STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00426019 and IN00417225. This visit included a State Residential Licensure Survey. Complaint IN00426019-Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00417225-Federal/State deficiencies related to the allegations are cited at F812. Survey dates: April 1, 2, 3, 4, and 5, 2024 Facility number: 011151 Provider number: 155794 Census Bed Type: SNF: 14 Residential: 24 Total: 38 Census Payor Type: Medicare: 7 Other: 7 Total: 14 These deficiencies/deficiency reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 15, 2024.	F 0000	This Plan of Correction represents The Retreat at the Stratford (community) Allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna Ray	Care Services Administrator	04/25/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure ordered wound treatments were completed as ordered for 1 of 4 residents reviewed for wound treatment (Resident B). Findings include: Resident B's closed clinical record was reviewed on 4/02/24 at 12:02 p.m. Discharge diagnoses included, chronic atrial fibrillation, heart failure, and pacemaker placement. The resident had a 12/22/23 care plan need regarding the placement of a cardiac pacemaker. Review of the resident's "Clinical Notes" indicated the following: 12/22/23- The resident was admitted to the facility following the placement of a pacemaker. 12/28/23-The resident was admitted after a recent pacemaker implantation. The resident had an incision on her left upper chest. No redness was present at the wound site. 1/2/24-The resident returned from a follow-up visit with the cardiologist. The resident had a new order to clean incision daily with soap and water, no lotions, creams or powders to the incision site. Review of the "Clinical Notes" indicated the entries were identical on four days, and included	F 0684	F 684 was already corrected, and no further Plan of Correction is needed	05/15/2024

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	the same typo and same wording. The identical notes were entered on the following dates and times: 12/27/23 at 8:59 a.m., 12/28/23 at 1:22 p.m., 12/29/23 at 2:16 p.m., 1/1/24 at 2:42 p.m. The entries read as follows, "Res. here after hospital stay fro (sic) bradycardia with pacemaker implantation. Res. has incision on left upper chest steri strips in place dry intact some bruising noted no redness warmth or drainage noted." The typo was corrected on 1/2/24. Following the correction of the typo the identical entry was made on the following dates and times: 1/2/24 at 1:49 p.m., 1/3/24 at 7:35 p.m., 1/8/24 at 9:17 p.m. Following the 14 day period of identical documentation, a 1/9/24 at 11:15 a.m., "Addendum Note" indicated the resident was having some redness around the left chest incision where the steri strips (wound closure strips) were present. The resident complained of pain and had a fever. The Medical Director was in the facility and assessed the area and indicated the resident needed to see her cardiologist as soon as possible. The resident went to the Cardiologist were she was placed on antibiotics for an infection at the pacemaker site. The resident had a 1/2/24, cardiology "Ambulatory Visit Summary" which contained an order to wash the pacemaker incision site with soap and water and pat dry, one time each day. The clinical record lacked documentation that the pacemaker incision site was washed and patted dry from 1/2/24, when the order was received, until 1/9/24, when the site was red and the resident had a fever. The resident had a 1/9/24 order for doxycycline			

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	hyclate 100 mg tablet (an antibiotic) - take one tablet two times a day for 10 days. A 1/11/24 at 3:34 p.m. Clinical Note indicated the resident had returned from a cardiology appointment and would need to go to the hospital for a pacemaker replacement. A 1/16/24 at 12:37 p.m., Clinical Note indicated "RISK MEETING." The resident was started on antibiotics for an infection to the pacemaker site. A grievance was received. During an interview, on 4/2/24 at 2:47 p.m. Resident B's family indicated the following: The family took the resident to a cardiology appointment on 1/2/24. The doctor changed an oral medication and order the pacemaker site be washed with soap and water and patted dry each day. On 1/9/24 the facility called the family and said the Medical Director wanted the resident to see the cardiologist that day or go to the hospital. The family took the resident to the cardiologist that day. When the incision was observed at the cardiologist, the site was red all around the incision and down the arm. The wound was draining a green liquid. The cardiologist ordered a very strong antibiotic and wanted them to return in a couple days. When they returned to the cardiologist on 1/11/24, the decision was made to remove and replace the pace maker because the infection was not healing quick enough. The family spoke with the DON, who could not show any proof that the facility had routinely monitored the site nor washed the wound with soap as ordered. The resident did not return to the facility following the pacemaker replacement. During an interview on 4/3/24 at 9:45 a.m., the Administrator indicated the facility had developed			

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	a plan of correction to address the concerns expressed in the grievance made by Resident B's family regarding monitoring wounds and providing wound care as ordered. The Administrator provided paperwork regarding the concern and the facilities actions. The paperwork included a "Grievance Form: and the corresponding documentation. A 1/10/24, "Grievance Form" indicated during a care conference Resident B's family expressed concern due to the resident's pacemaker site not being cleaned. The form indicated the "Action taken and Date" for this concern was as follows: 1/12/24-Nursing Inservice on charting and documentation for medication and treatment orders related to wound care, 1/13/24 Audit of all residents in house, 1/15/24 Resident Incident Reporting Form, (No date listed) QA review, 2/21/24 Nursing education on second (2nd) checks of orders. A current, 10/2010, facility policy titled, "Wound Care", which was provided by the DON on 4/5/24 at 10:34 a.m., indicated the following: "...Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. ... 6. All assessment data (i.e., wound bed color, size, drainage, etc) obtained when inspecting the wound...." The deficient practice was corrected by February 21, 2024, prior to the start of the survey, and was			

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	therefore past noncompliance. The facility had completed Nursing Inservices/education, completed audits, and taken the concern to the Quality Assurance Committee. This citation relates to complaint IN00426019. 3.1-37			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure ongoing communication for continuation of care with the dialysis center for 1 of 1 resident reviewed for dialysis services (Resident 6) Findings include: During an interview on 4/02/24 at 1:54 p.m., Resident 6 was sitting in bed in her room watching TV. She indicated she went to dialysis and had a port to her left chest. Resident 6's clinical record was reviewed on 4/2/24 at 3:18 p.m. Current diagnoses included end stage renal disease (ESRD), dependence on dialysis, and congestive heart failure. The resident had a current April 2024 order for dialysis. The resident had a current care plan problem/need regarding a diagnosis of ESRD and receiving hemodialysis. The goal for this problem was	F 0698	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Nurses were educated on “Shared Communication between the Nursing Home and the Dialysis facility” on 4/19/2024 The dialysis center for resident 6 was contacted on 4/19/2024 and given survey results, “Shared Communication between the Nursing Home and the Dialysis facility”, “LTCF Outpatient Dialysis Services Coordination Agreement” that was signed 4/3/2018 and given copy of “Nurses Dialysis Communication Record” communication form. They were informed of expectation for communication regarding dialysis treatment for facility residents.	05/15/2024

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	"Fluid balance will be maintained and resident will have no complications with hemodialysis through the next review." Approaches/interventions included: Interventions: "monitor for complications from dialysis such as: hypoglycemia, hypotension, irritation to access site, and muscle cramps " and "Dialysis is at (dialysis facility name) on Tuesday, Thursday, and Saturday" The clinical record for dialysis communication indicated, from January 2024 to April 2024, communication notes were not down loaded into the electronic medical record. The dialysis communication binder was reviewed on 4/3/24 at 10:02 a.m. Each "Nurses Dialysis Communication Record: contained three (3) sections as follows: a. "PRE- DIALYSIS ASSESSMENT" b. "DIALYSIS CENTER" c. "STRATFORD POST DIALYSIS ASSESSMENT" Review of communication records from 4/1/24 to 3/1/24 identified the following incomplete records: 4/1/24- Pre dialysis vitals only, 3/29, 3/27, 3/25, 3/22, 3/20, and 3/18 did not have any communication logs completed, 3/18/24- Pre dialysis vitals, dialysis vitals only, 3/15 and 3/13 did not have any communication log completed, 3/11/24- Pre dialysis vitals only. 3/8 and 3/6 did not have communication logs completed, 3/4/24- Pre dialysis vitals, dialysis vitals. January and February 2024 also had missing log pages and or missing information. During an interview on 4/03/24 at 2:32 p.m., both		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Resident 6 is the only resident receiving dialysis in the community. Any resident who admits with the need for dialysis services could be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: DON or designee will audit communication binder prior to dialysis appointment and after return to ensure all documentation was received. If communication was not entered by dialysis center on “Nurse Dialysis Communication Record”, DON will contact the dialysis center for completion of documentation. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will audit dialysis records twice a week x 4 weeks for Resident 6 and any other resident that receives dialysis services. Audits will then continue monthly until	

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	the DON and Administrator indicated this was an ongoing problem with the dialysis center not wanting to fill this form out. The DON had many calls with the dialysis center administrator and this issue never resolved. This company is the most local one to the facility, and that's why they were still utilized. These points of contact happen by phone and there were not records of the conversation. The Administrator and DON indicated the facility sent this form with the resident for every visit. A current facility contract titled " Long Term Care Facility Outpatient Dialysis Services Coordination Agreement", which was provided by the facility following the entrance conference on 4/1//24, indicated the following: "...Interchange of Information: The Long Term Care Facility shall provide for the interchange of information necessary for the care of ESRD Residents, including a contact person at the Long Term Care Facility whose responsibilities included assisting with the coordination of Renal Dialysis Services for ESRD residents...." 3.1-37(a)		100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was distributed under safe sanitary conditions for 14 of 14 residents who resided in the nursing home area of the facility. Findings include: During the lunch meal service observation on 4/3/24 from 11:54 a.m. to 12:38 p.m., the following concerns were identified: a. At 11:58 a.m., three meal trays were placed in the food service cart. During an interview on 4/3/24 at 11:59 a.m., Cook 3 indicated she had not taken the temperatures of the food prior to placing the three trays in the meal service cart. She was aware the temperature of all foods should be taken prior to placing any meal in the food service cart. b. At 12:03 p.m., Cook 3 was taking the temperatures of the food items on the steam table. She dropped the wrapper off of the alcohol wipe on the floor. She bent over an picked the wrapper up with her gloved hands. With the same soiled gloved hands, she continued to take temperatures	F 0812	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Cooks were educated on Food Temperature and Temperature on April 5, 2024 and April 6, 2024 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: CDM or designee will audit/ watch food service to ensure proper temping of food prior to service and to ensure proper food handling, glove donning, and handwashing. Audits will be conducted five days a week for each meal service for 4 weeks,	05/15/2024

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	of the food the steam table. c. At 12:19 p.m., Cook 3 was serving meals using her gloved hands to serve meals. With her gloved hands she touched, meal tickets, dishes, utensils counter tops, the bag containing hot dog buns, drawer handles, and other kitchen services. With the soiled gloved hands Cook 3 took a bun out of the bun bag. She opened the bun with the same gloves. While holding the bun in the palm of her same soiled gloved hand, she placed a sausage in the bun. d. At 12:21 p.m., she changed her gloves without washing her hands between doffing her soiled gloves and donning her new gloves. She then repeated the process of touching counter tops, meal tickets, utensils, counter tops, bun bags, drawer handles, and multiple other surfaces. Using her soiled gloved hands she opened a hot dog bun and held it in the palm of her hand while placing a sausage in the bun. At 12:25 p.m., she changed her gloves again without washing her hands between doffing and donning. She once again began the process of touching multiple surfaces and serving sausages in the bun. At 12:38 she changed gloves without washing her hands between doffing and donning new gloves. She again touched multiple surfaces with her gloved hands. She then used her soiled gloves to open a bun, holding it in her soiled palm, and serve a sausage in the bun. A current, 10/2017, facility policy, titled " Preventing Forborne Illness Employee Hygiene and Sanitary Practice", which was provided by the Administrator on 4/4/24 at 10;00 a.m., indicated the following: "...6. Employees must wash their hands... d, Before coming in contact with any food		then weekly x 6 meals, then weekly x 2 meals. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The Director of Dining or designee will review audits until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	

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	surface... f. After handling soiled equipment or utensils; g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination... 9. Food services employees will be trained in the proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent forborne illness. 10. Gloves are considered single -use items and must be discarded after completing the task...." This citation relates to complaint IN00417225.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00426019 and IN00417225. Complaint IN00417225- State deficiencies and Federal deficiencies related to the allegations are cited at R273 and F812. Complaint IN00426019-Federal/State deficiencies related to the allegations are cited at F684. Survey dates: April 1, 2, 3, 4, and 5, 2024 Facility number: 011151 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 15, 2024.	R 0000	This Plan of Correction represents The Retreat at the Stratford (community) Allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was distributed under safe sanitary conditions for 14 of 14 residents who resided in the nursing home area of the facility. Findings include: During the lunch meal service observation on 4/3/24 from 11:54 a.m. to 12:38 p.m., the following concerns were identified: a. At 11:58 a.m., three meal trays were placed in the food service cart. During an interview on 4/3/24 at 11:59 a.m., Cook 3 indicated she had not taken the temperatures of the food prior to placing the three trays in the meal service cart. She was aware the temperature of all foods should be taken prior to placing any meal in the food service cart. b. At 12:03 p.m., Cook 3 was taking the temperatures of the food items on the steam table. She dropped the wrapper off of the alcohol wipe on the floor. She bent over an picked the wrapper up with her gloved hands. With the same soiled gloved hands, she continued to take temperatures of the food the steam table. c. At 12:19 p.m., Cook 3 was serving meals using her gloved hands to serve meals. With her gloved hands she touched, meal tickets, dishes,	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Cooks were educated on Food Temperature and Temperature on April 5, 2024 and April 6, 2024 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: CDM or designee will audit/ watch food service to ensure proper temping of food prior to service and to ensure proper food handling, glove donning, and handwashing. Audits will be conducted five days a week for each meal service for 4 weeks, then weekly x 6 meals, then weekly x 2 meals. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	utensils counter tops, the bag containing hot dog buns, drawer handles, and other kitchen services. With the soiled gloved hands Cook 3 took a bun out of the bun bag. She opened the bun with the same gloves. While holding the bun in the palm of her same soiled gloved hand, she placed a sausage in the bun. d. At 12:21 p.m., she changed her gloves without washing her hands between doffing her soiled gloves and donning her new gloves. She then repeated the process of touching counter tops, meal tickets, utensils, counter tops, bun bags, drawer handles, and multiple other surfaces. Using her soiled gloved hands she opened a hot dog bun and held it in the palm of her hand while placing a sausage in the bun. At 12:25 p.m., she changed her gloves again without washing her hands between doffing and donning. She once again began the process of touching multiple surfaces and serving sausages in the bun. At 12:38 she changed gloves without washing her hands between doffing and donning new gloves. She again touched multiple surfaces with her gloved hands. She then used her soiled gloves to open a bun, holding it in her soiled palm, and serve a sausage in the bun. A current, 10/2017, facility policy, titled " Preventing Forborne Illness Employee Hygiene and Sanitary Practice", which was provided by the Administrator on 4/4/24 at 10;00 a.m., indicated the following: "...6. Employees must wash their hands... d, Before coming in contact with any food surface... f. After handling soiled equipment or utensils; g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination...		quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The Director of Dining or designee will review audits until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	

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	9. Food services employees will be trained in the proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent forborne illness. 10. Gloves are considered single -use items and must be discarded after completing the task...." This citation relates to complaint IN00417225.			