be reviewed monthly during Safety/QAPI meetings to ensure compliance or the need for changes.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a			

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	155231	A. BUILDING 01 B. WING	08/29/2023

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	room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 4 of 4 soiled linen receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect staff and up to 15 residents in 1 smoke compartment. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., there were two large 33-gallon soiled linen carts, unattended in the corridor on the 300 Hall, being stored side by side. Based on interview at the time of observation, the Director of Facilities Maintenance confirmed the capacity of the receptacles. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present.	K 0754	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The unattended soiled linen carts and trash receptacles were immediately removed from the hallway and stored in a hazardous storage area with a self-closer. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** No additional 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?** All unattended soiled linen carts and trash receptacles will be	09/22/2023

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	155231	A. BUILDING 01 B. WING	08/29/2023

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	3.1-19(b)		stored in a hazardous storage area with a self-closer.. Related staff will be in-serviced on protocols regarding the storage of unattended linen and trash receptacles in excess of 32 gallons. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The Maintenance Director or designee will audit the storage of unattended soiled linen carts and trash receptacles to ensure they are stored in a hazardous storage area with a self-closer. The alleged deficiency will be audited on a weekly basis for four (4) weeks and then monthly ongoing or until substantial compliance is reached. The results of the audit will be reviewed monthly during Safety/QAPI meetings to ensure compliance or the need for changes.	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to ensure the proper rating was provided for the rolling steel fire door was in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code	K 0761	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The metal rolling door between the kitchen and main Dining Room was bid out for replacement immediately to ensure the fire rating.	10/06/2023

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	155231	A. BUILDING 01 B. WING	08/29/2023

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	exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 25 residents, as well as staff and visitors while in the main Dining Room and kitchen staff. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the metal rolling fire door between the kitchen and main Dining Room appeared new and lacked an inspection sticker. When asked, the Director of Facilities Maintenance stated that the facility recently installed the roll-up door and then learned the door itself was not the correctly rated fire door which was required, stating that the correct door had been ordered and would be installed soon. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Any resident in the facility has 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?** The metal rolling door between the kitchen and main dining room was bid out for replacement immediately – the tentative installation date for a fire-rated door clearly-labeled as such is 10/6/2023. **How the corrective action will be monitored to ensure the deficient practice will not recur?** The metal rolling door between the kitchen and main dining room will be fire-rated in accordance with Life Safety Code and will be added to the Randolph Nursing & Rehabilitation Preventative Maintenance (PM) program; additionally, it will be inspected on schedule in accordance with said code. The alleged deficiency will be audited on a weekly basis for four weeks and then monthly until substantial compliance is reached. The results of the audit	

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			will be reviewed monthly during safety/QAPI meetings to ensure compliance or the need for changes.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect 15 residents. Findings include: Based on the facility tour and interview with the Director of Facilities Maintenance on 08/29/23 between 1:07 p.m. and 4:15 p.m., the oxygen storage/transfer room did not have a posted sign making a clear distinction between when transferring of oxygen is occurring in this location and when it is not.	K 0927	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Proper signage for oxygen trans-filling was immediately corrected as well as an in-service scheduled for properly training staff on trans-filling oxygen procedure. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** No additional residents were found to be affected. **What measures will be put into**	09/22/2023

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	Based on interview at the time of observation, the Director of Facilities Maintenance stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present. 2. Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect up to 15 residents. Findings include: Based on records review and interview with the Executive Director and Director of Facilities Maintenance on 08/29/23 between 10:30 a.m. and 1:07 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen are properly trained. Based on interview at the time of observation, the Executive Director stated that the computer program the facility uses to train, and in-service staff had this option however it was not selected and was not being done. This finding was acknowledged by the Executive Director and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Executive Director and Director of Facilities Maintenance present.		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** Proper signage now displays when oxygen trans-filling is now in place. Director of Nursing in-serviced all nursing staff on proper oxygen trans-filling procedures. Director of Nursing will train all new nursing staff during orientation on proper oxygen trans-filling procedures. **How the corrective action will be monitored to ensure the deficient practice will not recur?** Director of Nursing or designee will audit staff during oxygen trans-filling on a weekly basis for four weeks and then monthly until substantial compliance is reached. The results of the audit will be reviewed monthly during safety/QAPI meetings to ensure compliance or the need for changes.	

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	3.1-19(b)			