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	06/02/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00460150. Complaint IN00460150-Federal/state deficiencies related to the allegations are cited at F600. Unrelated deficiencies are cited. Survey date: June 2, 2025 Facility number: 011151 Provider number: 155794 Census Bed Type: SNF: 14 Total: 14 Census Payor Type: Medicare: 14 Total: 14 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 10, 2025.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team (IDT) assessed to determine a resident was safe to self-administer medications for 1 of 1 resident reviewed for self-medication administration. (Resident D) Findings include:	F 0554	·p paraid="404891605" paraeid="{9e35ca70-eda4-4d68-a6b9-1f1963c3040a}{12}" >Element 1 – Address how corrective action will be accomplished for those	06/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Care Service Administrator	06/20/2025

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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	During an observation and interview, on 6/2/25 8:46 a.m., Resident D had a clear plastic medication cup, with pills, on her bedside table next to her meal tray. The resident indicated the staff left her medications in her room. She would take the pills. The clinical record for Resident D was reviewed on 6/2/25 at 10:29 a.m. The diagnoses included, but were not limited to, a fracture of the lower end of the left humerus (upper arm bone) and cirrhosis of the liver. An assessment for self-administration of medication completed by the interdisciplinary team (IDT), a physician's order and a comprehensive care plan for the self-administration of medications was not located in the clinical record. During an observation and interview, on 6/2/25 at 8:52 a.m., LPN 1 indicated the resident's medications were on her bedside table. The resident had wanted to eat before she took her medications. She did not know if Resident D had been assessed for self-administration of medications. She was supposed to stay with the residents while they took their medications. During an interview, on 6/2/25 at 12:51 p.m., the Care Services Administrator indicated the resident did not have an assessment, a physician's order or a care plan to self-administer medications. A current facility policy, titled "Medication Self-Administration," undated and received from the Care Services Administrator on 6/2/25 at 3:00 p.m., indicated "...A Medication Self-Administration Evaluation shall be completed		residents found to have been affected by the deficient practice. All residents receiving medication could potentially be affected. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice The nurse administered medications in a cup and set them down, not waiting for the resident to ingest the medication which could potentially happen to any resident who does not self-administer their own medications. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All nurses or QMAs who have potential to administer medications have received training over the company's policies on self-administration of medications and have the education along with the training. The DON/interim DON will audit med passes to ensure safe practices are happening.	

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	for each resident who desires to self-administer medications...The Director of Health Services or designee will notify the attending physician of the evaluation results, and will obtain an order for the resident to self-administer medications...." 3.1-11(a)		• Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are The DON/interim DON will audit a random sample of med passes 3 times a week for four weeks and once weekly for four additional weeks or until no deficiencies are evident. • Element 5 – Include dates when corrective action will be completed. Observations will be completed in 8 weeks. Training and education will be completed on or before 6/16/2025. Education and disciplinary action were taken on the day of State Surveyor observation for the nurse responsible for the initial self-administration error. Compliance will be followed with monthly QAPI meetings and added to the plan.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, interview and record review, the facility failed to ensure residents were	F 0600	past non compliance	06/16/2025

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	free from verbal abuse and intimidation for 2 of 4 residents reviewed for abuse. (Resident B and C) The deficient practice was corrected on 5/25/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: 1. During an interview, on 6/2/25 at 8:56 a.m., Resident B indicated a staff member had been "cross" and impatient. She was unable to give the staff member's name (CNA 3). Resident B indicated she had slid down in her bed and CNA 3 accused her of doing it on purpose. She indicated she did not like the accusation. 2. During an interview, on 6/2/25 at 9:00 a.m., Resident C indicated CNA 3 had been verbally rude to her and she filed a complaint. Her remote control had fallen between the wall and the bed. The bed needed to be moved to get the remote. CNA 3 "threw her hands up and looked at me like I was crazy and said she don't move beds." Resident C indicated she then asked for some milk. CNA 3 went and got the milk, returned, opened the milk, slammed it down, and stormed out. Later in the evening, at 10-10:30 p.m., her roommate (Resident B) turned on the call light. CNA 3 had raised her voice and sounded belligerent toward Resident B. Resident C indicated she was afraid of CNA 3. She went to talk to Resident B to see if she was okay. Resident B told her she slid down in bed, needed help, and CNA 3 had started screaming. As Resident C was talking to Resident B, CNA 3 walked into their room. Resident C indicated she started walking to the door and had her hands on her walker when CNA 3 grabbed both of her wrists hard and pushed her back into her room. Resident C sat on her bed, picked up her phone to call her son, and			

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	CNA 3 grabbed her phone from her, put it on the chest of drawers, and stormed out. Resident C indicated she was shaking. Resident C contacted RN 4, and he informed her CNA 3 was gone for the night and the incident would be taken care of the next day. She indicated she was afraid CNA 3 would return with a gun, but RN 4 assured her she was safe, and CNA 3 could not get into the facility. The resident indicated she did feel safe now. The clinical record for Resident C was reviewed on 6/2/25 at 10:59 a.m. The diagnoses included, but were not limited to, left bundle branch block (electrical signals to the heart are blocked), atrioventricular block (electrical signal block from the upper chamber to the lower chamber of the heart) and atherosclerotic heart disease. A Basic Interview for Mental Status (BIMS) assessment, dated 5/26/25, indicated she was cognitively intact. A nursing progress note, charted late on 5/27/25 at 2:13 p.m., for the date of 5/23/25, indicated the nurse was called to Resident C's room. Resident C indicated she had been in an altercation with CNA 3. CNA 3 had taken the resident's phone away from her. The resident was upset and shaken but no injury was observed. RN 4 spoke with Resident C and her son and informed them CNA 3 was no longer in the facility. Resident C was asked to write down the details of what happened. RN 4 then spoke with Resident B, and she informed him CNA 3 was "...gruff and was yelling at her..." CNA 3 reported Resident C scratched her. There were no witnesses to the altercation. Resident C was assessed for injury and none were found. A facility document, titled "Coaching &			

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	Counseling Form," received from the Care Service Administrator on 6/2/25 at 3:48 p.m., indicated, CNA 3 was terminated. The document failed to state a reason for the termination. A facility letter addressed to CNA 3 indicated effective 5/23/25 the CNA's position had been terminated due to committing resident abuse. During an interview, on 6/2/25 at 9:46 a.m., the Care Services Administrator indicated CNA 3 had been terminated from the facility. According to Resident C, CNA 3 grabbed her wrist. Resident C grabbed her phone and told CNA 3 she was going to report her. CNA 3 grabbed the phone, put it on the dresser, and left. RN 4 sent the CNA home and the next working day she was terminated. He indicated she was terminated for abuse. She had put her hands on a resident, snatched a phone from her, and the facility had a zero-tolerance policy. During a telephone interview, on 6/2/25 at 12:29 p.m., CNA 3 indicated when she entered the residents' room, Resident C was attempting to pull Resident B up in the bed. CNA 3 told Resident C it was not safe. Resident C was screaming and yelling. Resident C then grabbed the staff member, spat on her, and scratched her. RN 4 came to the room about five minutes after it happened. CNA 3 denied all allegations made and indicated she was going to leave the facility anyway. During an interview, on 6/2/25 at 1:20 p.m., RN 4 indicated he was called to Resident B and C's room by CNA 3. When he arrived at the room, Resident C was crying and upset. Resident C indicated CNA 3 had taken her phone. RN 4 indicated he asked CNA 3 to leave the room, and he reported the incident to the Care Service			

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	Administrator. A current facility policy, titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," dated April 2021 and received from the Care Service Administrator on 6/2/25 at 3:00 p.m., indicated "...Residents have the right to be free from abuse, neglect...This includes but is not limited to...verbal, mental...or physical abuse...." A current facility policy, titled "Resident Rights," dated February of 2021 and received from the Care Service Administrator on 6/2/25 at 3:00 p.m., indicated "...Federal and state laws guarantee certain basic rights to all residents of this facility...These rights include the resident's right to...be free from abuse...." The deficient practice was corrected by 5/25/25 after the facility implemented a systemic plan which included an investigation of the incident, education to the staff on resident abuse and reporting, residents were interviewed related to abuse, and CNA 3 was terminated. This citation relates to Complaint IN00460150. 3.1-27(a)(1) 3.1-27(b)			