

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2016
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NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032
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K 0000 Bldg. 02	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/20/16</p> <p>Facility Number: 011151 Provider Number: 155794 AIM Number: NA</p> <p>At this Life Safety Code survey, Stratford Retirement LLC was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility, located on the second story of a three story building, was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms.</p>	K 0000	The Stratford would like to request a desk review	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0039 SS=F Bldg. 02	<p>The facility has a capacity of 18 and had a census of 13 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 04/21/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Director of Facility Services during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 04/20/16, the second floor Assisted Living exit access corridor measured five feet, four inches</p>	K 0039	<p><u>What corrective action will be taken by the facility?</u> An outside expert (Siemens) completed the Fire Safety Evaluation System report (FSES) on 4/29/16 (uploaded document). <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No residents were adversely affected by this practice. <u>What measures will be put into place to ensure the practice does not recur?</u> The FSES will be conducted on an annual basis. <u>How will the corrective action be</u></p>	04/29/2016	

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K 0050 SS=C Bldg. 02	<p>(64 inches) in clear width. The second floor Assisted Living exit access corridor provides one of two paths of egress from the second floor health care area since the elevator should not be used during a fire emergency. Based on interview at the time of observation, the Administrator and the Director of Facility Services acknowledged the second floor Assisted Living exit access corridor did not have a clear unobstructed width of at least 8 feet (96 inches).</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could</p>	K 0050	<p><u>monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Facility Services Director will report the findings to the QA Committee on an annual basis following the completion of the FSES.</p> <p><u>What corrective action will be taken by the facility?</u> The Facility Services Director will ensure the activation of the fire alarm system at unexpected times under varying conditions, at</p>	05/01/2016			

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	<p>affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Fire Plan" and "Fire Drills Summary Sheet" documentation with the Director of Facility Services during record review from 9:35 a.m. to 11:15 a.m. on 04/20/16, second shift fire drills conducted on 06/30/15, 09/30/15 and 02/05/16 were conducted at, respectively, 4:50 p.m., 4:50 p.m. and 5:05 p.m. Based on interview at the time of record review, the Director of Facility Services acknowledged the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>		<p>least quarterly on each shift. Following the completion of the fire drill documentation, the forms will be scanned to the Administrator for electronic storage. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> No residents have been adversely affected by this practice. <u>What measures will be put into place to ensure the practice does not recur?</u> The Facility Services Director and the Administrator will monitor the fire drill documentation (uploaded document) to ensure alarm system activation at unexpected times under varying conditions. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Facility Services Director will report the outcomes of the fire drill audits and report to the QA Committee on a monthly basis for review and recommendations. Any recommendation made by the committee will be followed up by the Facility Services Director and the results will be brought to the next scheduled QA Committee.</p>		