STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	03/27/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/27/25 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Emergency Preparedness survey, The Retreat at the Stratford was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 18 certified beds. At the time of the survey, the census was 12. Quality Review completed on 04/02/25	E 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. All tags reviewed at monthly QAPI for minimum of 3 months or until full compliance is reached.	
E 0009 SS=C Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(Local, State, Tribal Collaboration Process Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all	E 0009	E009 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice FEMA contact information is located in the Emergency Preparedness and Planning Guide • Element 2 – Address how the facility will identify other residents having the	04/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Care Services Administrator	04/14/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	03/27/2025

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
	occupants. Findings include: Based on records review and interview with the Care Services Administrator (CSA) on 03/27/25 at 10:55 a.m., no documentation could be located ensuring the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the CSA stated he did not know where the FEMA contact information was located. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present.		potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The FEMA contact information is in the binder and was in the binder at the time of the survey but could not be located. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting The information is in Section I: Introduction to the Emergency Management Plan of the Emergency Preparedness and Planning Guide. • Element 5 – Include dates when corrective action will be completed. 4/14/2025 Desk review is requested and documents can be provided to show compliance.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable	E 0031	E031 Element 1 – Address how corrective action	04/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	03/27/2025

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
	sources of assistance. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Care Services Administrator (CSA) on 03/27/25 at 10:53 a.m., documentation of the communication plan part of the facility's emergency operations plan reviewed did not include specific contact information, including telephone number, for notification of the State Long Term Care Ombudsman. The CSA agreed contact information for the office of the State Long Term Care Ombudsman was not included in the plan. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present.		will be accomplished for those residents found to have been affected by the deficient practice Ombudsman contact information is located in the Emergency Preparedness and Planning Guide. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Ombudsman contact information is in the binder and was in the binder at the time of the survey but could not be located. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting The information is in Section I: Introduction to the Emergency Management Plan of the Emergency Preparedness and Planning Guide. • Element 5 – Include dates when corrective action will be completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	03/27/2025

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
			4/14/2025 We request desk review as documentation for compliance can be supplied.	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 0039	E039 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Community based emergency exercise of large and small scale have been conducted annually. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. Drills were done and in binder, but were not located at time of survey. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Care Services Administrator will become more familiar with the Emergency Plan Binder, however missing small scale exercise was present at time of survey. • Element 4 – Indicate how the facility plans to	04/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	03/27/2025

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
	LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Care Services Administrator (CSA) on 03/27/25 at 11:25 a.m., the facility was able to provide documentation of a large scale exercise, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the SCA agreed that a second exercise of choice was not conducted. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Services Administrator and Executive Director present.		monitor its performance to make sure that solutions are Lasting The Care Services Administrator will continue to hold small scale or tabletop exercises during the month of June as previously held. No changes needed currently. • Element 5 – Include dates when corrective action will be completed. 4/14/2025 Desk review is requested as documentation can be provided to show compliance.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/27/25 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Life Safety Code survey, The Retreat at the Stratford was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection	K 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. All tags reviewed at monthly QAPI for minimum of 3 months or until full compliance is reached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility located on the second floor of a three-story building was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 18 and had a census of 12 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/02/25			
K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of	K 0324	K324 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Floor paint/Tile Adhesive will be added to the area to denote the space for each respective piece of cooking equipment under the hood area. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to	06/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 8 staff, and no residents. Findings include: Based on observations and interview during a facility tour with the Care Services Administrator (CSA) on 03/27/25 at 12:07 p.m., the wheeled cooking equipment located under the hood in the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the CSA the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Heat treated paint will be added to the floor below and slightly in front of the cooking equipment so that it can be moved back to the same exact location after cleaning or servicing. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Paint will be monitored by the kitchen team to track it's effectiveness and maintenance, however once installed it should remain for perpetuity. • Element 5 – Include dates when corrective action will be completed. 6/1/2025 Desk review requested as service requests and plan of action are in effect and compliance may be reached earlier than June first.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility	K 0345	K345	04/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on review of the Fire Alarm system inspection records with the Care Services Administrator (CSA) on 03/27/23 at 10:45 a.m., no documentation could be provided regarding a (1) current annual inspection. The date on the report provided was 02/23/24. The aforementioned report showed deficiencies with the Fire Alarm. And (2) no documentation was available for review for a visual semi-annual fire alarm system inspection 6 months prior or since the Annual inspection dated 02/23/24. The CSA stated that he was new to the facility and would make sure the documentation was found and placed in the manual. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present.		Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Annual Fire Alarm System Inspection was accomplished at the time of survey but was not in the Life Safety Binder. The inspection was performed 2/28/2025. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Facilities will print copies of all annual fire and security inspections and store them in their respective place. All Annual Fire Alarm System Inspections will be held in the red Life Safety Binder and stored in Director of Facilities office. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Executive Director or Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	3.1-19(b)		inspect Life Safety Binder within 3 weeks post annual inspection to ensure it is printed and in the proper location. • Element 5 – Include dates when corrective action will be completed. 4/14/2025 Desk review is requested as compliance documentation can be provided.	
K 0346 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Care Services Administrator (CSA) on 03/27/25 at 11:05 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the CSA acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at	K 0346	Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Indiana State Department of Health website and email added to the Emergency Response Plan in Section V: page 5 under Fire Watch. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Fire watch policy and procedure was present in Emergency	04/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	the e-mail address listed above. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		Preparedness binder during time of survey. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Care Services Administator will become more familiar with Life Safety and Preparedness binders. Fire Watch policy will remain in preparedness binder. • Element 5 – Include dates when corrective action will be completed. 4/15/2025 Desk review requested as documentation of compliance can be provided.	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 3 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the	K 0353	K353 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Semi Annual Sprinkler Inspection was last conducted on 11/8/24. Monthly wet system inspections will be conducted by the 20th of each month. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient	06/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Care Services Administrator (CSA) on 03/27/23 at 10:20 a.m., 3 of 4 quarterly sprinkler reports were missing. A Report was provided dated, 05/16/24, the remaining 3 reports were not available for review. During an interview at the time of record review, the CSA acknowledged there was no written documentation available to show the sprinkler system had been inspected for all 4 quarters. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and		practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Semi annual sprinkler inspection is scheduled twice a year with our current fire suppression management company. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Director of Facilities will monitor monthly to ensure wet valves are being checked and logged. Care Services Director will monitor bi-monthly to ensure compliance with monthly wet valve checks. Semi-Annual Sprinkler System Inspection is every 6 months on or around May and November annually. • Element 5 – Include dates when corrective action will be completed. 6/15 /2025 Desk review requested as documentation can be provided for compliance purposes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review, observation and interview with the Care Services Administrator (CSA) on 03/27/23 at 11:35 a.m., there was no recorded monthly inspection of the wet pipe sprinkler system's gauges and valves available for review. Observation in the riser room did find documentation either in the life safety manual or in the riser room. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)			
K 0354 SS=F Bldg. 02	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition,	K 0354	Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Indiana State Department of Health website and email added to	04/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the Care Services Administrator (CSA) on 03/27/25 at 11:05 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the CSA acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present.		the Emergency Response Plan in Section V: page 5 under Fire Watch. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents had the potential to be affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Fire watch policy and procedure was present in Emergency Preparedness binder during time of survey. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Care Services Administator will become more familiar with Life Safety and Preparedness binders. Fire Watch policy will remain in preparedness binder. • Element 5 – Include dates when corrective action will be completed. 4/15/2025 Desk review requested as documentation can be provided to show compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
K 0355 SS=F Bldg. 02	3.1-19(b) NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure all portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents. Findings include: Based on records review, observation and interview with the Care Services Administrator (CSA) on 03/27/25 at 10:10 a.m., the annual inspection documentation for the facility's fire extinguishers was dated 04/24/23. The CSA stated he was unsure where documentation would be since it was not in the life safety binder.	K 0355	K0355-Portable Fire Extinguisher Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Facilities or Designee will schedule annual inspection of fire extinguishers and copy Care Services Administrator with the annual date and time. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by the deficient practice. No further concerns were noted. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Facilities or designee will audit fire extinguishers monthly and will schedule annual inspection. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Director of Facilities or designee will bring the results of the audits	06/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		to the monthly QAPI Committee for review and recommendation. Any recommendations made by the committee will be followed up by the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This will continue for 3 months or until 100% compliance is met. • Element 5 – Include dates when corrective action will be completed. June 1st, 2025 Desk review requested as documentation of compliance can be provided.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents and 2 staff. Findings include: Based on observation and interview during a facility tour with the Care Services Administrator (CSA) on 03/27/25 at 12:50 p.m., the corridor doors to (1) the Spa Room and (2) Resident Room, # 263 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Care Services Administrator agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke.	K 0363	K363 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The maintenance team will be educated on requirements to ensure corridor doors latch. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice One resident was affected by the deficient practice. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the	06/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		deficient practice will not recur The maintenance technician have been assigned to repair the doors to ensure they latch. All maintenance orders regarding doors not latching are addressed within 24 hours of being entered in the work order system. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Quarterly audits of all skilled unit doors' ability to latch will be conducted by Director of Facilities, designess or Care Services Administrator on the 10th day the last month of each quarter and addressed in the final month of the quarter QAPI meeting. • Element 5 – Include dates when corrective action will be completed. 6/10/2025 Desk review requested as documentation for compliance can be provided.	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the sprinkler riser room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and	K 0511	K511 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Junction box cover has been added to the visible wiring near the riser sprinkler area.	06/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff 2 in the basement. Findings include: Based on observations and interview during a facility tour with the Care Services Administrator (CSA) on 03/27/25 at 12:50 p.m., an electrical junction box on ceiling near the sprinkler riser did not contain a cover and had exposed electrical wiring. Based on interview at the time of the observations, the CSA acknowledged the electrical junction box was not provided with a cover and had exposed wires. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		• Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could have been affected if the wires got shorted and disrupted sprinkler functionality. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Facilities or Designee will walk the sprinkler riser room semi-annually to ensure all appropriate junction covers are in place. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Dates set in Outlook reminder have been sent to Director of facilities, Care Services Administator and Executive Director to ensure compliance. Copy of facility walks will be stored in Life Safety Binder. Walks sent in Outlook for 6/10 and 12/10 each year. • Element 5 – Include dates when corrective action will be completed. 6/10/2025 Desk review is requested as documentation/photograph can be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
			provided to show compliance.	
K 0521 SS=F Bldg. 02	NFPA 101 HVAC Based on record review, observation and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review, observation and interview with the Care Services Administrator	K 0521	K521 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Damper Inspection has been scheduled. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could have been affected if the dampers do not work. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Facilities or Designee will schedule 4 year damper inspection and print it off within 3 weeks of receiving final results. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Director of Facilities or Designee will schedule 4 year damper inspection and print it off within 3 weeks of receiving final results. Will be reviewed continuously with	06/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	(CSA) on 03/27/25 at 10:25 a.m., no documentation was available for review to show dampers had been inspected. A damper was observed during the tour on the second floor in the mechanical room. The CSA stated there were dampers in the building, but he was unsure where the documentation was to verify they had been inspected. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		annual Emergency Preparedness Binder refresh. • Element 5 – Include dates when corrective action will be completed. 6/10/2025 Desk review requested as documentation of compliance can be provided.	
K 0531 SS=E Bldg. 02	NFPA 101 Elevators Based on record review, interview and observation, the facility failed to maintain testing of 1 of 1 elevator firefighter recall in accordance with LSC 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators equipped with fire fighters' emergency operations in accordance with LSC 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect 8 staff. Findings include: Based on observations and interview during a facility tour with the Care Services Administrator (CSA) on 03/27/25 at 12:45 p.m., the facility had one elevator servicing the residents on the second floor equipped with Firefighter Service. Based on record review in the elevator room at	K 0531	Element 1: Elevator recalls will be conducted on the 25th of the each month. Element 2: All residents could have been affected if elevators do not work properly. Element 3. Director of Facilities or designee now has a monthly reminder to send someone to initial monthly recalls for all elevators on the 25th of the month for perpetuity and sent as outlook calendar reminders for Care Services Administrator and Executive Director. Element 4: Director of Facilities or Designee now has a monthly reminder to send someone to run monthly elevator recall on the 25th day of the month of not sooner, for	05/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	12:45 p.m., documentation for the monthly firefighter recall testing for 2025 was not available. Records stopped in December of 2023 and no documentation for January - March of 2025 was available for review. The CSA acknowledged the lack of documentation indicating the facility has not been doing the firefighter recall testing in 2025. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		perpetuity. Care Services Administrator to schedule quarterly audits for one year to check compliance, again scheduled with Outlook Calendar. Audits will be held on the last Wednesday of the last month of each quarter. Element 5: completed by 5/25/2025 Desk review requested as plan is in place and documentation can be provided to show compliance.	
K 0761 SS=E Bldg. 02	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 9 of 9 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the	K 0761	K761 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Annual Smoke Door inspections were done to code, however the results were not in the Life Safety binder at the time of survey. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents could have been affected if smoke doors fail to work properly. • Element 3 – Address what measures will be	04/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on records review, observations and interview with the Care Services Administrator (CSA) on 03/27/25 at 10:51 a.m., no documentation for a current annual inspection for the fire door		put into place or systemic changes made to ensure that the deficient practice will not recur Director of Facilities or Designee is expected to print annual inspections within 3 weeks of inspection or as soon as results are available. Annual inspections were completed on time and within range of survey, yet was not printed and placed in Life Safety Binder. Date Smoke Door Inspection was 2-28-2025. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Director of Facilities or Designee has been trained and educated to print all completed audits or inspections and put them in Life Safety Binder within 3 weeks or receiving results. • Element 5 – Include dates when corrective action will be completed. 4/19/2025 Desk review requested as documentation for compliance can be provided.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	assemblies was available for review. The most recent inspection documentation was dated 02/19/24. Based on observation during throughout the day and during the tour there were fire doors in the corridors and stair towers. Based on interview at the time of records review and observation, the CSA agreed the documentation of the current annual fire door inspection was not available. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)			
K 0921 SS=F Bldg. 02	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance.	K 0921	K921 Element 1 – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. PCREE testing has been scheduled with Pheonix Biomedical Servicess LLC . • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using The Stratford's equipment could be affected by the lack of testing. • Element 3 – Address what measures will be put into place or systemic	06/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and observation with the Care Services Administrator (CSA) on 03/27/25 at 11:40 a.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observations throughout the day during the building tour revealed that the facility provided electric beds for all residents. The CSA stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, beds and other electrical medical equipment was present and in use at the facility. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the CSA and Executive Director present. 3.1-19(b)		changes made to ensure that the deficient practice will not recur Once all equipment is tested, results will be housed in DON or Administrator's office. All new equipment or adjusted electronics will be tested using the same company and service and kept with original results. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting Director of Facilities is responsible for ensuring all testing and inspections of PCREE. Once all current equipment is tested we will save results and add tests of new or altered equipment as needed. Administrator, Director of Facilites and DON educated on PCREE servicing of equipment from CMS website. • Element 5 – Include dates when corrective action will be completed. 6/15/2025 Desk review requested as documentation for compliance can be provided.	
K 0923 SS=F Bldg. 02	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen	K 0923	K923 Element 1 – Address how corrective action	05/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
	storage equipment in 1 of 1 oxygen trans-filling basement areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect all residents. Findings include: Based on observations and interview with the Care Services Administrator (CSA) on 03/27/25 at 12:45 p.m., in the facility's designated area for transfilling liquid oxygen, there were more than three 10 liters liquid oxygen tanks within a cage in the facility's basement parking garage. The oxygen tanks were within the cage with a large amount of material stored within the cage and within 5 feet of the aforementioned tanks. The CSA agreed that there was a large amount of unorganized combustible storage in the same cage and in close proximity to the oxygen being stored. This finding was acknowledged by the Care Services Administrator at the time of discovery and again at the exit conference with the Care Services Administrator and Executive Director present. 3.1-19(b)		will be accomplished for those residents found to have been affected by the deficient practice. O2 refill tanks in parking garage will be chained in place and behind a locked gate. • Element 2 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice. . Several residents could be put at risk if O2 is not stored properly and safely. • Element 3 – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Cage and chains have been implemented to secure O2 refill containers in the proper fashion. • Element 4 – Indicate how the facility plans to monitor its performance to make sure that solutions are Lasting O2 refill tanks are to be chained to the eye hooks which are bolted to the concrete walls. All combustibles have been moved beyond 5 feet away from O2 storage. Cage with lock has been installed to secure safe handling. All nurses and managers have been educated on new O2 set up. • Element 5 – Include dates when corrective action will be completed. 5/5/2025 Desk review requested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 02 B. WING	03/27/2025

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
			as proof of compliance can be provided.	