| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|----------------------|--|------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | | | | ETED |
| | | 155231 | B. W | ING | | 08/23/ | /2022 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | 701 S C | | | |
| RANDOL | PH NURSING HO | ME | | | ESTER, IN 47394 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | .TE | COMPLETION |
| TAG | REGULATORY OI | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| E 0000 | | | | | | | |
| Bldg | | | | | | | |
| Diag. | An Emergency Pre | paredness Survey was | E 0 | 000 | | | |
| | | ndiana Department of Health in | | 000 | The creation and submission | of | |
| | accordance with 42 | - | | | this plan of correction does no | | |
| | | | | | constitute an admission by this | | |
| | Survey Date: 08/2 | 3/22 | | | provider of any conclusion set | | |
| | | | | | in the statement of deficiencie | | |
| | Facility Number: (| 000136 | | | of any violation of regulation. | Γhis | |
| | Provider Number: | 155231 | | | provider respectfully requests | that | |
| | AIM Number: 100 |)275450 | | | the 2567 plan of correction be | | |
| | | | | | considered the letter of credib | | |
| | | Preparedness survey, | | | allegation and request a desk | | |
| | | Home was found in substantial | | | review of certification of | | |
| | _ | mergency Preparedness | | | compliance on or after 9/9/202 | 22 | |
| | 1 - | Medicare and Medicaid | | | | | |
| | | ders and Suppliers, 42 CFR | | | | | |
| | 483.73 | | | | | | |
| | The facility has 94 | certified beds. At the time of | | | | | |
| | the survey, the cens | | | | | | |
| | | 5 H W 5 1 1 | | | | | |
| | Quality Review con | mpleted on 08/25/22 | | | | | |
| E 0020 | 400.740/-1\/0\-44 | C E4/41/(2) 440 440/-1/(2) | | | | | |
| E 0039 SS=C | . , , , , | 6.54(d)(2), 418.113(d)(2), | | | | | |
| Bldg | | 32.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), | | | | | |
| Diag | 1 ' ' ' ' | | | | | | |
| | 1 ' ' ' ' | 5.727(d)(2), 485.920(d)(2), | | | | | |
| | EP Testing Requi | 11.12(d)(2), 494.62(d)(2) | | | | | |
| | 1 | .18.113(d)(2), §441.184(d)(2), | | | | | |
| | | .82.15(d)(2), §483.73(d)(2), | | | | | |
| | | 484.102(d)(2), §485.68(d)(2), | | | | | |
| | 1 | 485.727(d)(2), §485.920(d) | | | | | |
| | (2), §491.12(d)(2) | | | | | | |
| | (-), 3 :0 :: (2)(2) | ,, 3 | | | | | |
| | *[For ASCs at 84 | 16.54, CORFs at §485.68, | | | | | |
| | · | ions" under §485.727, | | | | | |
| | | 920, RHCs/FQHCs at | | | | | |
| | I | | | | | | |

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GEZZ21 Facility ID: 000136 If continuation sheet Page 1 of 30

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | | |
|--|---|---|-------|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. Bl | UILDING | | COMPL | ETED |
| | | 155231 | B. W | ING | | 08/23/ | 2022 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | 701 S C | | | |
| RANDOI | PH NURSING HO | MF | | | ESTER, IN 47394 | | |
| | Г | | - | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY | | DATE |
| | §491.12, and ESF | RD Facilities at §494.62]: | | | | | |
| | (O) T 4: TI 19 | 5 | | | | | |
| | (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | following: | | | | | | |
| | (i) Particinate in a | full-scale exercise that is | | | | | |
| | | every 2 years; or | | | | | |
| | | nunity-based exercise is | | | | | |
| | ` ' | enduct a facility-based | | | | | |
| | functional exercise every 2 years; or | | | | | | |
| | | ility] experiences an actual | | | | | |
| | . , , - | ade emergency that requires | | | | | |
| | | mergency plan, the [facility] | | | | | |
| | | gaging in its next required | | | | | |
| | - | or individual, facility-based | | | | | |
| | functional exercise | e following the onset of the | | | | | |
| | actual event. | | | | | | |
| | (ii) Conduct an ad | ditional exercise at least | | | | | |
| | every 2 years, opp | posite the year the full-scale | | | | | |
| | or functional exerc | cise under paragraph (d)(2) | | | | | |
| | (i) of this section is | s conducted, that may | | | | | |
| | | limited to the following: | | | | | |
| | 1 ' ' | scale exercise that is | | | | | |
| | 1 | or individual, facility-based | | | | | |
| | functional exercise | • | | | | | |
| | (B) A mock disast | | | | | | |
| | 1 ' ' | ercise or workshop that is | | | | | |
| | 1 | and includes a group | | | | | |
| | discussion using a | | | | | | |
| | | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | messages, or prepared questions designed | | | | | | |
| | to challenge an er | | | | | | |
| | | acility's] response to and | | | | | |
| | | ntation of all drills, tabletop | | | | | |
| | | nergency events, and revise ergency plan, as needed. | | | | | |
| | i ine fracilità si ettle | rgency plan, as fleeded. | | | | | |
| | | | | | | | |

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Event ID:

GEZZ21 Facility ID: 000136

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | | SURVEY |
|-----------|--|---------------------------------|---|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPL | |
| | | 155231 | B. W | ING | | 08/23/ | /2022 |
| | | <u> </u> | - | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | 701 S C | OAK ST | | |
| RANDOL | PH NURSING HO | ME | | WINCH | ESTER, IN 47394 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | *[For Hospices at | · / - | | | | | |
| | , , , | spices that provide care in | | | | | |
| | | e. The hospice must | | | | | |
| | | s to test the emergency | | | | | |
| | - | ally. The hospice must do | | | | | |
| | the following: | | | | | | |
| | | a full-scale exercise that is | | | | | |
| | community based | | | | | | |
| | ` ' | nunity based exercise is not | | | | | |
| | | ict an individual facility | | | | | |
| | | exercise every 2 years; or | | | | | |
| | | experiences a natural or | | | | | |
| | _ | ency that requires activation | | | | | |
| | | plan, the hospital is | | | | | |
| | | aging in its next required full | | | | | |
| | | based exercise or individual | | | | | |
| | onset of the emer | ctional exercise following the | | | | | |
| | | dditional exercise every 2 | | | | | |
| | ' ' | e year the full-scale or | | | | | |
| | | e under paragraph (d)(2)(i) | | | | | |
| | | conducted, that may | | | | | |
| | | limited to the following: | | | | | |
| | | scale exercise that is | | | | | |
| | , , | or a facility based | | | | | |
| | functional exercise | • | | | | | |
| | (B) A mock disas | | | | | | |
| | ` ' | ercise or workshop that is | | | | | |
| | | and includes a group | | | | | |
| | discussion using a | - · | | | | | |
| | _ | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | | pared questions designed | | | | | |
| | to challenge an er | | | | | | |
| | (3) Testing for hospices that provide inpatient | | | | | | |
| | care directly. The hospice must conduct | | | | | | |
| | | he emergency plan twice | | | | | |
| | | spice must do the following: | | | | | |
| | | an annual full-scale exercise | | | | | |

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Event ID:

GEZZ21 Facility ID: 000136

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | JILDING | NSTRUCTION | COMPL 08/23/ | ETED | |
|--|--|---|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | 701 S O | ADDRESS, CITY, STATE, ZIP COD DAK ST ESTER, IN 47394 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | accessible, conduractions designed and accessible, conduractions are recommended as a conduction of the emergency exempt from engatull-scale community conduct an acceptance of the emergency event. (ii) Conduct an acceptance of the emergency event. (iii) Conduct an acceptance of the emergency event. (iii) A second full-community-based functional exercises. (C) A tabletop exercise of the exercise of the emergency scenastatements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency's eme | nunity-based exercise is not ct an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based a following the onset of the dditional annual exercise but is not limited to the scale exercise that is or a facility based a; or ter drill; or ercise or workshop led by a audes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared and to challenge an ospice's response to and intation of all drills, tabletop nergency events and revise argency plan, as needed. | | | | |
| | §482.15(d), CAHs (2) Testing. The [Foundary exercises plan twice per year CAH] must do the (i) Participate in a | PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following: an annual full-scale exercise | | | | |
| | that is community (A) When a comm | -based; or nunity-based exercise is not | | | | |

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Event ID:

GEZZ21 Facility ID: 000136

If continuation sheet Page 4 of 30

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|--|----------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | <u></u> | COMPI | LETED |
| | | 155231 | B. W. | ING | | 08/23 | /2022 |
| N | NOTABLE CO. ST. ST. | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | 1 | |
| NAME OF P | PROVIDER OR SUPPLIE | K | | 701 S C | DAK ST | | |
| RANDOL | PH NURSING HO | ME | | WINCH | ESTER, IN 47394 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | _ | TAG | DEFICIENCY) | | DATE |
| | | uct an annual individual, | | | | | |
| | | ctional exercise; or | | | | | |
| | | Hospital, CAH] experiences | | | | | |
| | | or man-made emergency | | | | | |
| | • | vation of the emergency | | | | | |
| | | is exempt from engaging in | | | | | |
| | · · | ull-scale community based | | | | | |
| | | ity-based functional exercise | | | | | |
| | _ | et of the emergency event. | | | | | |
| | * * | an [additional] annual | | | | | |
| | | nat may include, but is not | | | | | |
| | limited to the follo | - | | | | | |
| | ` ' | -scale exercise that is | | | | | |
| | community-based | | | | | | |
| | • | ctional exercise; or | | | | | |
| | ` ' | ock disaster drill; or | | | | | |
| | , , | p exercise or workshop that | | | | | |
| | • | tor and includes a group | | | | | |
| | discussion, using | | | | | | |
| | - | emergency scenario, and a | | | | | |
| | - | atements, directed | | | | | |
| | to challenge an e | pared questions designed | | | | | |
| | _ | | | | | | |
| | , , , | the [facility's] response to umentation of all drills, | | | | | |
| | | s, and emergency events | | | | | |
| | · | cility's] emergency plan, as | | | | | |
| | needed. | cility sj emergency plan, as | | | | | |
| | *!=== DAO= =+ 0.4 | 00.04/4).1 | | | | | |
| | *[For PACE at §4 | · / - | | | | | |
| | | PACE organization must | | | | | |
| | | s to test the emergency | | | | | |
| | plan at least annu | - | | | | | |
| | organization must do the following: | | | | | | |
| | | an annual full-scale exercise | | | | | |
| | that is community | | | | | | |
| | • • | nunity-based exercise is not | | | | | |
| | accessible, conduct an annual individual, facility-based functional exercise; or | | | | | | |
| | • | | | | | | |
| | (B)If the PACE e | xperiences an actual natural | | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 08/23/2022 | | | |
|--|--|--|--------------|---|------|
| | PROVIDER OR SUPPLIEF | | 701 S C | ADDRESS, CITY, STATE, ZIP COD DAK ST ESTER, IN 47394 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | or man-made eme activation of the e is exempt from en full-scale communifacility-based functionset of the emercision of the emercision of the section is community-based based functional exercision of this section is community-based based functional execution of the part of problem star messages, or presto challenge an er (iii) Analyze the Finaintain document exercises, and emitted the PACE's emercitive to test the emergency problem of the part of problem of the part of problem of the part of problem star messages, or presto challenge an er (iii) Analyze the Finaintain document exercises, and emitted (2) The [LTC facilities (2) The [LTC facilities (2) The [LTC facilities (2) The facilities (2) The facility of the emergency problem of the | n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) onducted that may include, o the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. PACE's response to and ntation of all drills, tabletop mergency events and revise gency plan, as needed. es at §483.73(d):] ty] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: an annual full-scale exercise e-based; or aunity-based exercise is not oct an annual individual, | TAG | | DATE |

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actual natural or man-made emergency that

Event ID:

GEZZ21

Facility ID: 000136

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|-----------|---|---------------------------------------|--------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPL | |
| | | 155231 | B. W | ING | | 08/23/ | /2022 |
| NAME OF S | DROLUDER OR CLURY | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | • | |
| NAME OF I | PROVIDER OR SUPPLIEF | | | 701 S C | OAK ST | | |
| RANDOL | PH NURSING HON | ИE | | WINCH | ESTER, IN 47394 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY | | DATE |
| | 1 | n of the emergency plan, the | | | | | |
| | LTC facility is exempt from engaging its next required a full-scale community-based or | | | | | | |
| | required a full-scale community-based or individual, facility-based functional exercise | | | | | | |
| | | et of the emergency event. | | | | | |
| | _ | dditional annual exercise | | | | | |
| | | but is not limited to the | | | | | |
| | following: | but is not innited to the | | | | | |
| | • | scale exercise that is | | | | | |
| | | or an individual, facility | | | | | |
| | based functional e | · • | | | | | |
| | (B) A mock disas | • | | | | | |
| | ' ' | ercise or workshop that is | | | | | |
| | led by a facilitator | · · · · · · · · · · · · · · · · · · · | | | | | |
| | discussion, using | | | | | | |
| | | emergency scenario, and a | | | | | |
| | set of problem sta | | | | | | |
| | · · | pared questions designed | | | | | |
| | to challenge an er | nergency plan. | | | | | |
| | (iii) Analyze the [l | LTC facility] facility's | | | | | |
| | response to and n | naintain documentation of | | | | | |
| | all drills, tabletop | exercises, and emergency | | | | | |
| | events, and revise | e the [LTC facility] facility's | | | | | |
| | emergency plan, a | as needed. | | | | | |
| | *[For ICF/IIDs at § | ` ' - | | | | | |
| | | CF/IID must conduct | | | | | |
| | | he emergency plan at least | | | | | |
| | twice per year. Th | e ICF/IID must do the | | | | | |
| | following: | | | | | | |
| | | n annual full-scale exercise | | | | | |
| | that is community | • | | | | | |
| | | nunity-based exercise is not | | | | | |
| | accessible, conduct an annual individual, | | | | | | |
| | facility-based functional exercise; or. | | | | | | |
| | , , | experiences an actual | | | | | |
| | | ade emergency that requires | | | | | |
| | activation of the emergency plan, the ICF/IID | | | | | | |
| | · · | gaging in its next required | | | | | |
| | full-scale commun | nity-based or individual, | | | | | |

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Event ID:

GEZZ21 Facility ID: 000136

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE | SURVEY |
|-----------|--|--|----------------------------|----------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPL | |
| | | 155231 | B. W | ING | | 08/23/ | /2022 |
| NAME OF I | | | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ę. | | 701 S C | OAK ST | | |
| RANDOL | PH NURSING HON | ME | | WINCH | ESTER, IN 47394 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | ctional exercise following the | | | | | |
| | onset of the emer | | | | | | |
| | ' ' | ditional annual exercise | | | | | |
| | that may include, but is not limited to the | | | | | | |
| | following: | | | | | | |
| | (A) A second full-scale exercise that is | | | | | | |
| | community-based or an individual, facility-based functional exercise; or | | | | | | |
| | (B) A mock disast | | | | | | |
| | ` ' | er drill, or ercise or workshop that is | | | | | |
| | | and includes a group | | | | | |
| | discussion, using | - - | | | | | |
| | _ | emergency scenario, and a | | | | | |
| | set of problem sta | • | | | | | |
| | 3 | pared questions designed | | | | | |
| | to challenge an er | | | | | | |
| | _ | CF/IID's response to and | | | | | |
| | | ntation of all drills, tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | | rgency plan, as needed. | | | | | |
| | *[For HHAs at §48 | 34.102] | | | | | |
| | | e HHA must conduct | | | | | |
| | exercises to test t | he emergency plan at | | | | | |
| | | e HHA must do the | | | | | |
| | following: | | | | | | |
| | | full-scale exercise that is | | | | | |
| | community-based | | | | | | |
| | | ommunity-based exercise | | | | | |
| | | conduct an annual | | | | | |
| | | based functional exercise | | | | | |
| | every 2 years; or. | | | | | | |
| | ` ′ | A experiences an actual | | | | | |
| | natural or man-made emergency that requires | | | | | | |
| | | mergency plan, the HHA is | | | | | |
| | | aging in its next required | | | | | |
| | | nity-based or individual, | | | | | |
| | | tional exercise following the | | | | | |
| | onset of the emer | | | | | | |
| | I (II) Conduct an ad | ditional exercise every 2 | | | | | I |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | ì í | UILDING | NSTRUCTION | (X3) DATE COMPI 08/23 | LETED | | | |
|--|--------------------------|---|--|--|-----------------------------|--|--|--|--|
| | | PROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394 | | | | | |
| _ | (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE | | |
| | | functional exercise of this section is conclude, but is not (A) A second community-based facility-based function (B) A mock d (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the H maintain documer exercises, and enthe HHA's emerged (d)(2) Testing. The exercise is test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan. I actual natural or no requires activation OPO is exempt for required testing exercise of the emergency (ii) Analyze the OI maintain documents. | limited to the following: full-scale exercise that is lor an individual, ctional exercise; or isaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop nergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of nts, directed messages, or ns designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset | | | | | | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | (X3) DATE | SURVEY | |
|-----------|---|---|-------|---------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | | COMPL | |
| | | 155231 | B. W | NG | | 08/23 | /2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 701 S C | | | |
| RANDOL | PH NURSING HON | ИE | | WINCH | IESTER, IN 47394 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | i | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | _ | OPO's] emergency plan, as | | | | | |
| | needed. | | | | | | |
| | *[DNCUIs at 8401 | 2 7/01- | | | | | |
| | *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | er-based, tabletop exercise | | | | | |
| | | A tabletop exercise is a | | | | | |
| | | led by a facilitator, using a | | | | | |
| | | r-relevant emergency | | | | | |
| | scenario, and a se | et of problem statements, | | | | | |
| | directed message | s, or prepared questions | | | | | |
| | designed to challe | enge an emergency plan. | | | | | |
| | | NHCI's response to and | | | | | |
| | | ntation of all tabletop | | | | | |
| | | nergency events, and revise | | | | | |
| | | rgency plan, as needed. | | | | | |
| | | view and interview, the facility | E 00 |)39 | E 039 | | 09/09/2022 |
| | | tercises to test the emergency | | | Community has completed | | |
| | plan at least twice p | | | | second emergency preparedn | | |
| | | drills using the emergency C facility must do the | | | plan drill via table top educatio | on | |
| | following: | C facility must do the | | | exercise/process. Please see Attachment 1 for documentation | on of | |
| | _ | annual full-scale exercise that | | | table top exercise. | וט ווכ | |
| | is community-based | | | | table top excluse. | | |
| | | ity-based exercise is not | | | All residents have the potentia | l to | |
| | | an annual individual, | | | be affected by this practice an | | |
| | facility-based funct | ional exercise. | | | staff will follow the policies and | t | |
| | | y experiences an actual natural | | | procedures outlined in emerge | - | |
| | · · | gency that requires activation | | | preparedness plan and training | gs. | |
| | | lan, the LTC facility is exempt | | | | | |
| | | ext required full-scale in a | | | Polices have been updated an | | |
| | community-based or individual, facility-based | | | | table top emergency prepared | | |
| | full-scale functional exercise for 1 year following | | | | training has been completed to | | |
| | the onset of the actu | | | | ensure compliance with E 039 | | |
| | | itional exercise that may | | | standards | | |
| | include, but is not limited to the following: | | | | There we live - 1911 - 19 | -1 | |
| | a. A second full-sca | | | | These polices will be monitore | a for | |
| | community-based of | r an individual, facility-based | | | 6 (six) months by the | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPL B. WING 08/23, | | ETED | | | |
|--|---|---|--|---------------------|--|--------------------|----------------------|
| | PROVIDER OR SUPPLIER | | | 701 S C | ADDRESS, CITY, STATE, ZIP COD DAK ST ESTER, IN 47394 | | |
| RANDOL (X4) ID PREFIX TAG | SUMMARY: (EACH DEFICIEN REGULATORY OR functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or preparechallenge an emerginal (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergacordance with 42 deficient practice of Findings include: Based on records remaintenance Direct on 08/23/22 between facility was able to response to the COVE mergency, howeved documentation of a test the emergency interview at the tim Maintenance Direct were asked to proving entrance conference throughout the survival was made available agreed that docume choice was not avail. This finding was ac Maintenance Direct and again at the exit | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to rency plan. C facility's response to and ration of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This rould affect all occupants. The wiew and interview with the ror and Interim Administrator on 10:30 a.m. and 12:55 a.m., the provide documentation of its VID-19 Public Health rer, was unable to provide second exercise of choice to preparedness plan. Based on re of record review, the ror and Interim Administrator de the documentation at the rer, and on two other occasions rey day, but no documentation The Maintenance Director intation of a second exercise of lable for review. | | WINCH ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) ED/Designee to ensure that the remain in place. Results will be reported monthly to the Quality Assurance Committee. Attachment 2 auditing tool to be reviewed at Quality Assurance Committee each month. Date of compliance is 9/9/2022 | ey e y ee | (X5) COMPLETION DATE |
| | on present at 3:10 p | .m. | | | | | |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 01 | COMP | E SURVEY PLETED 3/2022 | |
|--|--|--|---------------------|---|---|----------------------------|
| | PROVIDER OR SUPPLIER | | 701 S | CADDRESS, CITY, STATE, ZIP COD OAK ST HESTER, IN 47394 | | |
| (X4) ID PREFIX TAG K 0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| Bldg. 01 | Licensure Survey w Department of Heal 483.90(a). Survey Date: 08/23 Facility Number: 0 Provider Number: 1002 At this Life Safety O Nursing Home was Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code, (I Health Care Occupa This one-story facil Type V (111) const: The facility has a findetection in the corn corridors and batter all resident sleeping capacity of 94 and b of this visit. All areas where resi were sprinkled and services were sprinkled. | 00136 155231 275450 Code survey, Randolph found not in compliance with | K 0000 | The creation and submiss this plan of correction do constitute an admission be provider of any conclusion in the statement of deficie of any violation of regulate provider respectfully requested the 2567 plan of correction considered the letter of callegation and request a review of certification of compliance on or after 9/1000 providers. | es not by this n set forth encies, or ion. This lests that on be redible desk | |

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| | | IDENTIFICATION NUMBER 155231 | JILDING | 01 | COMPL 08/23/ | ETED |
|-------------------|--|--|--------------|--|-----------------|--------------------|
| | ROVIDER OR SUPPLIER | | 701 S O | NDDRESS, CITY, STATE, ZIP COD NAK ST ESTER, IN 47394 | | |
| | | | | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | ΤE | (X5) COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| K 0222 | NFPA 101 | | | | | |
| SS=E | Egress Doors | | | | | |
| Bldg. 01 | Egress Doors | | | | | |
| | | d means of egress shall not | | | | |
| | be equipped with a | a latch or a lock that | | | | |
| | requires the use o | f a tool or key from the | | | | |
| | egress side unless | s using one of the following | | | | |
| | special locking arr | | | | | |
| | | OR SECURITY THREAT | | | | |
| | LOCKING | | | | | |
| | | king arrangements for the | | | | |
| | clinical security needs of the patient are | | | | | |
| | - | king device shall be | | | | |
| | | door and provisions shall | | | | |
| | | ipid removal of occupants | | | | |
| | _ | of locks; keying of all | | | | |
| | _ | ed by staff at all times; or | | | | |
| | | means available to the | | | | |
| | staff at all times. | 000 4000 54 | | | | |
| | | 2.2.6, 19.2.2.2.5.1, | | | | |
| | 19.2.2.2.6 | 1.00(4)10 | | | | |
| | SPECIAL NEEDS | | | | | |
| | ARRANGEMENTS | | | | | |
| | • | king arrangements for the | | | | |
| | • | e patient are used, all of | | | | |
| | | urity Locking requirements | | | | |
| | _ | addition, the locks must be | | | | |
| | | t fail safely so as to | | | | |
| | - | of power to the device; the | | | | |
| | building is protecte | | | | | |
| | • | r system and the locked | | | | |
| | | by a complete smoke | | | | |
| | - · | or is constantly monitored | | | | |
| | | ation within the locked | | | | |
| | | he sprinkler and detection | | | | |
| | - | ged to unlock the doors | | | | |
| | upon activation. | 2.2.5.2. TIA 42.4 | | | | |
| | 18.2.2.2.5.2, 19.2. | | | | | |
| | DELAYED-EGRES ARRANGEMENTS | | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 08/23/2022 | | |
|--------------------------|--|---|--|---|---------------------------------------|--|--|
| | PROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE | | |
| | systems installed 7.2.1.6.1 shall be assemblies servin contents in buildir an approved, supplemental detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTE LOCKING ARRAI Access-Controlled installed in according be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBI LOCKING ARRAI Elevator lobby exist accordance with 7 on door assemblied throughout by an automatic fire detection approved, supervisystem. 18.2.2.2.4, 19.2.2 Based on observation failed to ensure the courtyard exit was swithout a clinical disecurity measures. of egress shall not be lock that requires the egress side unless of 19.2.2.2.4. Door-lopermitted in according the service of the servic | COLLED EGRESS NGEMENTS I Egress Door assemblies I Egress Door assemblies I Earnes With 7.2.1.6.2 shall C.2.4 BY EXIT ACCESS NGEMENTS It access door locking in I.2.1.6.3 shall be permitted les in buildings protected approved, supervised lection system and an ised automatic sprinkler C.2.4 I Door and interview, the facility means of egress through the readily accessible for residents liagnosis requiring specialized Doors within a required means the equipped with a latch or the use of a tool or key from the otherwise permitted by LSC locking arrangements shall be lance with 19.2.2.2.5.2. This build affect over 15, staff and | K 0222 | K 222 Community has now posted of door/gate code to ensure the means of egress through the courtyard exit is in place. This code has been posted and is readily accessible for visitors staff, and for residents that we a clinical diagnosis requiring specialized security measure. All residents have the potention be affected by this practice. | s , ithout s. | | |

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| | F OF HEALTH AND HU! | | | | | RM APPROVED B NO. 0938-039 |
|----------------------------|---|--|--|---|--|----------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 01 | (X3) DATE SURVEY COMPLETED 08/23/2022 | |
| | PROVIDER OR SUPPLIER | | 701 S | ADDRESS, CITY, STATE, ZIP COD OAK ST HESTER, IN 47394 | | (X5) |
| PREFIX TAG | REGULATORY OR Based on observation facility tour with the Interim Administrate a.m. and 2:45 p.m., gates, each were man opened by entering was not posted at eif facility into the courthis finding was ac Maintenance Direct and again at the exist. | or at the time of observation t conference with the or and Interim Administrator | PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) All exit doors/egress and courtyard gate have been auc to ensure and an exit door/ga code is now posted to ensure means of egress for visitors, s and for residents that without clinical diagnosis requiring specialized security measures This will be monitored monthly 6 (six) months by the ED or Designee with results reporter monthly to the Quality Assura Committee. | gress and nave been audited n exit door/gate sted to ensure the s for visitors, staff, s that without a is requiring urity measures nitored monthly for by the ED or esults reported | |
| K 0232 SS=E Bldg. 01 | unobstructed) servat least 4 feet and convenient removon stretchers, exc 19.2.3.4, exceptio 19.2.3.4, 19.2.3.5 | Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by | K 0232 | See Attachment 3. Date of compliance is 9/9/202 | 2 | 09/09/2022 |

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floor or to the wall.

the clear width requirement for 1 of over 5

all of the following conditions are met:

corridors or met an exception per 19.2.3.4(5). LSC

shall be permitted for fixed furniture, provided that

19.2.3.4(5) states where the corridor width is at

least 8 feet, projections into the required width

(a) the fixed furniture is securely attached to the

(b) the fixed furniture does not reduce the clear

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Community has ensured that

serving as exits are no less than

4ft and maintained to provide the

stretchers, wheel chairs, and other

width of aisles and corridors

non-ambulatory patients on

non-ambulatory processes.

convenient removal of

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 08/23/2022 | |
|--|-----------------------|---|--------|--|---------|
| NAME OF P | PROVIDER OR SUPPLIER | · | | ADDRESS, CITY, STATE, ZIP COD | - |
| RANDOL | PH NURSING HON | ΜE | | OAK ST HESTER, IN 47394 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| TAG | | C LSC IDENTIFYING INFORMATION or width to less than six feet, | TAG | All residents that reside on th | DATE |
| | | by LSC 19.2.3.4(2). | | 300 Hall have the potential to | |
| | | re is located only on one side | | affected by this practice. | |
| | of the corridor. | | | | |
| | | re is grouped such that each | | All Units will be monitored to | |
| | | exceed an area of 50 square | | ensure 4 ft of access and will | |
| | feet. | re groupings addressed in LSC | | maintained to meet the needs | s of |
| | | separated from each other by a | | non-ambulatory residents and | 4 |
| | distance of at least | | | visitors. | |
| | (f) the fixed furnitu | re is located so as to not | | | |
| | | uilding service and fire | | All unit will be monitored for 6 | s (six) |
| | protection equipmen | | | months by the ED/Designee f | |
| | | hout the smoke compartment | | compliance with results repor | ted |
| | | electrically supervised etection system in accordance | | to the Quality Assurance Committee monthly. See | |
| | | the fixed furniture spaces are | | Attachment #4 | |
| | | d to allow direct supervision | | Attachment #4 | |
| | _ | from a nurse's station or similar | | | |
| | space. | | | | |
| | | partment is protected | | | |
| | | pproved, supervised automatic | | | |
| | | accordance with LSC 19.3.5.8 | | | |
| | staff and visitors ex | ice could affect 12 residents, | | | |
| | Starr and Visitors CA | ining the facilities. | | | |
| | Findings: | | | | |
| | Based on observation | on and interview during a | | | |
| | | e Maintenance Director and | | | |
| | | tor on 08/23/22 between 12:55 | | | |
| | - | in the corridor near resident | | | |
| | | ve seats extended into the | | | |
| | corridor approximat | tely 36 inches. The a/love seat was free standing, | | | |
| | not affixed to the w | <u> </u> | | | |
| | not arrived to the w | wii 01 11001. | | | |
| | This finding was ac | knowledged by the | | | |
| | | or at the time of observation | | | |
| | and again at the evi | t conference with the | 1 | | |

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 08/23/2022 | |
|----------------------------|--|--|--|---|--|---------------------------------------|------|
| | PROVIDER OR SUPPLIER | | | 701 S O | DDRESS, CITY, STATE, ZIP COD AK ST ESTER, IN 47394 | | |
| | 1 | | | <u> </u> | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULL CROSS-REFRENCED TO THE APPRO TAG TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFRENCED TO THE APPRO DEFICIENCY) | | | |
| ind | | or and Interim Administrator | | ind | | | DATE |
| | 3.1-19(b) | | | | | | |
| K 0321 SS=E Bldg. 01 | barrier having 1-h (with 3/4 hour fire automatic fire extinuction accordance with 8 approved automatioption is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor | - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 5.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4. | | | | | |
| | Area Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe | lons) orage Rooms/Spaces eet) classified as Severe | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | (X2) MULTIPLE A. BUILDING B. WING | construction 01 | (X3) DATE SURVEY COMPLETED 08/23/2022 | | |
|--|--|--|---------------------|--|---|----------------------------|
| | PROVIDER OR SUPPLIER | | 701 \$ | ET ADDRESS, CITY, STATE, ZIP COD S OAK ST CHESTER, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | Based on observation failed to ensure 1 of such as storage room properly working sedeficient practice of residents, as well as Findings include: Based on observation facility tour with the Interim Administration a.m. and 2:45 p.m., corridor door did not door frame when te This finding was ac Maintenance Direct and again at the exit | on and interview, the facility Fover 10 hazardous area doors, ms, were provided with elf-closing devices. This ould affect more than 5 staff and visitors. on and interview during a the Maintenance Director and for on 08/23/22 between 12:55 the oxygen transfilling room tot self-close and latch into the sted several times. knowledged by the or at the time of observation to conference with the or and Interim Administrator | K 0321 | K 321 Community has ensured to oxygen transfilling room or door now latches independent and now self-closes and later into the door frame. All residents have the potent be affected by this practice. Area will be monitored for self-closing and self-latching are closing by the ED/Designer results reported monthly to Quality Assurance Commissee Attachment #5 Date of compliance is 9/9/ | orridor dently atches ential to e. ng door. 6 (six) ad proper ee with o the ttee. | 09/09/2022 |
| K 0345 SS=C Bldg. 01 | in accordance with complying with the National Electric C National Fire Alarn Records of systen and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation | n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. | K 0345 | K 345 | | 09/09/2022 |

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 08/23/2022 |
|---|---|---|--|--|---------------------------------------|
| | PROVIDER OR SUPPLIEF | | 701 S | ADDRESS, CITY, STATE, ZIP COD OAK ST HESTER, IN 47394 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | N (X5) BE COMPLETION DATE |
| accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. | | | Community has ensured that fire alarm panel time and data accurate to local time and data. All residents have the potential accurate. | ate are late. | |
| | Findings include: | | | be affected by this practice. | |
| | facility tour with the Interim Administrat | on and interview during a e Maintenance Director and tor on 08/23/22 between 12:55 the date and time on the main | | Fire alarm company notified time and date discrepancy a time and date now updated reflect local time and date. | and |
| | fire alarm control p on the main fire ala time to be approxin actual local time. T | anel was incorrect. The display rm control panel indicated the nately 4 hours slower than the he date of this survey was attereflected on the main FACP | | Area will be monitored for 6 months by the ED/Designed ensure that the main fire pa date and time are accurate local area. Results will be re- | e to nel to the |
| | was 09/09/07. Base observation, the Mahe was unaware of | d on interview at the time of uintenance Director indicated the discrepancy and would ompany to update the fire alarm | | monthly to the Quality Assu committee. See Attachmen Date of compliance is 9/9/2/ | rance at 6. |
| | This finding was ac Maintenance Direct and again at the exi Maintenance Direct | or at the time of observation t conference with the or and Interim Administrator | | | |
| | on present at 3:10 p 3.1-19(b) | .m. | | | |
| K 0346 SS=C Bldg. 01 | services for more period, the author be notified, and th evacuated or an a | | | | |

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 08/23/2022 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 shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility K 0346 K 346 09/09/2022 failed to provide a complete 1 of 1 written policy for the protection of residents indicating Community has ensured that fire procedures to be followed in the event the fire plan policy now includes alarm system has to be placed out of service for contacting the Indiana Department four hours or more in a twenty four hour period in of Health via the ISDH gateway accordance with LSC, Section 9.6.1.6. This link as a primary method or deficient practice affects all occupants. secondary method of emailing the ISDH. Findings include: All residents have the potential to Based on records review and interview with the be affected by this practice. Maintenance Director and Interim Administrator on 08/23/22 between 10:30 a.m. and 12:55 a.m., the Fire Plan Policy has been updated fire watch plan failed to include contacting the to include new verbiage for Indiana Department of Health via the ISDH contacting ISDH for primary and Gateway link at https://gateway.isdh.in.gov as the secondary communication primary method or by the secondary method when methods. See Attachment 7 the ISDH Gateway is nonoperational by completing the Incident Reporting form and Process will be monitored for 6 e-mailing it to incidents@isdh.in.gov. Based on (six) months by the ED/Designee interview during the record review, the to ensure that the fire plan Maintenance Director acknowledged the fire communication methods are watch documentation provided stated to contact followed. Results will be reported the Indiana Department of Health at a phone monthly to the Quality Assurance number, and not via the ISDH Gateway link or at committee. See Attachment 8 the e-mail address listed above. Date of compliance is 9/9/2022 This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Interim Administrator on present at 3:10 p.m. 3.1-19(b)

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Event ID:

GEZZ21

Facility ID: 000136

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | (X2) MULTIPLE (A. BUILDING B. WING | <u></u> | | |
|--|---|---|--------------|---|------------------------------|
| | PROVIDER OR SUPPLIER | | 701 S | OAK ST HESTER, IN 47394 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCE | DATE |
| | | 0 | | | |
| K 0354 SS=C Bldg. 01 | extent and duration been determined, are inspected and recommendations management or duration and the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record reversided to provide 1 of the event the autom placed out-of-service 24-hour period in a 9.7.5. LSC 9.7.6 recomprocedures comply the Standard for the Maintenance of Wasystems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained per patrol the affected a extinguishers and the | er system is impaired, the of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, then and other authorities have been notified. Where of the building affected are pproved fire watch is sprinkler system has been es. 9.7.5, 15.5.2 (NFPA 25) riew and interview, the facility of 1 correct written policies in atic sprinkler system has to be the for 10 hours or more in a ecordance with LSC, Section quires sprinkler impairment with NFPA 25, 2011 Edition, Inspection, Testing and ter-Based Fire Protection (15.5.2 requires nine impairment coordinator shall to (b) states a fire watch should ersonnel who continuously trea. Ready access to fire the ability to promptly notify | K 0354 | K 354 Community has ensured that plan policy now includes contacting the Indiana Depart of Health via the ISDH gatewalink as a primary method or secondary method of emailing ISDH. All residents have the potentiable affected by this practice. Fire Plan Policy has been upon to include new verbiage for | ment ay g the al to |
| | consider. During the should not only be l sure that the other f building such as eguare available and fu | are important items to e patrol of the area, the person ooking for fire, but making ire protection features of the ress routes and alarm systems nctioning properly. This ould affect all occupants in the | | contacting ISDH for primary a secondary communication methods. See Attachment 7 Process will be monitored for (six) months by the ED/Design to ensure that the fire plan | 6 |

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Event ID:

GEZZ21 Facility ID: 000136

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PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROV | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | |
|------------------------------------|--|--|--------------------------------------|----------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 01 | COMPL | ETED |
| | | 155231 | B. WI | NG | | 08/23/ | 2022 |
| | | | | CTDEET A | DDDESS CITY STATE ZIR COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| RANDOL | PH NURSING HOM | Λ Ε | 701 S OAK ST WINCHESTER, IN 47394 | | | | |
| 1011000 | 111101011011 | | | WIINOIT | LOTER, IIV 47004 | | |
| (X4) ID | SUMMARY S | 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 | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | facility. | | | | communication methods are | | |
| | | | | | followed. Results will be report | | |
| | Findings include: | | | | monthly to the Quality Assurar | | |
| | D 1 | · · · · · · · · · · · · · · · · · · · | | | committee. See Attachment 8 | | |
| | | view and interview with the | | | | _ | |
| | | or and Interim Administrator | | | Date of compliance is 9/9/2022 | 2 | |
| | on 08/23/22 between 10:30 a.m. and 12:55 a.m., the | | | | | | |
| | - | ed to include contacting the | | | | | |
| | - | of Health via the ISDH os://gateway.isdh.in.gov as the | | | | | |
| | | by the secondary method when | | | | | |
| | | is nonoperational by | | | | | |
| | - | dent Reporting form and | | | | | |
| | | ents@isdh.in.gov. Based on | | | | | |
| | interview during the | - | | | | | |
| | - | or acknowledged the fire | | | | | |
| | | on provided stated to contact | | | | | |
| | | nent of Health at a phone | | | | | |
| | - | the ISDH Gateway link or at | | | | | |
| | the e-mail address li | | | | | | |
| | | | | | | | |
| | This finding was acl | knowledged by the | | | | | |
| | Maintenance Direct | or at the time of observation | | | | | |
| | and again at the exit | t conference with the | | | | | |
| | Maintenance Direct | or and Interim Administrator | | | | | |
| | on present at 3:10 p | .m. | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |
| | | | | | | | |
| K 0363 | NFPA 101 | | | | | | |
| SS=E | Corridor - Doors | | | | | | |
| Bldg. 01 | Corridor - Doors | | | | | | |
| | | corridor openings in other | | | | | |
| | • | osures of vertical openings, | | | | | |
| | | s areas resist the passage | | | | | |
| | | made of 1 3/4 inch | | | | | |
| | | wood or other material | | | | | |
| | • | g fire for at least 20 | | | | | |
| | | fully sprinklered smoke only required to resist the | | | | | |
| | companinents are | only required to resist the | 1 | | | | |

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Event ID:

GEZZ21 Facility ID: 000136

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|----------------------|---|-------|----------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 01 | COMPL | ETED |
| | | 155231 | B. W | NG | | 08/23/ | /2022 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | 701 S C | | | |
| RANDOL | PH NURSING HO | ME | | | ESTER, IN 47394 | | |
| (X4) ID | SIIMMADV | STATEMENT OF DEFICIENCIE | T | ID | | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | ` | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | DATE |
| 1110 | | e. Corridor doors and doors | | 1110 | | | Dille |
| | to rooms containir | | | | | | |
| | | rials have positive latching | | | | | |
| | | atches are prohibited by | | | | | |
| | | These requirements do not | | | | | |
| | apply to auxiliary | spaces that do not contain | | | | | |
| | flammable or com | bustible material. | | | | | |
| | | en bottom of door and floor | | | | | |
| | _ | ceeding 1 inch. Powered | | | | | |
| | | with 7.2.1.9 are permissible | | | | | |
| | • | device capable of keeping | | | | | |
| | | hen a force of 5 lbf is | | | | | |
| | • • | no impediment to the | | | | | |
| | - | rs. Hold open devices that door is pushed or pulled are | | | | | |
| | | ed protective plates of | | | | | |
| | • | re permitted. Dutch doors | | | | | |
| | _ | 6 are permitted. Door | | | | | |
| | _ | beled and made of steel or | | | | | |
| | | compliance with 8.3, | | | | | |
| | unless the smoke | compartment is | | | | | |
| | sprinklered. Fixed | l fire window assemblies are | | | | | |
| | allowed per 8.3. Ir | n sprinklered compartments | | | | | |
| | there are no restri | ictions in area or fire | | | | | |
| | | s or frames in window | | | | | |
| | assemblies. | | | | | | |
| | 40.0.0.0.40.050 | Darta 400, 440, 460, 400 | | | | | |
| | 483, and 485 | Parts 403, 418, 460, 482, | | | | | |
| | | S details of doors such as | | | | | |
| | | ngs, automatics closing | | | | | |
| | devices, etc. | nge, automaties sissing | | | | | |
| | | on and interview, the facility | K 0 | 363 | K 363 | | 09/09/2022 |
| | | resident room corridor doors | | | Community has ensured that | | |
| | were provided with | a means suitable for keeping | | | corridor door to resident room | 314 | |
| | | d no impediment to closing, | | | and all other corridor doors are | e not | |
| | - | resist the passage of smoke. | | | propped open with any object | | |
| | This deficient pract | tice could affect 2 residents. | | | device and will ensure door ca | ın be | |
| | | | | | closed. | | |
| | Findings include: | | | | All residents have the potentia | I to | |

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | r í | ILDING | nstruction 01 | (X3) DATE COMPL 08/23 / | ETED |
|----------------------------|--|---|------|---------------------|--|--------------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER PH NURSING HOM | | | 701 S C | ADDRESS, CITY, STATE, ZIP COD DAK ST ESTER, 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) | ΓE | (X5) COMPLETION DATE |
| K 0374 SS=E Bldg. 01 | facility tour with the Interim Administrat a.m. and 2:45 p.m., room 314 was propy door holder. Based observation, the Ma acknowledged the a would not close unlifirst. This finding was ac Maintenance Direct and again at the exit Maintenance Direct on present at 3:10 p 3.1-19(b) NFPA 101 Subdivision of Buil Barrie Subdivision of Buil Barrie Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that repermitted. Doof fixed fire window a are self-closing or require latching, a in the direction of provides a minimulator swinging or house the self-closing or house the | knowledged by the or at the time of observation a conference with the or and Interim Administratorm. Iding Spaces - Smoke Iding | K 03 | 374 | be affected by this practice. All corridor doors will be monit for object that are holding corridoors open. Area will be monitored for 6 (si months to ensure no corridor of is held open with any object by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #9 Date of compliance is 9/9/2022 | dor (x) door (| 09/09/2022 |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|--|--|----------------------|--------------|---|----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 01 | COMPL | ETED |
| | | 155231 | B. W | ING | | 08/23/ | 2022 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | 8 | | 701 S C | | | |
| RANDOL | PH NURSING HON | ΛE | WINCHESTER, IN 47394 | | | | |
| | | | | ID | | | (V5) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | (X5) |
| TAG | • | CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | t the movement of smoke for at | - | IAU | Community has ensured that | | DATE |
| | | SC 19.3.7.8 requires doors in | | | barrier doors on the 300 hall fi | rom | |
| | | | | | the lobby now latches | OIII | |
| | smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier | | | | _ | 0000 | |
| | | ing leaving only the minimum | | | independently and now self-cle completely and latches. | uses | |
| | - | for proper operation. This | | | All residents residing on 300 h | all. | |
| | | ould affect some 10 residents, | | | have the potential to be affect | | |
| | staff and visitors on | | | | by this practice. | c u | |
| | stall and visitors on the 300 Hall. | | | | by this practice. | | |
| | Findings include: Based on observation and interview during a facility tour with the Maintenance Director and Interim Administrator on 08/23/22 between 12:55 | | | | Area will be monitored for | | |
| | | | | | complete closing and self-late | hina | |
| | | | | | door. | illig | |
| | | | | | 4001. | | |
| | | | | | Area will be monitored for 6 (s | ix) | |
| | | the set of barrier doors on the | | | months for self-latching and pr | • | |
| | - | obby did not close completely | | | closing by the ED/Designee w | - | |
| | and latch. | | | | results reported monthly to the | | |
| | | | | | Quality Assurance Committee | | |
| | Based on interview | during the time of | | | See Attachment #10 | | |
| | | aintenance Director | | | | | |
| | | e barrier doors did not close | | | Date of compliance is 9/9/202 | 2 | |
| | completely and late | | | | | _ | |
| | | | | | | | |
| | This finding was ac | knowledged by the | | | | | |
| | Maintenance Direct | or at the time of observation | | | | | |
| | and again at the exi | t conference with the | | | | | |
| | | or and Interim Administrator | | | | | |
| | on present at 3:10 p | .m. | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |
| | | | | | | | |
| K 0511 | NFPA 101 | | | | | | |
| SS=E | Utilities - Gas and | | | | | | |
| Bldg. 01 | Utilities - Gas and | | | | | | |
| | | gas or related gas piping | | | | | |
| | · · | PA 54, National Fuel Gas | | | | | |
| | | iring and equipment | | | | | |
| | • | PA 70, National Electric | | | | | |
| | | tallations can continue in | | | | | |
| | service provided r | no hazard to life. | | | | | |

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| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155231 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 08/23/2022 | | |
|---|--|--|--|--|---|---------------------------------------|----------------------------|--|
| 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 | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | |
| | Based on observation 1 of 1 electrical splus box. LSC 9.1.2 reception equipment to compend Electrical Code. Are shall be made in list deficient practice of 100 hall. Findings include: Based on observation facility tour with the Interim Administra a.m. and 2:45 p.m., hall near resident received a junction be aforementioned with which contained Reconsiderate and application of the 100-hall attice the junction box and convire, but he did not originating in a 110 splices needed to be This finding was act Maintenance Direct and again at the exit | on, the facility failed to ensure ices were made in a junction quires electrical wiring and ly with NFPA 70, National ticle 322.56 (A) states splices ted junction boxes. This build affect 8 residents in the on and interview during a le Maintenance Director and tor on 08/23/22 between 12:55 above the ceiling on the 100 bom 101 there were two local together not contained box. It appeared one of the local trees came from a junction box lomex type electrical wire. Based time of the observation, the local to acknowledged there was an local the space above the ceiling on lat was not protected with a longer and why it was a junction box and agreed the local time of observation to the local time of observation to the local time of observation to conference with the loca | K 0 | 511 | Community has ensured that spliced wire on 100 hall ceilir now in a junction box. All residents have the potentibe affected by this practice. Area will be monitored for jurbox needs for spliced cables. Area will be monitored for 6 (months for any wiring connection outside of an approved junctibox by the ED/Designee with results reported monthly to the Quality Assurance Committee See Attachment #11 Date of compliance is 9/9/203 | ag is al to action six) ctions on ae | 09/09/2022 | |
| K 0712 SS=C | NFPA 101 Fire Drills | | | | | | | |

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GEZZ21 Facility ID: 000136

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|-------------------------------|---|---|--|----------|--|------------------|------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | <u>- </u> | | | COMPL | COMPLETED | |
| | | 155231 | B. WING | | | 08/23/2022 | | |
| NAME OF DROVINGS OR CURRY IFD | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 701 S C | | | | |
| RANDOLPH NURSING HOME | | | | WINCH | ESTER, IN 47394 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | • | CY MUST BE PRECEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| Bldg. 01 | Fire Drills | | | | | | | |
| | | he transmission of a fire | | | | | | |
| | - | imulation of emergency fire ills are held at expected | | | | | | |
| | | mes under varying | | | | | | |
| | - | t quarterly on each shift. | | | | | | |
| | | r with procedures and is | | | | | | |
| | | re part of established | | | | | | |
| | | ills are conducted between | | | | | | |
| | 9:00 PM and 6:00 | | | | | | | |
| | announcement may be used instead of | | | | | | | |
| | audible alarms. | | | | | | | |
| | 19.7.1.4 through 19.7.1.7 | | | | | | | |
| | | riew and interview, the facility | K 0' | 712 | K 712 | | 09/09/2022 | |
| | failed to conduct qu | | | | | | | |
| | | d at unexpected times under | | | Community has ensured fire d | | | |
| | | This deficient practice could | | | will be held at unexpected time | es | | |
| | affect aff residents, s | staff and visitors in the facility. | | | and days. Change to fire drill times and days of the month h | .010 | | |
| | Findings include: | | | | been created in TELS to ensu | | | |
| | i manigs meiade. | | | | this schedule is updated. | ic | | |
| | Based on records re | view of the Tels "Logbook | | | All residents have the potentia | l to | | |
| | | arding Fire Drills" and | | | be affected by this practice. | | | |
| | _ | Maintenance Director and | | | , | | | |
| | Interim Administrator on 08/23/22 between 10:30 | | | | Change to fire drill times sche | dule | | |
| | | , 9 of 12 quarterly fire drills were | | | has been created in TELS to | | | |
| | conducted near the end of the month, between | | | | ensure this schedule is update | ed | | |
| | - | f the month. These conditions | | | | | | |
| | | lls to be conducted at | | | Fire Drills will be monitored for | | | |
| | unexpected times ar | nd on unpredictable days. | | | (six) months to ensure each di | | | |
| | This finding | Irmaryladaad by tha | | | performed at unexpected time | | | |
| | This finding was ac | or at the time of observation | | | and days by the ED/Designee | | | |
| | | t conference with the | | | results reported monthly to the Quality Assurance Committee | | | |
| | | or and Interim Administrator | | | See Attachment #12 | • | | |
| | on present at 3:10 p. | | | | OGG Augument #12 | | | |
| | present at 5.10 p | | | | Date of compliance is 9/9/202 | 2 | | |
| | 3.1-19(b) | | | | | | | |
| | | | | | | | | |

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| | | X1) PROVIDER/SUPPLIER/CLIA | | | | | (3) DATE SURVEY COMPLETED | |
|---|--|---|--|--------------------|---|-------|---------------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | | | | | |
| 155231 | | | B. W | B. WING 08/23/2022 | | | 2022 | |
| NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME | | | STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394 | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | | DROVIDEDIC DI AN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY 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 | |
| K 0920 | NFPA 101 | | | | | | | |
| SS=E | Electrical Equipment - Power Cords and | | | | | | | |
| Bldg. 01 | Extens | | | | | | | |
| | Electrical Equipme | ent - Power Cords and | | | | | | |
| | Extension Cords | | | | | | | |
| | Power strips in a p | patient care vicinity are only | | | | | | |
| | used for compone | nts of movable | | | | | | |
| | patient-care-relate | d electrical equipment | | | | | | |
| | , , | es that have been | | | | | | |
| | | lified personnel and meet | | | | | | |
| | | 0.2.3.6. Power strips in | | | | | | |
| | • | cinity may not be used for | | | | | | |
| | non-PCREE (e.g., personal electronics), except in long-term care resident rooms that | | | | | | | |
| | | | | | | | | |
| | | E. Power strips for PCREE | | | | | | |
| | | UL 60601-1. Power strips | | | | | | |
| | | the patient care rooms | | | | | | |
| | • |) meet UL 1363. In | | | | | | |
| | • | ooms, power strips meet | | | | | | |
| | | s. All power strips are | | | | | | |
| | - | precautions. Extension | | | | | | |
| | | d as a substitute for fixed | | | | | | |
| | - | re. Extension cords used moved immediately upon | | | | | | |
| | | purpose for which it was | | | | | | |
| | | is the conditions of 10.2.4. | | | | | | |
| | | 9), 10.2.4 (NFPA 99), 400-8 | | | | | | |
| | , | (D) (NFPA 70), TIA 12-5 | | | | | | |
| | • | | K 0 | 20 | K 920 | | 09/09/2022 | |
| | Based on observation and interview, the facility failed to ensure power strips in 3 locations met UL | | KU | 20 | 1 320 | | 09/09/2022 | |
| | | 60601-1. Patient care vicinity is | | | Community has ensured the a | II . | | |
| | - | within a location intended for | | | power strips, including rooms | | | |
| | - | I treatment of patients, | | | and 110, meet the proper UL | .00 | | |
| | | yond the normal location of the | | | rating for patient care areas. | | | |
| | | admill, or other device that | | | Community has also ensured t | that | | |
| | | during examination and | | | proper power strip use is now | | | |
| | | t care vicinity extends | | | place for resident in room 301 | | | |
| | • | inches above the floor. This | | | relates to high power draw | | | |
| | deficient practice af | | | | equipment(dorm style refriger | ator) | | |
| | - | | | | not being plugged into a powe | , | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | |
|--|---|-----------------------------------|----------------------------|-----------------------|---|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | a. building <u>01</u> | | COMPLETED | |
| 155231 | | 155231 | B. WING | | | 08/23/2022 | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 701 S C | | | |
| RANDOLPH NURSING HOME | | | | | ESTER, IN 47394 | | |
| | T | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | Findings include: | | | | strip. | | |
| | D 1 1 2 | 11. | | | All residents have the potentia | I to | |
| | | on and interview during a | | | be affected by this practice. | | |
| | _ | e Maintenance Director and | | | N | - 4 | |
| | | tor on 08/23/22 between 12:55 | | | New patient care grade power | | |
| | _ | resident rooms 108, and 110 | | | being used in rooms 108 and | | |
| | and it could not be | ver strips which were in use | | | High power draw equipment (c | | |
| | | wer strips met the proper UL | | | style refrigerator) now plugged | 1 1(1 | |
| | _ | at care location. In resident | | | to fixed power outlet. | | |
| | | | | | Area will be monitored for 6 (s | i۷۱ | |
| | room 108 the power strip was attached to the wall | | | | months to ensure no unapprov | , | |
| | near the TV. In resident room 110 two power strips were in use and a UL rating could not be | | | | power strips are being used | eu | |
| | determined and they did not meet the requirement | | | | throughout by the ED/Designe | ۵ | |
| | of a UL rating of 1363A or 60601-1 label on each | | | | with results reported monthly t | | |
| | power strip. | | | | the Quality Assurance Commit | | |
| | power surp. | | | | See Attachment #13 | | |
| | This finding was acknowledged by the | | | | coo, macriment ii 10 | | |
| | Maintenance Director at the time of observation | | | | Date of compliance is 9/9/2022 |) | |
| | | t conference with the | | | | | |
| | _ | tor and Interim Administrator | | | | | |
| | on present at 3:10 p.m. 2. Based on observation and interview, the facility | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | failed to ensure 1 of | f 1 power strips were not used | | | | | |
| | as a substitute for fi | xed wiring to provide power | | | | | |
| | equipment with a hi | igh current draw. | | | | | |
| | NFPA-70/2011, 400 | 0.8 state unless specifically | | | | | |
| | permitted in 400.7 f | flexible cords and cables shall | | | | | |
| | not be used for (1) a | as a substitute for fixed wiring. | | | | | |
| | This deficient pract | ice could affect up to 3 | | | | | |
| | residents. | | | | | | |
| | | | | | | | |
| | Findings include: | | | | | | |
| | | | | | | | |
| | Based on observation and interview during a facility tour with the Maintenance Director and Interim Administrator on 08/23/22 between 12:55 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | _ | in resident room 301 a power | | | | | |
| strip was being used to power a dorm style | | | | | | | |

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PRINTED: 09/13/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155231 | , | ILDING | INSTRUCTION 01 | (X3) DATE COMPL 08/23 / | ETED | |
|---|---|--|---|--|--|--------------------------------------|------------|--|
| NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME | | | | STREET ADDRESS, CITY, STATE, ZIP COD 701 S OAK ST WINCHESTER, IN 47394 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OF | | | TAG | DEFICIENCY) | | DATE | |
| | This finding was ac Maintenance Direct and again at the exi | or at the time of observation t conference with the or and Interim Administrator | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GEZZ21 Facility ID: 000136 If continuation sheet Page 30 of 30