

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  04/30/2014
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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 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: 04/30/14</p> <p>Facility Number: 011151 Provider Number: 155794 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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</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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K020039 SS=F	<p>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 10 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 05/05/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 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 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>	K020039	What corrective action will be done by the facility? An outside expert (Siemens) completed the Fire Safety Evaluation System report (FSSES) on 5/16/14. How will the facility identify other residents having the potential to	05/16/2014

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K020052 SS=F	<p>Findings include:</p> <p>Based on observation with the Administrator and the Director of Facility Services during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 04/30/14, 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 Administrator and the Director of Facility Services acknowledged the second floor Assisted Living exit access corridor did not have a clear and unobstructed width of at least 8 feet (96 inches).</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program</p>		<p>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. 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 will report the findings to the QA Committee on an annual basis following the completion of the FSES.</p>				

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	<p>complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review, observation, and interview; the facility failed to document 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires an annual check of fire alarm system batteries. Section 7.1.1.2 states system defects and malfunctions shall be corrected. NFPA 72, 7-5.2.2 states a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Siemens Building Technologies "Fire Safety System Inspection and Test Report" documentation dated 04/04/14 with the Director of Facility Services at 2:30 p.m. on 04/30/14, the main fire alarm panel batteries were listed as "Fail" for the annual fire alarm system inspection and test. The aforementioned inspection report stated "Mar-13" for the date the batteries were installed. Based on interview at the time of record review, the Director of Facility Services stated documentation of repair or replacement</p>	K020052	<p>What corrective action will be done by the facility? The corridor smoke detector near Room 262 that failed the annual sensitivity test was replaced by Siemens on 5/14/14. The main fire alarm panel batteries that were listed as "Fail" on the Fire Safety Inspection and Test Report <u>did</u> pass at 25AH for 35AH (please see attached email). This information was incorrectly documented in the Fire Safety Inspection Test Report. 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? Siemens will conduct a Fire Safety System Inspection and Test audit on an annual basis. The Facility Services Director will ensure that all deficiencies are corrected. 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 will report the outcomes of the Fire Safety System Inspection and Test Report along with an update regarding any corrections made by the facility to the QA Committee on an annual basis.</p>	05/14/2014	

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	<p>of the fire alarm system batteries was not available for review and acknowledged the aforementioned inspection report listed the batteries as fail. Based on observations with the Administrator and the Director of Facility Services during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 04/30/14, the main fire alarm system batteries had a sticker affixed to each battery stating "March 27, 2013".</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 18 second floor smoke detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2.1 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be</p>			

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	<p>maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Siemens Building Technologies "Fire Safety System Inspection and Test Report" documentation dated 04/04/14 with the Director of Facility Services at 2:30 p.m. on 04/30/14, the corridor smoke detector</p>			
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K020064 SS=C	<p>by Room 262 was listed as "Fail" for sensitivity testing. Based on interview at the time of record review, the Director of Facility Services stated no additional sensitivity testing documentation was available for review and acknowledged documentation for the repair or replacement of the smoke detector by Room 262 which failed sensitivity was not available for review. Based on observations with the Administrator and the Director of Facility Services during a tour of the facility from 12:50 p.m. to 2:30 p.m. on 04/30/14, smoke detectors hard wired to the fire alarm system were observed installed in the corridors and in all areas open to the corridor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to ensure 1 of 4 second floor portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers,</p>	K020064	<p>What corrective action will be done by the facility?</p> <p>The fire extinguisher that was missed during the Annual Fire Inspection was serviced by Siemens</p>	05/14/2014

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	<p>in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. 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 12:50 p.m. to 2:30 p.m. on 04/30/14, the maintenance tag attached to the portable fire extinguisher located in the pantry by Room 268 did not indicate the date the most recent annual maintenance procedure was performed. Based on interview at the time of observation, the Director of Facility Services stated no other documentation of portable fire extinguisher maintenance was available for review and acknowledged documentation of the most recent annual maintenance for the portable extinguisher located in the pantry was not available for review.</p> <p>3.1-19(b)</p>		<p>on 5/14/14.</p> <p>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</p> <p>No residents were adversely affected by this practice.</p> <p>What measures will be put into place to ensure this practice does not recur?</p> <p>Siemens will conduct a Fire Safety Inspection and Test on an annual basis. The Facility Services Director will ensure that all deficiencies are corrected.</p> <p>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</p> <p>The Facility Service Director will report the outcomes of the Fire Safety System Inspection and Test Report along with an update regarding any corrections made by the facility to the QA Committee on an annual basis.</p>	

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