STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/23/22 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 At this Emergency Preparedness survey, Randolph Nursing Home was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 61. Quality Review completed on 08/25/22	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review of certification of compliance on or after 9/9/2022	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional 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 disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional 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 disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, 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 disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional 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	E 0039	E 039 Community has completed second emergency preparedness plan drill via table top education exercise/process. Please see Attachment 1 for documentation of table top exercise. All residents have the potential to be affected by this practice and staff will follow the policies and procedures outlined in emergency preparedness plan and trainings. Polices have been updated and table top emergency preparedness training has been completed to ensure compliance with E 039 standards These polices will be monitored for 6 (six) months by the	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING -- B. WING	08/23/2022

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
	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and Interim Administrator on 08/23/22 between 10:30 a.m. and 12:55 a.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Maintenance Director and Interim Administrator were asked to provide the documentation at the entrance conference, and on two other occasions throughout the survey day, but no documentation was made available. The Maintenance Director agreed that documentation of a second exercise of choice was not available for review. 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.		ED/Designee to ensure that they 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/23/22 Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450 At this Life Safety Code survey, Randolph Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 61 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had three detached wooden storage buildings which were not sprinkled. Quality Review completed on 08/25/22	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review of certification of compliance on or after 9/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through the courtyard exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility. Findings include:	K 0222	K 222 Community has now posted exit 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 without a clinical diagnosis requiring specialized security measures. All residents have the potential to be affected by this practice.	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview during a facility tour with the Maintenance Director and Interim Administrator on 08/23/22 between 12:55 a.m. and 2:45 p.m., the main courtyard had two exit gates, each were magnetically locked and could be opened by entering a four-digit code but the code was not posted at either exit gate. Doors from the facility into the courtyard were marked as exits. 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)		All exit doors/egress and courtyard gate have been audited to ensure and an exit door/gate code is now posted to ensure the means of egress for visitors, staff, and for residents that without a clinical diagnosis requiring specialized security measures This will be monitored monthly for 6 (six) months by the ED or Designee with results reported monthly to the Quality Assurance Committee. See Attachment 3. Date of compliance is 9/9/2022	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of over 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear	K 0232	K 232 Community has ensured that width of aisles and corridors serving as exits are no less than 4ft and maintained to provide the convenient removal of non-ambulatory patients on stretchers, wheel chairs, and other non-ambulatory processes.	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC 19.3.5.8 This deficient practice could affect 12 residents, staff and visitors exiting the facilities. Findings: Based on observation and interview during a facility tour with the Maintenance Director and Interim Administrator on 08/23/22 between 12:55 a.m. and 2:45 p.m., in the corridor near resident room 314 a sofa/love seats extended into the corridor approximately 36 inches. The aforementioned sofa/love seat was free standing, not affixed to the wall or floor. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the		All residents that reside on the 300 Hall have the potential to be affected by this practice. All Units will be monitored to ensure 4 ft of access and will be maintained to meet the needs of convenient removal of non-ambulatory residents and visitors. All unit will be monitored for 6 (six) months by the ED/Designee for compliance with results reported to the Quality Assurance Committee monthly. See Attachment #4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	Maintenance Director and Interim Administrator on present at 3:10 p.m. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors. 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 a.m. and 2:45 p.m., the oxygen transfilling room corridor door did not self-close and latch into the door frame when tested several times. 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)	K 0321	K 321 Community has ensured that the oxygen transfilling room corridor door now latches independently and now self-closes and latches into the door frame. All residents have the potential to be affected by this practice. Area will be monitored for self-closing and self-latching door. Area will be monitored for 6 (six) months for self-latching and proper closing by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #5 Date of compliance is 9/9/2022	09/09/2022
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in	K 0345	K 345	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	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. 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 a.m. and 2:45 p.m., the date and time on the main fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be approximately 4 hours slower than the actual local time. The date of this survey was 08/23/22 and the date reflected on the main FACP was 09/09/07. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to update the fire alarm control panel to display the correct date and time 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)		Community has ensured that main fire alarm panel time and date are accurate to local time and date. All residents have the potential to be affected by this practice. Fire alarm company notified of time and date discrepancy and time and date now updated to reflect local time and date. Area will be monitored for 6 (six) months by the ED/Designee to ensure that the main fire panel date and time are accurate to the local area. Results will be reported monthly to the Quality Assurance committee. See Attachment 6. Date of compliance is 9/9/2022	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the	K 0354	K 354 Community has ensured that fire plan policy now includes contacting the Indiana Department of Health via the ISDH gateway link as a primary method or secondary method of emailing the ISDH. All residents have the potential to be affected by this practice. Fire Plan Policy has been updated to include new verbiage for contacting ISDH for primary and secondary communication methods. See Attachment 7 Process will be monitored for 6 (six) months by the ED/Designee to ensure that the fire plan	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	facility. Findings include: Based on records review and interview with the Maintenance Director and Interim Administrator on 08/23/22 between 10:30 a.m. and 12:55 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 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)		communication methods are followed. Results will be reported monthly to the Quality Assurance committee. See Attachment 8 Date of compliance is 9/9/2022	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include:	K 0363	K 363 Community has ensured that corridor door to resident room 314 and all other corridor doors are not propped open with any object or device and will ensure door can be closed. All residents have the potential to	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview during a facility tour with the Maintenance Director and Interim Administrator on 08/23/22 between 12:55 a.m. and 2:45 p.m., the corridor door to resident room 314 was propped open with a wedge type door holder. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door would not close unless the wedge was moved first. 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)		be affected by this practice. All corridor doors will be monitored for object that are holding corridor doors open. Area will be monitored for 6 (six) months to ensure no corridor door 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	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of over 3 sets of smoke barrier	K 0374	K 374	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect some 10 residents, staff and visitors on the 300 Hall. 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 a.m. and 2:45 p.m., the set of barrier doors on the 300 Hall from the lobby did not close completely and latch. Based on interview during the time of observations, the Maintenance Director acknowledged these barrier doors did not close completely and latch. 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)		Community has ensured that barrier doors on the 300 hall from the lobby now latches independently and now self-closes completely and latches. All residents residing on 300 hall have the potential to be affected by this practice. Area will be monitored for complete closing and self-latching door. Area will be monitored for 6 (six) months for self-latching and proper closing by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #10 Date of compliance is 9/9/2022	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical splices were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect 8 residents in the 100 hall. 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 a.m. and 2:45 p.m., above the ceiling on the 100 hall near resident room 101 there were two electrical wires spliced together not contained inside a junction box. It appeared one of the aforementioned wires came from a junction box which contained Romex type electrical wire. Based on interview at the time of the observation, the Maintenance Director acknowledged there was an electrical splice in the space above the ceiling on the 100-hall attic that was not protected with a junction box and commented it looked like control wire, but he did not understand why it was originating in a 110 junction box and agreed the splices needed to be in a junction box. 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)	K 0511	K 511 Community has ensured that spliced wire on 100 hall ceiling is now in a junction box. All residents have the potential to be affected by this practice. Area will be monitored for junction box needs for spliced cables. Area will be monitored for 6 (six) months for any wiring connections outside of an approved junction box by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #11 Date of compliance is 9/9/2022	09/09/2022
K 0712 SS=C	NFPA 101 Fire Drills			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review of the Tels "Logbook Documentation regarding Fire Drills" and interview with the Maintenance Director and Interim Administrator on 08/23/22 between 10:30 a.m. and 12:55 a.m., 9 of 12 quarterly fire drills were conducted near the end of the month, between the 27th and 31st day of the month. These conditions do not allow fire drills to be conducted at unexpected times and on unpredictable days. 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)	K 0712	K 712 Community has ensured fire drills will be held at unexpected times and days. Change to fire drill times and days of the month have been created in TELS to ensure this schedule is updated. All residents have the potential to be affected by this practice. Change to fire drill times schedule has been created in TELS to ensure this schedule is updated Fire Drills will be monitored for 6 (six) months to ensure each drill is performed at unexpected times and days by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #12 Date of compliance is 9/9/2022	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure power strips in 3 locations met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 4 resident.	K 0920	K 920 Community has ensured the all power strips, including rooms 108 and 110, meet the proper UL rating for patient care areas. Community has also ensured that proper power strip use is now in place for resident in room 301 as it relates to high power draw equipment(dorm style refrigerator) not being plugged into a power	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	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 a.m. and 2:45 p.m., resident rooms 108, and 110 each contained power strips which were in use and it could not be determined if the aforementioned power strips met the proper UL rating for the patient care location. In resident room 108 the power strip was attached to the wall near the TV. In resident room 110 two power strips were in use and a UL rating could not be determined and they did not meet the requirement of a UL rating of 1363A or 60601-1 label on each power strip. 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. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice 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 a.m. and 2:45 p.m., in resident room 301 a power strip was being used to power a dorm style		strip. All residents have the potential to be affected by this practice. New patient care grade power strip being used in rooms 108 and 110. High power draw equipment (dorm style refrigerator) now plugged in to fixed power outlet. Area will be monitored for 6 (six) months to ensure no unapproved power strips are being used throughout by the ED/Designee with results reported monthly to the Quality Assurance Committee. See Attachment #13 Date of compliance is 9/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155231	A. BUILDING 01 B. WING	08/23/2022

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
	refrigerator (high power draw equipment). 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)			