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	10/12/2023

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/29/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/12/23 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 At this PSR Emergency Preparedness survey, Randolph Nursing Home was found in 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 PSR survey, the census was 51. Quality Review completed on 10/16/23	E 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/29/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/12/23 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450	K 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Hopkins	RN	11/03/2023

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	155231	A. BUILDING 01 B. WING	10/12/2023

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	At this PSR 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 51 at the time of this PSR 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 10/16/23		is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to ensure the rolling metal fire door recently installed was in accordance with NFPA 80 to prevent or retard the spread of fire and smoke within, into, or out of buildings. 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	K 0761	1)Immediate actions taken for those residents identified: No resident was found to be affected by this alleged deficiency. The Maintenance Director called the vendor that will be installing the new door to confirm the installation date for this new door. Confirmed to be installed on 11/3/23. 2) How the facility identified other	11/10/2023

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	maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 4.1.1 states fire doors and fire windows shall be classified by designating a required fire protection rating expressed in hours or fractions thereof. Section 4.3.5 states rolling steel fire doors shall be labeled and shall be furnished as a complete assembly that includes curtain, bottom bar, barrel, guides, brackets, hood, automatic closing device, and any other components required by their listing for a complete assembly. 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 and Regional Facilities Support Person on 10/12/23 between 12:50 p.m. and 2:15 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 rolling door itself was not the correctly rated rolling fire door which was required. The Director of Facilities Maintenance then stated the correct rolling door had been ordered and would be installed soon. On 10/12/23 the Director of Facilities Maintenance and Regional Facilities Support Person stated that the door was scheduled to be installed soon but that it has not yet been replaced. A discussion was had concerning applying for a waiver. This finding was acknowledged by the Regional		residents: Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. No one was affected. 3) Measures put into place/ System changes: The Maintenance Director or Designee will conduct rounds once weekly to ensure all doors in the community meet all applicable NFPA regulations. The new rolling door was installed on 11/3/23. The new door meets all applicable NFPA regulations. 4)How the corrective actions will be monitored: The Executive Director will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Facilities Support Person and Director of Facilities Maintenance at the time of discovery and again at the exit conference with the Regional Facilities Support Person and Director of Facilities Maintenance present. This deficiency was cited on 08/29/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			