

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
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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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K020000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/03/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/31/13</p> <p>Facility Number: 011151 Provider Number: 155794 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this PSR 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</p>	K020000		
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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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	<p>corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 18 and had a census of 6 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/06/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020014 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. Lower portions of corridor walls can be Class C. 18.3.3.1, 18.3.3.2</p> <p>Based on record review, observation and interview; the facility failed to ensure interior finish installed in 1 of 2 inside stairs serving as an exit or exit component had a flame spread rating of Class A or Class B. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Vice President for Facility Services during a tour of the facility from 9:00 a.m. to 10:30 a.m. on 05/31/13, the exit passageway in the Stair 1 stairwell on the first floor had carpeting installed on the wall. The carpet was installed on the wall in a fifteen foot section in length and three feet high from the floor. Based on record review with the Vice President for Facility Services from 10:30 am. to 11:40 a.m. on 5/31/13, the flame spread rating for the carpeting used as an interior finish in the stairwell was not available for review. Based on interview at the time of record review and at the time of the observation, the Vice President for</p>	K020014	<p>What corrective action will be done by the facility? The interior finish on the inside stairs has a flame spread rating of Class A. This information is maintained by the Facility Service Director. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director will monitor the interior finish to ensure that it complies with the flame spread rating of Class A or Class B. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Service Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	06/19/2013			

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	<p>Facility Services acknowledged the flame spread rating for the interior finish used in the aforementioned stairwell was not available for review.</p> <p>3.1-19(b)</p>				

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K020018 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 4 of 9 resident room corridor doors did not have an impediment to closing and latching. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Vice President for Facility Services during a tour of the facility from 9:00 a.m. to 10:30 a.m. on 05/31/13, the corridor door to resident rooms 260, 261, 265 and 268 were each held in the fully open position by a door stop wedge on the floor which provided an impediment to closing and latching. Based on interview at the time of the observations, the Vice President for Facility Services acknowledged each of the aforementioned doors were held open and were provided with an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p>	K020018	<p>What corrective action will be done by the facility? The automatic door closures will be removed from the resident rooms. Door stops or objects will not be placed to keep the doors open. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur?The Facility Services Director or designee will monitor the resident room doors to ensure that an object is not placed to impede the closing of the door. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Service Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	06/30/2013	

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K020039 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is 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 Vice President for Facility Services during a tour of the facility from 9:00 a.m. to 10:30 a.m. on 05/31/13, the second floor Assisted Living exit access corridor measured five feet, four inches (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 Vice President for Facility Services acknowledged the second floor Assisted Living exit access corridor did not have a clear an unobstructed width of at least 8 feet (96 inches).</p>	K020039	<p>What corrective aciton will be done by the facility? An outside expert (Siemens) has been contracted to complete the Fire Safety Evaluation System (FSES). How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The FSES will be conducted on an annual basis.</p>	06/30/2013			

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	<p>This deficiency was cited on 04/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

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K020062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Vice President for Facility Services during a tour of the facility from 9:00 a.m. to 10:30 a.m. on 05/31/13, the sprinkler gauge on the sprinkler system riser and the sprinkler system gauge in the Stair 1 stairwell by the Manigault Street exit each had a manufacture date of 2005. Based on review of Siemens "Report of Inspection" sprinkler system inspection documentation dated 05/13/13 with the Vice President for Facility Services</p>	K020062	<p>What corrective action will be done by the facility? The sprinkler guage on the sprinkler system riser and the sprinkler system gauge in the Stair 1 stairwell have been replaced by Siemens. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will monitor the fire sprinkler inspections on a quarterly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the findings to the QA Committee on a quarterly basis.</p>	06/05/2013			

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	<p>during record review from 10:30 a.m. to 11:40 a.m. on 05/31/13, documentation of sprinkler gauge recalibration or replacement was not available for review. Based on interview at the time of observation and record review, the Vice President for Facility Services acknowledged each of the aforementioned pressure gauges had exceeded the five year requirement for recalibration or replacement.</p> <p>This deficiency was cited on 04/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			

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K020144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Load Test Log" with the Vice President for Facility Services during record review from 10:30 a.m. to 11:40 a.m. on 05/31/13, documentation of emergency power transfer times for the most recent twelve consecutive month period was not available for review.</p>	K020144	<p>What corrective action will be done by the facility? The transfer time of the emergency power to the emergency generator will occur within 10 seconds of building power loss and will be documented on a monthly basis. The staff has been trained to observe and document all generator and load inspections appropriately. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice not recur? The Facility Services Director or designee will monitor the load test on a monthly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	06/30/2013			

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	<p>Based on interview at the time of record review, the Vice President for Facility Services acknowledged documentation of emergency power transfer time for the most recent twelve consecutive month period was not available for review.</p> <p>This deficiency was cited on 04/03/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>			