			PRINTED:	09/20/20
PARTMENT OF HEALTH AND HUM	FORM API	PROVED		
NTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0	1938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE	Y
AND DE LIVER CORRESPONDE	TD T1 100 100 100 100 100 100 100 100 100		a a l ent Emph	

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155231		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/29/2023				
	PROVIDER OR SUPPLIER	E		701 S C	ADDRESS, CITY, STATE, ZIP CO DAK ST IESTER, IN 47394)D	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	EECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
E 0000							
Bldg	accordance with 42 (Survey Date: 08/29/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency P Randolph Nursing H compliance with Em Requirements for Mo Participating Provide 483.73	tiana Department of Health in CFR 483.73. 23 0136 55231 75450 reparedness survey, ome was found in substantial ergency Preparedness edicare and Medicaid ers and Suppliers, 42 CFR ertified beds. At the time of s was 49.	EO	000	It is the practice of this ensure federal participal requirements for nursin participating in Medicar Medicaid programs are accordance with federa law. The creation and s of this Plan of Correction does not constitute an aby this provider of any of set forth in the statement deficiencies, or any violation regulation (s). This provider respectful this CMS-2567 Plan of the considered the Letter Credible Allegation of Cand requests a desk revolation of a Post-Survey Review or after 09/22/2023.	attion g homes e and/or met in I and state submission on (POC) admission conclusion at of ation of Illy requests Correction er of compliance view in lieu	
E 0025 SS=C Bldg	482.15(b)(7), 483.4 485.625(b)(7), 485. Arrangement with (§403.748(b)(7), §4 (7), §460.84(b)(8), (7), §483.475(b)(7) §485.920(b)(6), §49. [(b) Policies and promust develop and ipreparedness policion the emergency (a) of this section, response to the complex of	18.113(b)(5), §441.184(b) §482.15(b)(7), §483.73(b) , §485.625(b)(7), 94.62(b)(6). occedures. The [facilities] mplement emergency ies and procedures, based plan set forth in paragraph					

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

TITLE (X6) DATE

Eric Ahlbrand **Executive Director** 09/15/2023

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155231	B. WING		08/29/2023	
			<u> </u>		,	
NAME OF I	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD		
DANDO	DITMINDONO LICA	AF		DAK ST		
KANDOL	PH NURSING HO	VIE	WINCE	IESTER, IN 47394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	communication pl	an at paragraph (c) of this				
	section. The police	cies and procedures must				
	be reviewed and ι	updated at least every 2				
		r LTC facilities]. At a				
	-	cies and procedures must				
	address the follow	ving:]				
		§418.113(b), PRFTs at				
		pitals at §482.15(b), and				
	_	3483.73(b):] Policies and				
		r (5)] The development of				
	_	h other [facilities] [and]				
		receive patients in the event				
		essation of operations to				
		nuity of services to facility				
	patients.					
	*(Ear DAGE -+ 0.4)	CO 04/h) IOE/IIDc -+				
		60.84(b), ICF/IIDs at				
	` '	Is at §486.625(b), CMHCs				
	- ' '	d ESRD Facilities at				
	- ' ' -	ies and procedures. (7) [or lopment of arrangements	1			
	. , . , .	es] [or] other providers to				
	_	is the event of limitations or				
	· ·	ations to maintain the				
	-	ces to facility patients.				
	John Millianty Of Servi	oos to lacility patients.				
	*IFor RNHCls at 8	§403.748(b):] Policies and				
		he development of				
	. , ,	n other RNHCIs and other				
	_	ve patients in the event of				
	-	sation of operations to				
		nuity of non-medical				
	services to RNHC	•				
		view and interview, the facility	E 0025	What corrective action will b	oe 09/22/2023	
		ergency preparedness policies		accomplished for those	07/22/2023	
		ude the development of		residents found to have been	n	
	_	other LTC facilities and other		affected by the deficient		
	_	e residents in the event of		practice?		

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limitations or cessation of operations to maintain

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Mutual Aid Agreement with other

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			r '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILE			COMPLETED
		155231	B. WING			08/29/2023
	PROVIDER OR SUPPLIER	-	7	'01 S O	DDRESS, CITY, STATE, ZIP COD PAK ST ESTER, IN 47394	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	Т	`AG	DEFICIENCY)	DATE
	the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This				LTC facilities and other provide	
					were immediately reviewed an	ıd
	deficient practice co	ould affect all occupants.			updated.	II
	Eindines includes				How other residents having t	
	Findings include:				potential to be affected by th	
	Dagad on records re	eview and interview with the			same deficient practice will be identified and what corrective	
		and Director of Facilities			action will be taken?	e
		/29/23 between 10:30 a.m. and			All residents have the potentia	l to
		nent of arrangements with other			be affected.	11 10
		other providers to receive			What measures will be put in	ıto l
		nt of limitations or cessation			place and what systemic	
		vailable for review but the			changes will be made to	
	-	ore than 3 years old. Based on			ensure that the deficient	
	-	records review, the Executive			practice does not recur?	
	-	vas unsure if the agreements			Executive Director will review	
	were still in force as	nd he would make sure to			emergency preparedness police	cies
	revisit the mutual ai	id and transfer agreements the			and procedures are reviewed	
	facility currently ha	s.			annually to ensure arrangeme	nts
					with LTC facilities and other	
	_	knowledged by the Executive			providers to receive residents	in
		or of Facilities Maintenance at			the event of limitations or	
		ry and again at the exit			cessation of operation to main	
		Executive Director and			the continuity of services to LT	c
	Director of Facilitie	es Maintenance present.			residents.	
					How the corrective action will	II
					be monitored to ensure the	
					deficient practice will not	
					recur?	
					Executive Director of designed	
					audit emergency preparednes	
					policies and procedures on an annual basis to ensure the alle	
					deficient practice no longer	,gcu
					occurs. Audit results will be	
					reviewed during monthly	
					Safety/QAPI meetings for	
					compliance or need for addition	nal
					actions taken.	
				j		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	LETED
		155231	B. W	B. WING 08/29/2023			/2023
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ADDRESS, CITY, STATE, ZIP COD		
DANDO		45		701 S C			
RANDOL	PH NURSING HON	/IE		WINCH	IESTER, IN 47394		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 0	000	It is the practice of this provide	er to	
	Licensure Survey w	as conducted by the Indiana			ensure federal participation		
	Department of Heal	th in accordance with 42 CFR			requirements for nursing home	es	
	483.90(a).				participating in Medicare and/	or	
					Medicaid programs are met in		
	Survey Date: 08/29	0/23			accordance with federal and s	tate	
					law. The creation and submiss		
	Facility Number: 0				of this Plan of Correction (PO	C)	
	Provider Number: 155231 AIM Number: 100275450				does not constitute an admiss	ion	
					by this provider of any conclus	sion	
					set forth in the statement of		
	-	Code survey, Randolph			deficiencies, or any violation o	of	
	-	found not in compliance with			regulation(s).		
	Requirements for Pa	-			This provider respectfully requ		
		, 42 CFR Subpart 483.90(a),			this CMS-2567 Plan of Correc	tion	
	-	re and the 2012 edition of the			be considered the Letter of		
		etion Association (NFPA) 101,			Credible Allegation of Complia		
	• .	LSC), Chapter 19, Existing			and requests a desk review in		
	Health Care Occupa	ancies and 410 IAC 16.2.			of a Post-Survey Review (PSF	₹) on,	
					or after 09/22/2023.		
		ity was determined to be of					
		ruction and fully sprinkled.					
	•	re alarm system with smoke					
		ridors, spaces open to the					
	· ·	y-operated smoke detectors in					
		rooms. The facility has a					
	of this visit.	nad a census of 49 at the time					
	of this visit.						
	All areas where	idents have customary access					
		all areas providing facility					
	_	all areas providing facility kied. The facility had three					
	-	orage buildings which were					
	not sprinkled.	orage bundings willen were					
	not sprinkled.						
	Quality Review con	npleted on 08/31/23					
	Quality Review Coll	mprocod 011 00/31/23					
ı			1		I .		1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE (A. BUILDING B. WING	B. WING 08/29/2023			
	PROVIDER OR SUPPLIER		701 S	STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRECEDED BY FULL PREFIX PROVIDERS PLAN OF CORRE (BACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		(X5) COMPLETION DATE	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of egresses were continuous three to the egresses were continuous to the required with wheeled equipment following condition (a) The wheeled equipment following condition (a) The wheeled equipment ensure training program and wheeled equipment emergency. (c) The wheeled equipment emergency. (c) The wheeled equipment in use ii. Medical emerger iii. Patient lift and to the training program in the entry of the equipment in use iii. Medical emerger iiii. Patient lift and to the training include: Based on the facilitie between 1:07 p.m. a near Resident Room	Ays, corridors, exit cations, and accesses are in Chapter 7, and the means uously maintained free of full use in case of is modified by 18/19.2.2 in and interview, the facility fover 4 corridor means of inuously maintained free of 9.2.3.4 (4) states projections dth shall be permitted for a provided that all of the is are met: Airpment does not reduce the corridor width to less than 60 indicates the relocation of the during a fire or similar ipment is limited to the and carts in use icy equipment not in use	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 a 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 potential to be affected. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? All PPE carts have been replated with carts that have wheels to ensure they can be moved in event of an emergency. How the corrective action with the deficient practice will not recur?	the lie oe re lie other the li	

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ENTERS FOR MEDICARE & MEDICAID SERVICES						OW	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155231	B. WING			08/29/	/2023
	PROVIDER OR SUPPLIED PH NURSING HOI SUMMARY		7 V	01 S O	ESTER, IN 47394		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the halls during an This finding was ac Director and Direct the time of discove conference with the	when the cart to be moved out of emergency. Eknowledged by the Executive for of Facilities Maintenance at try and again at the exit executive Director and the Executive Director and the Maintenance present.			Director of Nursing or designed audit the alleged deficiency or weekly basis for four (4) weekly and then monthly ongoing or usubstantial compliance is reached. The results of the audith will be reviewed monthly during Safety/QAPI meetings to ensurcompliance or the need for changes.	i a s until dit g	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and clinical security not used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks and safety needs of the Clinical or Secure being met. In	cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants I of locks; keying of all ied by staff at all times; or a means available to the .2.2.6, 19.2.2.2.5.1,					

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release upon loss of power to the device; the

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/29/2023	
RANDOL	ROVIDER OR SUPPLIER	ΛE	701 S (WINCH	ADDRESS, CITY, STATE, ZIP COD DAK ST IESTER, IN 47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	building is protected automatic sprinkled space is protected detection system of at an attended lock space); and both it systems are arrand upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGREIARRANGEMENTS Approved, listed do systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superdetection system automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRANDACCESS-CONTR LOCKING ARRANDELEVATOR LOBEL LOBEL LOBEL LOCKING ARRANDELEVATOR LOBEL LOBEL LOBEL LOBEL LOBEL LOBEL LOBEL L	ed by a supervised or system and the locked or system and the locked or system and the locked of the sprinkler and detection ged to unlock the doors. 2.2.5.2, TIA 12-4 SS LOCKING Selayed-egress locking in accordance with permitted on door go low and ordinary hazard gs protected throughout by ervised automatic fire for an approved, supervised or system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 SY EXIT ACCESS NGEMENTS It access door locking in access door locking in access door locking in access in buildings protected approved, supervised ection system and an seed automatic sprinkler	W. 0222		
	failed to ensure the Main Entrance exit	on and interview, the facility means of egress through the was readily accessible for clinical diagnosis requiring	K 0222	What corrective action will b accomplished for those residents found to have been affected by the deficient	03:22:2028

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	01	COMPLETED	
		155231	B. WIN	IG		08/29/2023	
RANDOL	PROVIDER OR SUPPLIEF	МЕ		STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		measures. Doors within a			practice?		
	required means of egress shall not be equipped				The door code protocol at the		
		that requires the use of a tool			Main Entrance was immediate	•	
		ess side unless otherwise			changed to a clear code for ex	kit of	
		9.2.2.2.4. Door-locking			the facility.	44	
	_	be permitted in accordance			How other residents having		
		This deficient practice could			potential to be affected by th		
	the facility.	and visitors if needing to exit			same deficient practice will to identified and what corrective		
	the facility.				action will be taken?	e	
	Findings include:					ol to	
	Based on the facility tour and interview with the				All residents have the potential be affected.	11 10	
					What measures will be put in	nto	
	Director of Facilities Maintenance on 08/29/23				place and what systemic	110	
		and 4:15 p.m., the Main			changes will be made to		
	_	marked as a facility exit, was			ensure that the deficient		
		d and could be opened by			practice does not recur?		
		t code but the code was			Main Entrance door code has		
		"flapper" and required special			been made readily accessible	for	
		to figure out where the code			residents without a clinical	101	
	was being hidden.	to figure out where the code			diagnosis requiring specialized	d I	
	was some maden				security measures.	"	
	This finding was ac	knowledged by the Executive			How the corrective action wi	.	
	1	or of Facilities Maintenance at			be monitored to ensure the	=	
		ry and again at the exit			deficient practice will not		
		Executive Director and			recur?		
		es Maintenance present.			The Executive Director or		
		*			designee will audit the alleged	ı	
	3.1-19(b)				deficiency on a daily basis for		
					seven (7) days, a weekly basi		
					three (3) weeks and then mon		
					ongoing or until substantial	·	
					compliance is reached. The		
					results of the audit will be revi	ewed	
					monthly during Safety/QAPI		
					meetings to ensure compliance	e or	
					the need for changes.		
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 08/29/2023			
		100201	D. WING		00/29/2023
	PROVIDER OR SUPPLIER PH NURSING HON		701	EET ADDRESS, CITY, STATE, ZIP COD S OAK ST NCHESTER, IN 47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
Bldg. 01	Hazardous Areas Hazardous areas barrier having 1-he (with 3/4 hour fire automatic fire extinaccordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas t REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe	are protected by a fire our fire resistance rating rated doors) or an anguishing system in 6.7.1 or 19.3.5.9. When the stic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) mance, and Paint Shops from soms (exceeding 64 on Rooms lons) orage Rooms/Spaces	IAG		DATE
	failed to maintain proposers. The	2) tion and interview, the facility rotection of 1 of 1 hot oil is deficient practice could o 20 residents' staff and	K 0321	What corrective action was accomplished for those residents found to have affected by the deficient practice? The popcorn machine four Activity room was immediate.	been nd in the

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18XL21

Facility ID: 000136

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155231	B. WI	ING		08/29/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER	8			DAK ST		
RANDOL	.PH NURSING HON	ИE		WINCHESTER, IN 47394			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					placed in a proper location wit		
		y tour and interview with the			limited access and a door with	ı a	
		es Maintenance on 08/29/23			self-closing device.		
	·	and 4:15 p.m., a hot oil popcorn			How other residents having		
		tored in the activity area.			potential to be affected by the		
		the machine was used the			same deficient practice will I		
		es Maintenance stated it was			identified and what correctiv	e	
	I -	the aforementioned area is			action will be taken?		
	•	and did not have a door with			Residents inside the Activity re		
	a self-closing device	e installed.			have the potential to be affect		
					What measures will be put ir	nto	
	This finding was acknowledged by the Executive				place and what systemic		
	Director and Director of Facilities Maintenance at				changes will be made to		
		ry and again at the exit			ensure that the deficient		
		Executive Director and			practice does not recur?		
	Director of Facilitie	es Maintenance present.			The popcorn machine will be		
					stored in a proper location with		
		ation and interview, the facility			limited access and a door with		
		f over 10 hazardous area doors,			self-closing device. Additional	ly,	
	_	ms, were provided with			the popcorn machine will be		
		elf-closing devices. This			operated outdoors to avoid an	-	
	_	ould affect 2 staff in the			potentially-combustible items.		
	activities room.				How the corrective action wi	II	
					be monitored to ensure the		
	Findings include:				deficient practice will not		
					recur?		
		y tour and interview with the			The Executive Director or		
		es Maintenance on 08/29/23			designee will audit the storage		
	_	and 4:15 p.m., the Activities			use of the popcorn machineor		
	_	50 square feet contained a			weekly basis for four weeks a	nd	
		ible items, such as, paper,			then monthly until substantial		
	1 -	and cardboard boxes. The			compliance is reached. The		
		s area was did not self-close			results of the audit will be revi	ewed	
	and latch into the do	oor frame.			monthly during safety/QAPI		
					meetings to ensure compliance	e or	
		knowledged by the Executive			the need for changes.		
		or of Facilities Maintenance at					
		ry and again at the exit					
	conference with the	Executive Director and					
	Director of Facilities Maintenance present.						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLETE B. WING 08/29/20			ETED		
	PROVIDER OR SUPPLIER		<u> </u>	701 S C	ADDRESS, CITY, STATE, ZIP COD DAK ST ESTER, IN 47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure sprinkle edition, at 5.2.1.1.1 of leakage; shall be materials, paint, and be installed in the coup-right, pendent, or 5.2.1.1.2 any sprink the following shall to Corrosion (3) Physical the glass bulb heat rand Loading (6) Painting the glass bulb heat rand coup-right pendent, or 5.2.1.1.2 any sprink the glass bulb heat rand coupling the glass bulb	supply source RKS information on non-required or partial r system. and NFPA 25 on and interview, the facility inkler heads in the laundry area covered with foreign material LSC 9.7.5. NFPA 25, 2011 sprinklers shall not show signs free of corrosion, foreign a physical damage; and shall correct orientation (e.g., or sidewall). Furthermore, at ler that shows signs of any of the replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in responsive element (5) gunless painted by the rer. This deficient practice	K 0	353	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 cleare dust and debris. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents do not have access this area. What measures will be put in	d of he e he to	09/22/2023

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Event ID:

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Facility ID: 000136

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		A. BUILDING <u>01</u> COMP			(X3) DATE COMPL 08/29/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Director of Facilities between 1:07 p.m. a behind the dryers w signs of loading. This finding was ac Director and Director the time of discover conference with the	y tour and interview with the s Maintenance on 08/29/23 and 4:15 p.m., the sprinkler head as covered in dust or showed knowledged by the Executive or of Facilities Maintenance at ry and again at the exit Executive Director and s Maintenance present.			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 prevesystems inspections from out vendors. How the corrective action will be monitored to ensure the deficient practice will not recur? The Maintenance Director or designee will audit The allege deficiency will be audited on a weekly basis for four weeks at then monthly until substantial compliance is reached. The results of the audit will be revimonthly during safety/QAPI meetings to ensure compliance the need for changes.	ntion side iiII ad a nd		
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller lies	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke only required to resist the concentration of the confidence of the						

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Event ID:

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Facility ID: 000136

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COM		COMPLETED			
155231			B. WING 08/29/2023				
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R					
BANDOI	DH VII IDGIVIC HO	ME	701 S OAK ST WINCHESTER, IN 47394				
RANDOLPH NURSING HOME			WINCI	1E31EK, IN 47394			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	apply to auxiliary	spaces that do not contain					
	flammable or con	nbustible material.					
	Clearance between	en bottom of door and floor					
	covering is not ex	ceeding 1 inch. Powered					
	_	with 7.2.1.9 are permissible					
		device capable of keeping					
	•	when a force of 5 lbf is					
		no impediment to the					
		ors. Hold open devices that					
	_	door is pushed or pulled are					
		ted protective plates of					
	-	are permitted. Dutch doors					
	meeting 19.3.6.3.6 are permitted. Door						
	_	abeled and made of steel or					
	other materials in	compliance with 8.3,					
	unless the smoke	-					
		d fire window assemblies are					
		n sprinklered compartments					
	-	rictions in area or fire					
		ss or frames in window					
	assemblies.						
	19.3.6.3. 42 CFR	Parts 403, 418, 460, 482,					
	483, and 485						
		KS details of doors such as					
		ings, automatics closing					
	devices, etc.						
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no		K 0363	What corrective action will b	e 09/22/2023		
			1 0505	accomplished for those	0)12212023		
				residents found to have been	,		
	impediment to closing and latching into the door frame and would resist the passage of smoke.			affected by the deficient	'		
	This deficient practice could affect 2 staff and 2			practice?			
	residents.			The 300-hall shower room doo	or		
				was immediately adjusted to	, i		
	Findings include:			self-close and latch and the			
	i maniga metade.			kitchen room storage door wa	6		
	Rased on the facili	ty tour and interview with the		removed of the bungee cord a			
		es Maintenance on 08/29/23		floor mat that was obstructing			
		and 4:15 p.m., the (1) corridor		door to self-close and latch.	u IC		
	_	room on the 300 hall failed to		How other residents having t	the		
	GOOT TO THE SHOWER	room on the 300 han failed to		Trow other residents having t	uic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Based on interview observations, the Di Maintenance agreed door did not close a and would not resis (2) the kitchen stora kitchen area was be cord and was obstruand not allowing the into the door frame. This finding was ac Director and Director the time of discover conference with the	the aforementioned corridor and latch into the door frame the passage of smoke. And ge room door, leading into the ling held open with a bungee cted with a thick floor mat e door to self-close and latch		potential to be affected by the same deficient practice will identified and what corrective action will be taken? No additional resident have the potential to be affected. What measures will be put in 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 sate protocols and importance of mobstructing or impeding doors 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 do to ensure they self-close and and no doors are obstructed for closing. The alleged deficience be audited on a weekly basis four weeks and then monthly substantial compliance is reached. The results of the audit will be reviewed monthly durit Safety/QAPI meetings to ensure compliance or the need for changes.	fety not from iill oors latch for until dit			
K 0754 SS=E Bldg. 01	shall not exceed 3							

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION 1		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155231	B. WING 08/29/2023			/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2	701 S OAK ST				
BANDOI	PH NURSING HO	ΛE	WINCHESTER, IN 47394				
IVAINDOL	- THINOROING HOR	VIL		WINCH			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	room or space sha	all not exceed 0.5					
	gallons/square fee	et. A total container					
	capacity of 32 gall	lons shall not be exceeded					
	within any 64 squa	are feet area. Mobile soiled					
	linen or trash colle	ection receptacles with					
	capacities greater	than 32 gallons shall be					
	located in a room	protected as a hazardous					
	area when not atte						
		solely for recycling are					
		cluded from the above					
		re each container is less					
	· ·	6 gallons unless attended,					
		combustibles are labeled					
		ting FM Approval Standard					
	6921 or equivalen						
	18.7.5.7, 19.7.5.7						
		on and interview, the facility	K 0754		What corrective action will be		09/22/2023
		f 4 soiled linen receptacles in			accomplished for those		
		exceed 32 gallons in capacity			residents found to have beer	1	
		foot area. This deficient			affected by the deficient		
		et staff and up to 15 residents			practice?		
	in 1 smoke compart	tment.			The unattended soiled linen ca	arts	
	P' 1' ' 1 1				and trash receptacles were		
	Findings include:				immediately removed from the		
	D 1 41 C 114	4 114 1 24 4			hallway and stored in a hazard		
		y tour and interview with the			storage area with a self-closer		
		es Maintenance on 08/29/23			How other residents having t		
		and 4:15 p.m., there were two			potential to be affected by th		
		ed linen carts, unattended in			same deficient practice will be		
	the corridor on the 300 Hall, being stored side by side. Based on interview at the time of				identified and what corrective action will be taken?	е	
					No additional residents were for	ound	
	observation, the Director of Facilities Maintenance confirmed the capacity of the				to be affected.	Juliu	
	receptacles.	med the capacity of the				to	
	receptacies.				What measures will be put in place and what systemic	w	
	This finding was an	knowledged by the Executive			changes will be made to		
	_	or of Facilities Maintenance at			ensure that the deficient		
		ry and again at the exit			practice does not recur?		
		Executive Director and			All unattended soiled linen car	te	
		es Maintenance present.			and trash receptacles will be	ıo	
	Director of Facilitie	o manifemente present.	1		and trastificceptactes will be		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)			stored in a hazardous storage area with a self-closer Relative staff will be in-serviced on protocols regarding the storage unattended linen and trash receptacles in excess of 32 gallons. How the corrective action we be monitored to ensure the deficient practice will not recur? The Maintenance Director or designee will audit the storage unattended soiled linen carts trash receptacles to ensure the are stored in a hazardous sto area with a self-closer. The all deficiency will be audited on a weekly basis for four (4) week and then monthly ongoing or substantial compliance is reached. The results of the audit be reviewed monthly durin Safety/QAPI meetings to ensure compliance or the need for changes.	ed ge of ge of and gey grage gleged grage gleged grage grantil grantil		
K 0761 SS=E Bldg. 01							
	failed to ensure the the rolling steel fire NFPA 80. LSC 4.5 equipment, system, of protection, or any compliance with the device, equipment, arrangement, level of	on and interview, the facility proper rating was provided for door was in accordance with .8 requires any device, condition, arrangement, level y other feature is required for e provision of this Code, such system, condition, of protection, or other feature maintained unless the Code	K 0761	What corrective action will be accomplished for those residents found to have bee affected by the deficient practice? The metal rolling door betwee kitchen and main Dining Room was bid out for replacement immediately to ensure the fire rating.	n the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/29/2023 155231 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 S OAK ST RANDOLPH NURSING HOME WINCHESTER, IN 47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other How other residents having the Opening Protectives, Section 11.4.1.1 requires an potential to be affected by the automatic-closing device shall be installed on same deficient practice will be every rolling steel door. Section 11.4.1.2 states identified and what corrective rolling steel doors shall close automatically upon action will be taken? activation or release of a fusible link or detector. Any resident in the facility has the Section 11.4.2.2.1 states after the automatic potential to be affected. closing is activated, the door shall remain in the closed position until the automatic-closing device What measures will be put into has been reset. This deficient practice could place and what systemic affect over 25 residents, as well as staff and changes will be made to visitors while in the main Dining Room and ensure that the deficient kitchen staff. practice does not recur? The metal rolling door between the Findings include: kitchen and main dining room was bid out for replacement Based on the facility tour and interview with the immediately - the tentative Director of Facilities Maintenance on 08/29/23 installation date for a fire-rated between 1:07 p.m. and 4:15 p.m., the metal rolling door clearly-labeled as such is fire door between the kitchen and main Dining 10/6/2023. Room appeared new and lacked an inspection sticker. When asked, the Director of Facilities How the corrective action will Maintenance stated that the facility recently be monitored to ensure the installed the roll-up door and then learned the deficient practice will not door itself was not the correctly rated fire door recur? which was required, stating that the correct door The metal rolling door between the had been ordered and would be installed soon. kitchen and main dining room will be fire-rated in accordance with This finding was acknowledged by the Executive Life Safety Code and will be added Director and Director of Facilities Maintenance at to the Randolph Nursing & the time of discovery and again at the exit Rehabilitation Preventative conference with the Executive Director and Maintenance (PM) program; Director of Facilities Maintenance present. additionally, it will be inspected on schedule in accordance with said 3.1-19(b) code. The alleged deficiency will be audited on a weekly basis for four weeks and then monthly until

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substantial compliance is reached. The results of the audit

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	01	COMPLETED		
		155231	B. WIN	2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394					
(X4) ID			1	ID	DROUDERIC DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0927 SS=E Bldg. 01	Gas Equipment -	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to			will be reviewed monthly durin safety/QAPI meetings to ensu compliance or the need for changes.			
	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)		K 09	27	What corrective action will be	e	09/22/2023	
	rooms was provided transferring is occur states, the area is por that trans-filling is of the immediate area practice could affect Findings include: Based on the facility Director of Facilities between 1:07 p.m. a storage/transfer room making a clear disti	f 1 oxygen storage/transfer d with a sign indicating that rring. NFPA 99 11.5.2.3.1(3) osted with signs indicating occurring and that smoking in is not permitted. This deficient t 15 residents. by tour and interview with the ses Maintenance on 08/29/23 and 4:15 p.m., the oxygen m did not have a posted sign anction between when gen is occurring in this location			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-serv scheduled for properly training staff on trans-filling oxygen procedure. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No additional residents were for to be affected. What measures will be put in	vice g the e oe e ound		

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS		f '		DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155231	B. WI	B. WING 08/29/2023			2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8		701 S C				
RANDOL	PH NURSING HON	ΛE			ESTER, IN 47394			
	T				, I	1	are:	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		at the time of observation, the		TAG			DATE	
		es Maintenance stated there			place and what systemic			
		ng when trans-filling oxygen is			changes will be made to ensure that the deficient			
	occurring and when				practice does not recur?			
	occurring and when	it is not.			Proper signage now displays	when		
	This finding was ac	knowledged by the Executive			oxygen trans-filling is now in	WIICII		
	1	or of Facilities Maintenance at			place. Director of Nursing			
		ry and again at the exit			in-serviced all nursing staff on			
		Executive Director and			proper oxygen trans-filling			
		es Maintenance present.			procedures. Director of Nursin	ıg İ		
					will train all new nursing staff			
	2. Based on records	review and interview, the			during orientation on proper			
	facility failed to ens	sure staff was properly trained			oxygen trans-filling procedure	s.		
	on trans-filling proc	cedures in 1 of 1 oxygen			How the corrective action wi	II		
	_	oxygen transferring takes			be monitored to ensure the			
	1 ~	012 edition, 11.5.2.3.1 (4) the			deficient practice will not			
		ing the container(s) has been			recur?			
		the trans-filling procedures.			Director of Nursing or designe	e will		
	1	ice could affect up to 15			audit staff during oxygen	_		
	residents.				trans-filling on a weekly basis			
	F' 1' ' 1 1				four weeks and then monthly	until		
	Findings include:				substantial compliance is			
	Rosed on magarda ma	eview and interview with the			reached. The results of the au			
		and Director of Facilities			will be reviewed monthly during safety/QAPI meetings to ensu	-		
		29/23 between 10:30 a.m. and			compliance or the need for	10		
		nentation was available for			changes.			
	_	taff that trans-fill liquid oxygen			onangos.			
		Based on interview at the						
		, the Executive Director stated						
		rogram the facility uses to						
		e staff had this option however						
		and was not being done.						
		-						
	This finding was ac	knowledged by the Executive						
	Director and Direct	or of Facilities Maintenance at						
		ry and again at the exit						
		Executive Director and						
	Director of Facilitie	es Maintenance present.						
			I					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2023 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/29/2023	
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BY		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	3.1-19(b)						

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