

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 04/20/2015
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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 000 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: 04/20/15</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 000		

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 038 SS=F Bldg. 02	<p>The facility has a capacity of 18 and had a census of 15 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>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through delayed egress locks at 1 of 2 exits was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided an irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 shall not be required to exceed 15 lbf nor required to be continuously applied for</p>	K 038	<p><u>What corrective action will be taken by the facility?</u></p> <p>The delayed egress lock pertaining to the skilled nursing smoke compartment exit doors nearest the elevator has been adjusted to activate in 15 seconds on 4/21/15.</p> <p>The signage will be placed on the west door from assisted living to the skilled unit that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. This will be posted by 5/4/15.</p> <p><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></p> <p>No residents have been adversely affected by this practice.</p>	05/04/2015

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	<p>more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. This deficient practice could affect all residents, staff or visitors trying to exit the skilled nursing smoke compartment using the exit doors nearest the elevator.</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 12:00 p.m. to 1:00 p.m. on 04/20/15, the skilled nursing smoke compartment exit doors nearest the elevator were provided with delayed egress locks and were provided with the proper signage in the path of egress from the skilled nursing facility side indicating the doors can be opened in 15 seconds by pushing on the door, however, when the doors were pushed, the irreversible process to release the lock was not initiated four out of five times. Based on interview at the time of observation, the Director of Facility Services acknowledged the skilled</p>		<p><u>What measures will be put into place to ensure the practice does not recur?</u></p> <p>The Facility Services Director will monitor the activation of the egress locks (attachment #1) on the skilled unit on a monthly basis beginning 4/21/15.</p> <p><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></p> <p>The Facility Services Director will report the outcomes of the audits 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>		

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	<p>nursing smoke compartment exit doors nearest the elevator did not release the lock within 15 seconds after application of force to the release device and open each exit door when it was pushed for four out of five times.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door.</p>			

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	<p>Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect all residents, staff or visitors trying to exit the assisted living smoke compartment into the skilled nursing smoke compartment using the exit doors nearest the elevator.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Director of Facility Services during a tour of the facility from 12:00 p.m. to 1:00 p.m. on 04/20/15, the west door in the exit door set from the assisted living smoke compartment into the skilled nursing smoke compartment is marked as a facility exit and is equipped with a delayed egress lock but is not provided with the necessary signage</p>			

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K 039 SS=F Bldg. 02	<p>stating the door could be opened in 15 seconds by pushing on the door release device. The exit door released within 15 seconds when the door was pushed with the application of force one out of five separate times. Based on interview at the time of the observations, the Administrator and the Director of Facility Services stated skilled nursing residents have customary access to the second floor Therapy Gym in the assisted living unit smoke compartment and acknowledged the aforementioned exit door is a facility exit, is equipped with a delayed egress lock but is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3.1-19(b)</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).</p>	K 039	<p><u>What corrective action will be taken by the facility?</u> An outside expert (Siemens) will complete the Fire Safety Evaluation System report (FSES) by 5/5/15. <u>How</u></p>	05/05/2015

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K 050 SS=F Bldg. 02	<p>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 12:00 p.m. to 1:00 p.m. on 04/20/15, 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 an 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 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</p>		<p><u>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 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>				

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	<p>conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 18.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Emergency or Drill Evaluation Form" documentation with the Director of Facility Services during record review from 9:40 a.m. to 12:00 p.m. on 04/20/15, documentation for the first shift fire drill conducted on 02/26/15 at 2:45 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned documentation stated "type of simulated</p>	K 050	<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 and transmission of the fire alarm signal between the hours of 6:00 am and 9:00 pm. All staff participating in the fire drills will sign the fire drill evaluation form. Following the completion of the fire drill documentation, the forms will be scanned to the Administrator for electronic storage. This procedure will allow the safe storage of the fire drill documentation. <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 (attachment #2) to ensure alarm system activation, staff member participation and safe storage of the documents. <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</p>	04/27/2015

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	<p>drill" as "fire". In addition, review of "Fire Drills Summary Sheet" documentation stated the 02/26/15 was a "fire" drill. Based on interview at the time of record review, the Director of Facility Services acknowledged documentation for the aforementioned first shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document staff participation in 4 of 12 quarterly fire drills conducted during the most recent twelve month period. LSC 18.7.2.3 states all health care occupancy personnel shall be instructed in the use of and response to fire alarms. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency or Drill Evaluation Form" documentation with the Director of Facility Services during record review from 9:40 a.m. to 12:00 p.m. on 04/20/15, documentation for four fire drills conducted during the</p>		<p>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>	

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K 144 SS=C Bldg. 02	<p>period of 07/31/14 through 10/31/14 did not list the staff who participated in the fire drill. Based on interview at the time of record review, the Director of Facility Services stated documentation for the aforementioned four fire drills was damaged by a water leak where the documents had been stored and could not be recreated to indicate which staff participated in each fire drill and acknowledged documentation for fire drills conducted during the period of 07/31/14 through 10/31/14 did not list the staff who participated in the fire drill.</p> <p>3.1-19(b) 3.1-51(c)</p> <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. Based on record review and interview, the facility failed to ensure the starting batteries for the generator were replaced and maintained in reliable operating condition. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon</p>	K 144	<p><u>What corrective action will be taken by the facility?</u></p> <p>The generator batteries will be replaced on 5/4/15.</p> <p><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></p>	05/04/2015

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	<p>discovery of defects. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. Furthermore, NFPA 110, 3-5.4.5 states all batteries used in this service shall have been designated for this duty and shall have demonstrable characteristics of performance and reliability acceptable to the authority having jurisdiction. NFPA 110, A-3-5.4.4 recommends lead acid starting batteries be replaced every 24 to 30 months. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Buckeye Power Sales preventive maintenance inspection documentation dated 02/27/15 with the Director of Facility Services during record review from 9:40 a.m. to 12:00 p.m. on 04/20/15, the "generator batteries are five years old and needs replaced." Based on interview at the time of record review, the Director of Facility Services stated the starting batteries have not been replaced and acknowledged the aforementioned documentation indicated the starting batteries needed to be replaced due to the age of the batteries.</p>		<p>No residents were adversely affected by this practice.</p> <p><u>What measures will be put into place to ensure the practice does not recur?</u></p> <p>The generator batteries will be replaced in a timely manner based on manufacturer specifications and the preventative maintenance inspections. The installation dates will be written on the batteries and monitored by Facility Services Director. Service vendor reports will also be monitored during routine maintenance inspections and all recommendations will be followed.</p> <p><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></p> <p>The Facility Services Director will report the findings to the QA Committee on a quarterly basis following routine maintenance inspections.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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