STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155794	A. BU B. WI	JILDING NG	00	COMPL: 03/14/	
		155794	B. WI	NG		03/14/	2023
NAME OF P	ROVIDER OR SUPPLIE	ER.			ADDRESS, CITY, STATE, ZIP COD		
	T AT THE OTDAT	CORD THE		2460 GLEBE ST			
RETREA	T AT THE STRAT	FORD, THE		CARIME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Diag. 00	This visit was for a	a Recertification and State	F 00	000	This Plan of Correction repres	ents	
	Licensure Survey. This visit included a State		1 00	,00	The Retreat at the Stratford	JOING	
	Residential Licens				allegation of compliance.		
		3			Submission of this response a	and	
	Survey dates: Mar	ch 9, 10, 13 and 14, 2023			Plan of Correction is NOT a le		
					admission that a deficiency ex	-	
	Facility number: 0	11151			or, that this Statement of		
	Provider number:	155794			Deficiencies was correctly cite	ed,	
					and is also NOT to be constru	ıed	
	Census Bed Type:				as an admission against inter	est	
	SNF/NF: 13				by the residence, or any		
	Residential: 22				employees, agents, or other		
	Total: 35				individuals who drafted or ma	-	
					discussed in the response or	Plan	
	Census Payor Typ	e:			of Correction. In addition,		
	Medicare: 4 Other: 9				preparation and submission o	t this	
	Total: 13				Plan of Correction does NOT constitute an admission or		
	10tai. 13				agreement of any kind by the		
	These deficiencies	reflect State Findings cited in			facility of the truth of any facts		
	accordance with 4	_			alleged or the correctness of a		
					conclusions set forth in this	,	
	Quality review wa	s completed on March 20, 2023.			allegation by the survey agen	cv.	
	-	-				, l	
F 0578	483.10(c)(6)(8)(g	ı)(12)(i)-(v)					
SS=D	Request/Refuse/	Dscntnue Trmnt;FormIte Adv					
Bldg. 00	Dir						
	- ' ' ' '	e right to request, refuse,					
		ue treatment, to participate in					
		cipate in experimental					
		formulate an advance					
	directive.						
	8/18/2 10/5\/\@\ NI5	thing in this paragraph					
	- ' ' ' '	othing in this paragraph ued as the right of the					
		ve the provision of medical					
		lical services deemed					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Lorna Ray Care Services Administrator 04/03/2023

Any defiency statement 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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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2023
	PROVIDER OR SUPPLIER		2460 0	ADDRESS, CITY, STATE, ZIP COD GLEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION SSARY OF INAPPROPRIATE.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	§483.10(g)(12) The the requirements of 489, subpart I (Ad (i) These requirements of the residents coordined and provided adult residents coordined resident's of directive. (ii) This includes a facility's policies to directives and approper (iii) Facilities are prother entities to further entities to further entities to further entities to further equirements of (iv) If an adult indicting the time of admissing receive information to the or she has directive, the facility directive information to provide this information. Follow place to provide the individual directly	the facility must comply with specified in 42 CFR part vance Directives). The part include provisions to the written information to all procerning the right to accept or surgical treatment and, potion, formulate an advance of written description of the primplement advance	F 0578	What corrective actions will be	04/28/2023
	failed to update adv	anced directives upon residents reviewed for	F 05/8	what corrective actions will be accomplished for those reside found to have been affected by deficient practice: Resident 13 no longer lives in community.	nts y the
	The Face Sheet for	Resident 13 indicated the		How the facility will identify oth residents having the potential	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/14/2023
NAME OF D	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	•
				SLEBE ST	
RETREA	T AT THE STRATF	ORD, THE	CARM	EL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		Code for advance directive		be affected by the same defice	
	status.			practice and what corrective	action_
	A care plan indicated Resident 13 had a Full code status on admission to the facility.			will be taken:	alta
				All residents have the potenti be affected by the deficient	ai to
	status on admission	to the facility.		practice. SSD audited all resi	dent
	An "Internal Medic	ine Progress Note," dated		medical records for accuracy	
		.m., indicated Resident 13's		documented code status.	
	•	R (do not resuscitate), and		Resident records found to be	
	DNI (do not intubat			accurate.	
	`			What measures will be put in	
	During an interview, on 03/14/23 at 11:05 a.m., the			place or what systemic change	
	Executive Director	(ED) indicated upon admission		the facility will makes to ensu	<u>re</u>
	normally the social	worker would update the code		that the deficient practice doe	es not
	status.			occur:	
				SSD will meet with all new	
	_	y, on 03/14/23 at 11:19 a.m., the		admission/return admission to	0
		cated the facility did not have		obtain code status and add a	•
	-	atus in the record. The family		updates. SSD will discuss co	
		d changed Resident 13's code		status during care plans. Any	
	status during the las	t hospital visit.		update will require new POS	
	D	02/14/22 -4 1.24 41 -		form. POST forms will be upl	
		y, on 03/14/23 at 1:34 p.m., the admission to the skilled		into medical records to ensur	e
		dent 13's code status was not		accuracy. SSD will be educated on Adv	vanaa
	addressed.	dent 13's code status was not		Directive policy.	ance
	addressed.			Don or designee will audit ne	w.
	A current policy. tit	led "Advance Directives,"		admission medical records w	
		D on 3/14/23 at 2:34 p.m.,		72 hours of admission to ens	
		sident has the right to		medical record has code stat	
		ce directive, including the right		entered. Audits will continue	
	to accept or refuse i			weekly x 4 weeks, then every	12
	treatmentPrior to	or upon admission of a		weeks x 2 months, then mon	thly
	resident, the social	services director or designee		until 100% compliance is	
	_	lent, his/her family members		achieved. Review will be ong	oing.
		resentative, about the		SNF nursing staff including b	
	existence of any wr	itten advance directives"		limited to LPN, RN, CNA will	
				educated on Advance Directi	ve
	3.1-4(f)(5)			and CPR policy.	
			1	How the corrective actions w	ill be

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMI	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIEF		2460 0	ADDRESS, CITY, STATE, ZIP SLEBE ST EL, IN 46032	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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 0625 SS=D Bldg. 00	§483.15(d) Notice return- §483.15(d)(1) Not nursing facility trainospital or the research leave, the nursing information to the representative that (i) The duration of any, during which return and resume facility; (ii) The reserve be state plan, under state plan, under stany; (iii) The nursing fabed-hold periods, with paragraph (epermitting a reside (iv) The information (1) of this section.	the state bed-hold policy, if the resident is permitted to e residence in the nursing ed payment policy in the § 447.40 of this chapter, if cility's policies regarding which must be consistent b(1) of this section, ent to return; and on specified in paragraph (e)		monitored to ensure a practice will not recur quality assurance proput into place The SSD or designed any changes in code discuss in monthly Q. Committee for review recommendation unticompliance is met. A recommendation made committee will be foll the SSD or designee	e will record status and API and I 100% ny de by the owed up by	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE C A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/14/2023
	ROVIDER OR SUPPLIEF		2460 (ADDRESS, CITY, STATE, ZIP COD GLEBE ST IEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	At the time of tran hospitalization or a facility must provide resident represent specifies the durated described in parage Based on interview failed to provide do bed-hold policy was reviewed for bed-hold (Resident 11) Finding includes: The record for Resident 11) Finding includes: The record for Resident 11 was set intravenous therapy There was no note of record indicating the was provided a bed transfer or within 24. A nursing note, date Resident 11 was set the evaluation and to a protein in the redoxygen to the organ. There was no note of record indicating the was provided a bed transfer or within 24.	sfer of a resident for therapeutic leave, a nursing de to the resident and the tative written notice which tion of the bed-hold policy graph (d)(1) of this section. and record review, the facility cumentation to show the s provided to 1 of 1 resident old policy notification. dent 11 was reviewed on .m. Diagnoses included, but heart failure, anemia, and	F 0625	What corrective actions will accomplished for those reside found to have been affected deficient practice: Resident 11 returned to the community. No corrective accomplished at this time. How the facility will identify coresidents having the potential be affected by the same defipractice and what corrective will be taken: All residents have the potential be affected by the deficient practice. SSD was educated bed-hold policy on 3-14-23. What measures will be put in place or what systemic channel the facility will makes to ensith the deficient practice do occur: SSD or designee will provide written information regarding bed-hold policy to residents family members at admission SSD or designee will provide written information regarding bed-hold policy to residents family members within 24 hours fami	be 04/28/2023 dents by the otions other al to icient action tial to lon on on one of the otion o
	During an interview	v, on 03/03/23 at 9:18 a.m., LPN	1	quality assurance program v	VIII DE

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794		LDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/14/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
F 0656	facility, they were to hold policy. A facility policy, tit dated as revised in 0 the Executive Direct indicated "All resist provided written infand state bed-hold pholding or reserving periods of absence source, are provided policiesnotice	led "Bed-Holds and Returns," Detober 2022 and provided by tor on 03/14/23 at 1:30 p.m., idents/representatives are formation regarding the facility policies, which address a resident's bed during Residents regardless of payer I written notice about these ell in advance of any transfer on packet); andnoticeat the if the transfer was an 24 hours)"			put into place Don or designee will audit wee medical records of all transfers ensure documentation of bed-I review is documented in the medical record. Audits will be conducted weekly x 4 weeks, t every 2 weeks x 2 months, the monthly until 100% compliance met. Results of audits will be brougl and discussed in monthly QAF Committee for review and recommendation until 100% compliance is met. Any recommendation made by the committee will be followed up the sSD or designee.	s to nold then n e is	
SS=D Bldg. 00	Develop/Implemer §483.21(b) Compr §483.21(b)(1) The implement a compcare plan for each the resident rights and §483.10(c)(3) objectives and tim resident's medical psychosocial need comprehensive as comprehensive can following - (i) The services the attain or maintain practicable physic	n, nursing, and mental and that are identified in the esessment. The esessment must describe the estat are to be furnished to the resident's highest al, mental, and being as required under					

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M3UT11

Facility ID: 011151

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 03/14/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	(ii) Any services the required under §4 but are not provide exercise of rights the right to refuse (6). (iii) Any specialized rehabilitative serve provide as a result recommendations the findings of the its rationale in the (iv) In consultation resident's represed (A) The resident's desired outcomes (B) The resident's future discharge. Whether the resident's future discharge. Whether the resident's future discharge of the community was at the local contact agaptropriate entities (C) Discharge placare plan, as appoint the requirements this section. §483.21(b)(3) The arranged by the facomprehensive case (iii) Be culturally contact and the comprehensive case (iii) All the contact and the comprehensive case (iii) All the contact and the contact and the comprehensive case (iii) All the contact and the co	A. If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the intative(s)-goals for admission and preference and potential for Facilities must document ent's desire to return to the assessed and any referrals gencies and/or other es, for this purpose. In the comprehensive ropriate, in accordance with set forth in paragraph (c) of esservices provided or acility, as outlined by the are plan, must-ompetent and	TAG		DATE		
	failed to develop a related discharge pl psychoactive medic	and record review, the facility comprehensive care plan anning and the use of cations for 2 of 6 residents rehensive care plans. (Resident	F 0656	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: Resident 9 no longer resides the community. Resident 11 h comprehensive care plan upd on 3-15-23. How the facility will identify other accomplished to the facility will identify the facility will identify the facility will identify the facility will be accomplished to the	nts y the n ad ated		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155794	B. W	ING		03/14/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
DETDEA	T AT THE OTDATE	ODD THE			LEBE ST		
RETREA	T AT THE STRATF	ORD, THE		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	1. The record for Re	esident 9 was reviewed on			residents having the potential	to	
	03/10/23 at 3:36 p.r	n. Diagnoses included, but were			be affected by the same defici		
	•	ired mobility, and Parkinson's			practice and what corrective a		
	disease.	37			will be taken:		
	discuse.				All residents have the potentia	ıl to	
	The resident did not	t have a discharge goal care			be affected by the deficient		
		ne comprehensive care.			practice. Audit of all residents		
	1	-F			residing on skilled nursing was	5	
	During an interview	y, on 03/14/23 at 10:37 a.m., the			conducted for discharge care	-	
	Executive Director indicated Resident 9				plans and psychotropic care		
		er facility due to financial			plans. Residents without		
	_	esident 9 was to be long term			discharge care plan had one		
	care.	sident y was to be long term			initiated. No other concerns no	oted	
	carc.				for psychotropic care plans.	leu	
	During an interview	y, on 03/14/23 at 3:27 p.m., the			What measures will be put in		
	_	linical (VPC) indicated a care			place or what systemic change	00	
		en developed anticipating the			the facility will makes to ensur		
	-	er a Medicare Part A (care in a			that the deficient practice does		
		ity, hospice care, and some			occur:	S HOL	
	home health care) s	-			DON and MDS coordinator wi	ll bo	
	nome nearm care) s	ay was completed.			educated on policy "Care Plan		
	2 The record for R	esident 11 was reviewed on			Comprehensive Person-Center		
		n. Diagnosis included, but were			How the corrective actions will		
		protein malnutrition, cognitive			monitored to ensure the defici		
		icit, and dysphagia (difficulty			practice will not recur, I,e., who		
	swallowing).	ieri, and dysphagia (difficulty			quality assurance program wil		
	swanowing).				put into place	i bc	
	A nhysician's order	, initiated on 02/24/23,			DON or designee will audit		
		irtazapine (an antidepressant)			residents' medical records we	ekly	
		once a day for anorexia (an			for discharge care plans. DON	•	
	abnormal loss of the				designee will audit medical	1 01	
	451101111111 1035 01 till	appende for 100d).			records of residents on		
	There was no care r	plan addressing the use of the			psychotropic medication for		
		azapine off label use for			psychotropic care plan. Audits	will	
	-	e effects to monitor for during			be conducted weekly x 4 weel		
	the use of the medic	_			then every 2 weeks x 2 month	-	
	the use of the medic	ation.			then monthly until 100%	o,	
	Duning on intermi	on 02/14/22 at 2,22 the			1		
		y, on 03/14/23 at 3:33 p.m., the			compliance is met.		
		re plan should have been			Administrator or designee will		
	developed for the us	se of an antidepressant for	1		review audits weekly to ensure	9	

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	OF CORRECTION	IDENTIFICATION NUMBER 155794	A. BUILDING B. WING	00	COMPLETED 03/14/2023		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST				
RETREA	T AT THE STRATE	ORD, THE	CARME	EL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
	revised March 2022 Executive Director of indicated "The intronjunction with the legal representative, comprehensive, perseach residentThe operson-centered care that are to be furnish resident's highest prand psychosocial we resident's state goals outcomesAssessmand care plans are rethe residents and the change" 3.1-35(a)	son-Centered," dated as and provided by the on 03/14/23 at 3:32 p.m., erdisciplinary team (IDT), in the resident and his/her family or develops and implements a son-centered care plan for		compliance. Results of audits be brought and discussed in monthly QAPI Committee for review and recommendation u 100% compliance is met. Any recommendation made by the committee will be followed up the SSD or designee.	ıntil		
F 0695 SS=D Bldg. 00	tracheostomy care The facility must e needs respiratory tracheostomy care is provided such coprofessional stand comprehensive pe the residents' goal 483.65 of this subp Based on observatio review, the facility for	atory care, including and tracheal suctioning. Insure that a resident who care, including and tracheal suctioning, are, consistent with ards of practice, the Irson-centered care plan, and preferences, and coart. In, interview and record Cailed to maintain and store for 1 of 3 residents reviewed	F 0695	What corrective actions will be accomplished for those resided found to have been affected by deficient practice:	nts_		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155794	B. W	ING		03/14/	2023
			<u> </u>	CTDEET A	ADDRESS CITY STATE 7ID COD	I	
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
DETDE A	T	OPD THE	2460 GLEBE ST				
KEIKEA	T AT THE STRATE	TOND, THE		CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Resident 10 no longer resides	in	
	Finding includes:				the community.		
					How the facility will identify oth	<u>ner</u>	
	_	ion, on 03/09/23 at 10:18 a.m.,			residents having the potential	<u>to</u>	
	Resident 10's nasal cannula (device for putting				be affected by the same defici	<u>ient</u>	
	oxygen into the nasal passage) and tubing was				practice and what corrective a	ction	
	lying on top of the oxygen concentrator in				will be taken:		
	Resident 10's room and dated 3/3.				All residents have the potentia	al to	
					be affected by the deficient		
	During an observation, on 03/10/23 at 8:24 a.m.,				practice. All residents receivin	-	
	Resident 10's nasal cannula and tubing was lying				oxygen had nasal cannula and	b	
	on top of the oxygen concentrator in Resident 10's				tubing replaced.		
	room and dated 3/3.				What measures will be put in		
					place or what systemic change	<u>es</u>	
	_	ion, on 03/10/23 at 2:37 p.m.,			the facility will makes to ensur	<u>e</u> _	
		cannula and tubing was lying			that the deficient practice does	s not	
		en concentrator in Resident 10's	occur:				
	room and dated 3/3		DON, RCD and nursing staff will				
					be educated on policy		
		ion, on 03/13/23 at 8:33 a.m.,			"Department (Respiratory The	rapy)	
		cannula and tubing was lying			-Prevention of Infection"		
		en concentrator in Resident 10's			How the corrective actions wil	l be_	
	room and dated 3/3				monitored to ensure the defici		
					practice will not recur, I,e., wh		
	_	ion and interview, on 03/13/23			quality assurance program wil	<u>l be</u>	
		sed Practical Nurse (LPN) 1			<u>put into place</u>		
	observed Resident	10's oxygen tubing and nasal			DON or designee will audit we	-	
		e oxygen concentrator and			the oxygen tubing on all reside		
	· ·	t sitting on the oxygen			requiring oxygen. Audit will inc	clude	
		exygen tubing and nasal			location of tubing and date of		
		en changed and the date on			changing. Audits will be		
		and it was greater than 1 week			conducted weekly x 4 weeks,		
	1	gen tubing and cannula should			every 2 weeks x 2 months, the		
	be changed weekly				monthly until 100% complianc	e is	
					met.		
		dent 10 was reviewed.	1		Any items found to be out of		
		l, but were not limited to,			compliance will be immediatel	-	
		inspecified with hypoxia (low			changed and education will be	•	
	oxygen level in blo	od).			provided to staff.		
			1		Administrator or designee will		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIER		2460 0	ADDRESS, CITY, STATE, 2 GLEBE ST EL, IN 46032	ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO DEFICIENCE	DEF CORRECTION TION SHOULD BE TO THE APPROPRIATE CY) CX5) COMPLETION DATE	
	oxygen (O2) at 1 L/cannula 3 times daii A care plan, dated 2 was unable to maintand received oxyge During an interview Vice President of C tubing and cannula and changed weekly A current policy, tit Therapy)- Prevention the Executive Directing indicated "The pure guide prevention of respiratory therapy including ventilator staffChange the overy seven (7) day	t/26/23, indicated Resident 10 tain O2 (oxygen) saturation, in at 1 L/min. 7, on 03/13/23 at 2:11 p.m., the linical indicated the oxygen needed to be dated, bagged, for of Infection," received from tor (ED) on 3/13/23 at 3:42 p.m., prose of this procedure is to infection associated with tasks and equipment, so, among residents and axygen cannula and tubing so, or as neededKeep the litubing used PRN (as needed)		review audits week compliance. Result be brought and disconnected monthly QAPI Commercial review and recommendation of the SSD or designed.	its of audits will cussed in inmittee for nendation untiles met. Any nade by the ollowed up by	
F 0812 SS=F Bldg. 00	§483.60(i) Food so The facility must - §483.60(i)(1) - Pro approved or consi federal, state or lo (i) This may include	le food items obtained producers, subject to				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION NG 00	(X3) DATE SURVEY COMPLETED 03/14/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	CROSS-REFERENCED TO THE API	CCTION (X5) ULD BE PROPRIATE COMPLETIC DATE	ON	
	facilities from using gardens, subject to applicable safe grapractices. (iii) This provision from consuming for facility. §483.60(i)(2) - Store serve food in accordance serve food in accordance standards for food Based on observative conditions in the kirt for food borne illner consume food from Findings include: 1. During an initial a.m., with the Direct the following were a) a large bin of yell was noted with no open c) a large bin of bronoted with no open c) a large bin of whoted with no open During an interview DDS indicated he downs placed in the late on the bins. 2. A review of the Log," dated March	con, interview and record failed to maintain sanitary techen resulting in the potential ses for all residents who at the kitchen. kitchen tour, on 03/09/23 at 9:48 etor of Dining Services (DDS) observed: low cornmeal like substance open date on the bin. and crumb like substance was date on the bin. itte sugar like substance was date on bin. v, on 03/09/23 at 9:48 a.m., the lid not know when the food arge bins without an open date Dish Machine Temperature 2023, indicated there was no ishwasher temperatures after	F 0812	What corrective actions accomplished for those found to have been affed deficient practice: The Executive Chef and members of Dining Serveducated on 3/30/2023 policies "Dishwashing Muse", "Sanitization", and Receiving and Storage". large bins were labeled dates. All other items list SOD were thrown out. How the facility will identified the members of Dining Serveducated on 3/30/2023 policies "Dishwashing Muse", "Sanitization", and Receiving and Storage". large bins were labeled dates. All other items list SOD were thrown out. How the facility will identified the facility will identified affected by the same practice and what correct will be taken: All residents have the policies affected by the deficient practice. Executive Chefundesignee will audit dishwaster for completion, all food sareas to ensure all items labeled and dated, and of solution for proper PPM. What measures will be policies in the policy of the policy of the proper PPM. What measures will be policies for the policy of the pol	team ices were regarding achine "Food Items in with open ted in tify other ential to deficient ctive action otential to ent f and or vasher log storage s are QAC out in	23	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155794	B. W	ING		03/14/2023
				CEDELET	ADDRESS OF A STATE OF COD	
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD	
DETDEA	T AT THE OTDATE	ODD THE			LEBE ST	
RETREAT AT THE STRATFORD, THE				CARME	EL, IN 46032	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	During an interview	y, on 03/13/23 at 11:02 a.m., the			the facility will makes to ensure	e
	Executive Chef (EC	c) reviewed the dish machine			that the deficient practice does	
	temperature log and	l indicated nobody			occur:	
	documented the disl	hwasher temperatures. It was			Executive Chef or designee w	ill
	not known if the dis	shwasher was at the proper			review all logs weekly to ensu	
	temperature to know	w if the dishes were sanitized			compliance. They will conduct	
	_	entation on the dishwasher log.			storage walkthrough audit of fo	
		<u> </u>			storage, refrigerator, and freez	
	3. A review of the s	anitizing logs indicated there			ensure all items are labeled ar	
		sanitizer concentration			dated. QAC will be checked d	
	checks after 3/9/23	at 11:30 a.m., through 3/13/23.			to ensure proper PPM. Any ite	-
					found out of compliance will be	
	During an interview, on 03/13/23 at 11:30 a.m., the				corrected and staff will be	
	EC indicated there was no sanitizing log				educated. Audits will be	
		he sanitizer concentration			conducted weekly x 4 weeks,	then
	after 3/9/23 at 11:30	a.m., until the present day and			every 2 weeks for 2 months, th	
	time.	-			monthly until 100% compliance	
					achieved.	
	4. During an observ	ration of the 3 (three)			How the corrective actions will	be
	compartment sink,	on 03/13/23 at 11:33 a.m., the			monitored to ensure the deficie	
	quaternary ammoni	um compound (QAC) solution			practice will not recur, I,e., who	
	was checked for con	ncentration by the EC. The			quality assurance program will	
	observed result of th	he QAC was 300 ppm (parts			put into place	
	per million).				The Administrator or designed	e will
					bring the results of the audits t	0
	5. During an observ	ration and interview with EC,			the monthly QAPI Committee	
	on 03/13/23, the fol	lowing was observed:			review and recommendation.	
	a) 11:10 a.m., a plas	stic wrapped open bag of crispy			recommendation made by the	
	onions was noted. T	The EC indicated it was an			committee will be followed up	by
	open food item with	nout an open date.			the Executive Chef or designe	e
	b) 11:12 a.m., an op	pen 5-pound bag of long grain			and the results will be brought	
	rice was noted. The	EC indicated it was not dated			the next scheduled QAPI	
	and it was open.				committee meeting. This pract	ice
	c) 11:14 a.m., an op	en 10-pound bag of spaghetti			will continue until 100%	
	noodles was noted v	with no date. The EC indicated			compliance is achieved.	
	there was no date or	n the open bag of spaghetti			-	
	noodles.					
	d) 11:16 a.m., an op	en 1 liter of club soda was				
		date on the bottle. The EC				
	_	vas open, but no date was on				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILDING 00 B. WING			COMPLETED 03/14/2023		
	PROVIDER OR SUPPLIER			2460 GL	ddress, city, state, zip cod EBE ST L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	noted with no date. bag of mixed greens when opened. f) 11:23 a.m., a bag an open date. The E date on the broccoli g) 11:25 a.m., an op was wrapped in plast indicated it was open h) 11:25 a.m., multinoted with a missing in plastic with no open EC indicated the open EC indicated the open A current policy, tit Use," received from on 3/13/23 at 1:15 p will check temperat with each dishwash record the results in EC in A current policy, tit from the ED on 3/13."The food service clean and sanitary numbers on the following (parts per million) on compound (QAC) A current policy, tit Storage," received from the ED on and the following (parts per million) on compound (QAC) Storage," received from the following (parts per million) on compound (QAC) The food service clean and sanitary numbers per million on the following (parts per million) on compound (QAC) The food service clean and sanitary numbers per million or compound (QAC) A current policy, tit storage," received from a manner thandling practices bins will be removed labeled, and dated (the following practices bins will be removed labeled, and dated (the following practices bins will be removed labeled, and dated (the following practices	stic with no open date. The EC n without a date. ple pieces of corn bread were g piece of corn bread covered on date on the cornbread. The en cornbread was not dated. Ided "Dishwashing Machine the Executive Director (ED) o.m., indicated "The operator ures using the machine gauge ing machine cycle, and will a facility approved log" Ided "Sanitization," received 3/23 at 1:15 p.m., indicated area shall be maintained in a mannerSanitizing of the second of the second of the solutions: 150 - 200 ppm of quaternary ammonium					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2023			
RETREA	ROVIDER OR SUPPLIER	ORD, THE	STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	during storage" 3.1-21(i)(3)						
F 9999							
Bldg. 00	written and implement prospective employed Specific inquiries shemployees. The facing policy that consider (t) A physical exame each employee of a prior to employment include a tuberculin (1) At the time of emonth prior to employee facilities shall be schealth care workers documented negative during the preceding	nall be made for prospective ility shall have a personnel s references. ination shall be required for facility within one (1) month t. The examination shall skin test. mployment, or within one (1) loyment, and at least annually es and nonpaid personnel of reened for tuberculosis. For	F 9999	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Nursing, Reside Care Director, and HR Director were educated on policy titled "Tuberculosis, Employee Screening for" on 3/29/2023. C.N.A 5: missing Initial TB questionnaire was located. C. had 1st step on 12/24/22 and step on 1/9/23. C.NA 6: had 2nd step TB on 3/9/23. How the facility will identify off residents having the potential be affected by the same deficient will be taken: All residents have the potential be affected by the deficient	ents by the dent or N.A 2nd ner to ient oction		
	Based on interview failed to ensure a 2-	and record review, the facility step tuberculosis test was f 5 new employees. (CNA 5 and		practice. HRD or designee will audit all employee records to identify non-compliance with i TB testing. Any staff identified not having completed the initial testing will be required to	nitial las		
	Findings include: The employee record and 03/14/23.	rds were reviewed on 03/13/23		immediately complete to be compliant. What measures will be put in place or what systemic chang the facility will makes to ensure			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2023	
	PROVIDER OR SUPPLIER		2460 G	ADDRESS, CITY, STATE, ZIP COD LEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	date of 09/19/22, hashe had started the 27. The facility was unato show the testing 19. The records indicated date of 12/07/22, hashe 02/21/23. The facility documentation to show the testing 19. During an interview. Executive Director have any documenta a 2-step tuberculosis received the first sk tuberculosis testing. The tuberculosis testing tuberculosis testing tuberculosis testing 4. Facility policy, titt Screening for," date and provided by the 03/14/23 at 9:00 a.m. hired employee is set tuberculosis infection.	she indicated the 2-step should have been completed. led "Tuberculosis, Employee ed as revised in March 2021 Executive Director on n., indicated "Each newly creened for LTBI (latent on) and active TB an employment offer has been		that the deficient practice does occur: HRD will audit each new emplierecord weekly x 1 month to end TB skin tests and health assessments have been completed. DON or designee maintain a calendar with hire dates of all employees and dudate of 1st and 2nd step TB testing. How the corrective actions will monitored to ensure the deficit practice will not recur, I,e., who quality assurance program will put into place. The HR Director or designee will be monthly QAPI Committee review and recommendation. The recommendation made by the committee will be followed up the HR Director or designee as the results will be brought to the next scheduled QAPI committee will continue until 100% compliant achieved. Review will be ong	loyee asure will te I be ent at II be will to for Any by and the eee ce is
R 0000					
Bldg. 00	Survey. This visit in State Licensure Sur	State Residential Licensure acluded a Recertification and vey. h 9, 10, 13, and 14, 2023	R 0000	This Plan of Correction repres The Retreat at the Stratford allegation of compliance. Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex	and egal

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155794			UILDING	nstruction 00	(X3) DATE SURVEY COMPLETED 03/14/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	Facility number: 011151 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.				or, that this Statemer Deficiencies was cornand is also NOT to be as an admission again by the residence, or a employees, agents, condividuals who drafted discussed in the resport Correction. In adding preparation and submit Plan of Correction do constitute an admission agreement of any kin facility of the truth of alleged or the correct conclusions set forth allegation by the survival.	rectly cited, e construed inst interest any or other ed or may be conse or Plan tion, nission of this cos NOT ion or id by the any facts tness of any in this	
R 0092 Bldg. 00	disaster prepared continuity of care emergency as foll (1) Fire exit drills i transmission of a simulation of eme except that the more residents to safe at the building is not conducted quarter familiarize all facil and emergency acconditions. At least held every year. We between 9 p.m. ar announcement manudible alarms.	d Management - st maintain a written fire and ness plan to assure of residents in cases of ows: n facilities shall include the fire alarm signal and rgency fire conditions, ovement of nonambulatory areas or to the exterior of required. Drills shall be					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILDING B. WING	<u>00</u>	COMPLETED 03/14/2023	
	PROVIDER OR SUPPLIER		2460	ET ADDRESS, CITY, STATE, ZIP COD GLEBE ST MEL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	shall attempt to he in conjunction with A record of all train documented with to of the personnel p Based on interview failed to conduct a freviewed for fire dri October, and December, and December includes: The documentation 03/13/23. The facility documentation to she following months: J and December 2022 During an interview Executive Director is say why the facility information provided A facility policy, titt and Drills," dated as and provided by the 03/13/23 at 9:32 a.n. safety drills are contarea fire Department.	old the fire and disaster drill the local fire department. In the local fire department on the local fire department of the names and signatures resent. In and record review, the facility fire drill for 5 of 12 months of 13 months of 14 months of 15 m	R 0092	What corrective actions will accomplished for those reside found to have been affected deficient practice: The facilities team was re-educated on fire drill policiprocedure on 3/16/2023. The community currently does not have a Director of Facilities. How the facility will identify oresidents having the potentiable affected by the same definition practice and what corrective will be taken: All residents have the potentiable affected by the deficient practice. Director of Facilitie designee will create a year calendar that will state fire died be done and what shift it will in that month. What measures will be put in place or what systemic chart the facility will makes to ensith the deficient practice do occur: Director of Facilities or designee will audit Fire Drill compliant weekly to ensure drills have completed. The Director of Facilities or designee will ide any issues and educate staf corrective action. How the corrective actions we monitored to ensure the definitions.	be 04/28/2023 dents by the exp and exp and exp and exp and exp action tial to exp action

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
		155794	B. WING 03/14/2023				
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					LEBE ST		
RETREA	T AT THE STRATF	ORD, THE		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					practice will not recur, I,e., who	<u>at</u>	
					quality assurance program wil	l be	
					put into place		
					The Care Services Administra	tor	
					or designee will conduct audits	s of	
					fire drill monthly to ensure pro		
					procedure is followed. Audits v	-	
					continue monthly until 100%		
					compliance is achieved. Revie	:W	
					will be ongoing. Any		
					concerns/deficient practice wil	l be	
					corrected immediately. Any		
					negative patterns will be prese	ented	
					at QAPI monthly for further		
					review/recommendations for tl	ne	
					need to increase, decrease or		
					discontinue the auditing.		
R 0117	410 IAC 16.2-5-1.	• •					
	Personnel - Defici	•					
Bldg. 00	, ,	sufficient in number,					
	-	training in accordance with					
		ws and rules to meet the					
	• ,	our scheduled and					
		ds of the residents and					
	=	The number, qualifications,					
	_	ff shall depend on skills					
		e for the specific needs of					
		inimum of one (1) awake					
	•	current CPR and first aid					
	•	oe on site at all times. If					
		esidents of the facility					
		esidential nursing services					
		of medication, or both, at					
		ng staff person shall be on					
		esidential facilities with					
		(100) residents regularly					
	receiving resident	ial nursing services or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			ETED	
		155794	B. W	NG	03/14		/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			LEBE ST		
DETDEA	T	OPD THE			EL, IN 46032		
RETREAT AT THE STRATFORD, THE			CARIVIE	EL, IN 40032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	administration of r	nedication, or both, shall					
		(1) additional nursing staff					
	•	d on duty at all times for					
		fty (50) residents. Personnel					
	_	only those duties for which					
	-	perform. Employee duties					
		written job descriptions.					
		and record review, the facility	R 0	117	What corrective actions will be		04/28/2023
		of 21 shifts were covered with			accomplished for those reside		
		ed in first aid and 3 of 21 shifts			found to have been affected b	<u>y the</u>	
		an employee certified in			deficient practice:		
		suscitation (CPR) between			The Director of Nursing and		
	03/03/23 to 03/09/23.				Resident Care Director were		
					educated on the requirement t		
	Findings include:				the Indiana State Guidelines for	or	
					CPR/First Aid on 3/29/2023.		
		dules were reviewed alongside			How the facility will identify oth		
		ns for CPR and first-aid. The			residents having the potential		
	-	re found to be missing staff			be affected by the same defici		
	with CPR, first aid,	or both:			practice and what corrective a	ction_	
	0.00/00/00 1				will be taken:		
		were no staff members found			All residents have the potentia	ıl to	
		been certified in first aid.			be affected by the deficient		
		were no staff members found			practice. All nurses will be		
		been certified in first aid. The			certified in CPR and First Aid.		
		and to be without a staff			What measures will be put in		
		CPR from 7:00 a.m. to 7:00 p.m.			place or what systemic change		
		were no staff members found			the facility will makes to ensur		
		been certified in first aid. were no staff members found			that the deficient practice does	s not	
					OCCUR:		
	•	been certified in first aid. The and to be without a staff			Director of Nursing or designe		
	-	CPR from 7:30 a.m. to 7:00 a.m.			audit all LPN, RN, and QMA fi	ies	
		were no staff members found			to ensure that everyone has current CPR and First Aid.		
		been certified in first aid.				st will	
	•	were no staff members found			Anyone found to not be currer be required to take BLS CPR		
		been certified in first aid.	1		First Aid by April 28, 2023.	anu	
		were no staff members found			How the corrective actions will	l he	
		been certified in first aid.			monitored to ensure the defici		
	on any sinit to have	occir certifica in first aid.			practice will not recur, I,e., who		
			1		practice will not recur, i.e., will	<u>aı</u>	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILDING B. WING	00	COMPLETED 03/14/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RETREA	T AT THE STRATF	ORD, THE		EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director is have any first aid central description. During an interview Executive Director is have a policy address coverage on all shift Indiana State Regular	on 03/14/23 at 3:38 p.m., the indicated the facility did not ssing CPR and first aid at and the facility followed the ations.		quality assurance program will put into place The Care Services Administrator designee will conduct audit the schedule weekly to ensure there is 1 person on each shift that is CPR and First Aid certing Audits will then continue montuntil 100% compliance is achieved. Review will be ongoing Any concerns/deficient practic will be corrected immediately. Any negative patterns will be presented at QAPI monthly for further review/recommendation the need to increase, decreas discontinue the auditing.	tor s of e t fied. hly ping. ee
R 0121 Bldg. 00	employee of a faci contact. The scree skin test, using the PPD), unless a pre can be documented recorded in millimed date given, date readministered. The following: (1) At the time of each (1) month prior to a annually thereafted personnel of facility tuberculosis. The facility tuberculosis. The facility work. For health can had a documented test result during the	ompliance shall be required for each lity prior to resident shall include a tuberculin Mantoux method (5 TU, eviously positive reaction ed. The result shall be eters of induration with the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2023			
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		first step is negative performed one (1) first step. The free depend on the risk tuberculosis. (2) All employees reaction to the skinhave a chest x-ray laboratory examina a diagnosis. (3) The facility share of each employee employment-relate (4) An employee wactive disease, (sy active tuberculosis to, cough, fever, in loss) shall not be pure tuberculosis is rule Based on interview failed to ensure a 2-administered to 2 of CNA 6) Findings include: The employee record and 03/14/23. The records indicated date of 09/19/22, has she had started the 2 findings included to show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility active facility was unator show the testing of 12/07/22, has 02/21/23. The facility active facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23. The facility was unator show the testing of 12/07/22, has 02/21/23.	who have a positive In test shall be required to If and other physical and If ations in order to complete If all maintain a health record If that includes reports of all If health screenings. If health screenings of If ymptoms suggestive of If including, but not limited If ight sweats, and weight If the streen in the stree	R 0	121	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Nursing, Resid Care Director, and HR Directo were educated on policy titled "Tuberculosis, Employee Screening for" on 3/29/2023. C.N.A 5: missing Initial TB questionnaire was located. C.I had 1st step on 12/24/22 and 3 step on 1/9/23. C.NA 6: had 2nd step TB on 3/9/23. How the facility will identify oth residents having the potential be affected by the same deficipractice and what corrective a will be taken:	nts y the dent r N.A 2nd eer to ent	04/28/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILDING B. WING	00	COMPLETED 03/14/2023	
	OF PROVIDER OR SUPPLIEF		2460 G	ADDRESS, CITY, STATE, ZIP COD SLEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	During an interview Executive Director have any document a 2-step tuberculosi received the first sk tuberculosis testing	y, on 03/14/23 at 1:31 p.m., the indicated the facility did not ation to show CNA 5 received s test and CNA 6 had only	IAG	All residents have the potential be affected by the deficient practice. HRD or designee will audit all employee records to identify non-compliance with in TB testing. Any staff identified not having completed the initial testing will be required to immediately complete to be compliant. What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: HRD will audit each new empleted assessments have been completed. DON or designee maintain a calendar with hire dates of all employees and dudate of 1st and 2nd step TB testing. How the corrective actions will monitored to ensure the deficit practice will not recur, I,e., where the properties of the audits of the monthly QAPI Committee review and recommendation. The testing will be followed up the HR Director or designee as the results will be brought to the next scheduled QAPI committee at the results will be brought to the next scheduled QAPI committee at the results will be brought to the next scheduled QAPI committee at the results will be brought to the next scheduled QAPI committee at the results will be brought to the next scheduled QAPI committee at the results will be brought to the next scheduled QAPI committee will continue until 100% compliance.	es es es not es ent es

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/14/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				achieved. Review will be ong	oing.	
R 0217	410 IAC 16.2-5-2(
Bldg. 00	facility, using appresent members, shall ideservices to be profollows: (1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as approperesident and facility change. Either the request a service (3) The agreed up signed and dated of the service planter resident upon requested and the services provided subsequent to the no need for a characteristic provision of resided both, is needed, a involved in identifithe services to be	pletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as offered to the individual appropriate to the: Iffered shall be reviewed and riate and discussed by the try as needs or desires a facility or the resident may plan review. If the resident, and a copy in shall be given to the treatment of its needed if evaluations initial evaluation indicate ange in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation of its needed in the ential nursing services, or licensed nurse shall be cation and documentation of	R 0217	What corrective actions will be	<u>a</u> 04/28/2023	
	failed to ensure served dated by the resident for 6 of 7 residents	and record review, the facility vice plans were signed and at or resident's representative reviewed for service plans. 404, 405, 406, and 407)	K 021/	what corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Nursing and Resident Care Director were	ents_	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155794	B. W	B. WING		03/14/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DETDEA	T AT THE OTDATE	ODD THE			LEBE ST		
RETREA	T AT THE STRATF	ORD, THE		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· L	DATE
	Findings include:				educated on 3/31/2023 regard	ing	
					policy related to Resident Serv	_	
	1. The record for Ro	esident 402 was reviewed on			Plans .		
		n. Diagnoses included, but were			Residents 402 and 404 no lone	ger	
	not limited to, hype	_			reside in the community.	5 0.	
	, ,,				Residents 403, 405, 406, and	407	
	A service plan was	not signed and dated by the			will have service plans signed		
	resident or resident'	-			dated.	ana	
		F			How the facility will identify oth	er	
	2. The record for Re	esident 403 was reviewed on			residents having the potential		
		n. Diagnoses included, but were			be affected by the same defici-		
	not limited to, hype				practice and what corrective a		
	hypothyroidism.	p.uea, u.tu		will be taken:			
	in pour protein in				All residents have the potentia	l to	
	A service plan was	not signed and dated by the			be affected by the deficient		
	resident or resident'	-			practice. RCD or designee will		
		5 1 - P 1 - S - S - S - S - S - S - S - S - S -			audit all resident records for a		
	3. The record for Re	esident 404 was reviewed on			signed service plan. Any resident		
		n. Diagnoses included, but were			that does not have a signed		
	not limited to, hype	_			resident service plan on file will		
	,,,				have service plan updated and		
	A service plan was	not signed and dated by the			signed.	•	
	resident or resident'	-			What measures will be put in		
		1			place or what systemic change	es	
	4. The record for Re	esident 405 was reviewed on			the facility will makes to ensure		
		n. Diagnoses included, but were			that the deficient practice does		
		rtension, anemia, anxiety, and			occur:		
	encephalopathy.	· · · · · · · · · · · · · · · · · · ·			DON or designee will audit nev	N	
				resident charts within 1 wee			
	A service plan was	not signed and dated by the			admission to ensure residents		
	resident or resident'	-			have a signed service plan in t	heir	
		•			medical records. Any medical	= **	
	5. The record for Re	esident 406 was reviewed on			record that does not have a sig	aned	
		m. Diagnoses included, but were			service plan will have one	,	
		rtension, depression, anorexia,			completed and signed within a		
	and dysphagia.	* * /	1		week of audit. Audits will be		
					conducted weekly x 4 weeks, t	hen	
	A service plan was	not signed and dated by the			every 2 weeks x 2 months,	=	
	resident or resident'				followed by monthly until 100%	, 0	
		•	1		compliance has been achieved		
	Ī		1		1		

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155794	B. WING 03/14/202			2023	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
DETDE A	T AT THE OTDATE	OBD THE			LEBE ST EL, IN 46032		
KETKEA	T AT THE STRATF	ORD, THE		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	6. The record for Re	esident 407 was reviewed on			Review will be ongoing.		
	3/13/23 at 11:50 a.n	n. Diagnoses included, but were			How the corrective actions will	be	
	not limited to, major	r depressive disorder,			monitored to ensure the deficie	ent_	
	hypertension, and ir	nsomnia.			practice will not recur, I,e., who	at_	
					quality assurance program will	be	
	A service plan was	not signed and dated by the			<u>put into place</u>		
	resident or resident's	s representative.			Administrator or designee will		
					bring the results of the audits t	0	
		y, on 3/13/23 at 2:40 p.m., the			the monthly QAPI Committee	or	
		linical indicated service plans			review and recommendation. A	∖ny	
		the resident or the resident's			recommendation made by the		
	-	he could not provide signed			committee will be followed up	by	
	service plans.				the RCD or designee and the		
					results will be brought to the n	ext	
		olicy, "Assessment/Service			scheduled QAPI committee		
		n the Vice President of Clinical			meeting. This practice will		
	-	o.m., indicated "Current			continue until 100% compliand	e is	
	Service PlanServi	ce Plan Signature Form"			achieved.		
R 0273	410 IAC 16.2-5-5.	1(f)					
		nal Services - Deficiency					
Bldg. 00		ation and serving areas					
ŭ	• • • • • • •	n residents ' units) are					
		ordance with state and					
		d safe food handling					
	standards, includir	•					
		on, interview and record	R 02	273	What corrective actions will be		04/28/2023
	review, the facility	failed to maintain sanitary	1100	-,0	accomplished for those reside		0 20. 2020
		chen resulting in the potential			found to have been affected by		
		ss for all residents who			deficient practice:		
	consume food from	the kitchen.			The Executive Chef and team		
					members of Dining Services w	ere	
	Findings include:				educated on 3/30/2023 regard		
	-				policies "Dishwashing Machine	•	
	1. During an initial	kitchen tour, on 03/09/23 at 9:48			Use", "Sanitization", and "Food		
	-	tor of Dining Services (DDS)			Receiving and Storage". Items		
	the following were	-			large bins were labeled with o		
		low cornmeal like substance			dates. All other items listed in		
		ppen date on the bin.			SOD were thrown out.		
	b) a large bin of bre	ad crumb like substance was			How the facility will identify oth	<u>er</u>	
I	, ,		1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2023		
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	noted with no open During an interview	ite sugar like substance was			residents having the potential be affected by the same defici practice and what corrective a will be taken: All residents have the potential be affected by the deficient	ent_ ction_	
	on the bins. 2. A review of the '	Dish Machine Temperature			practice. Executive Chef and of designee will audit dishwasher for completion, all food storage areas to ensure all items are	r log	
	documentation of d 3/9/23 at dinner thr	2023, indicated there was no ishwasher temperatures after ough 3/13/23. y, on 03/13/23 at 11:02 a.m., the			labeled and dated, and QAC solution for proper PPM. What measures will be put in place or what systemic change the facility will makes to ensure		
	Executive Chef (EC temperature log and documented the dis	C) reviewed the dish machine			that the deficient practice does occur: Executive Chef or designee w review all logs weekly to ensur	s not	
	temperature to known without the docume	w if the dishes were sanitized entation on the dishwasher log.			compliance. They will conduct storage walkthrough audit of for storage, refrigerator, and freez ensure all items are labeled ar	ood er to	
	3. A review of the sanitizing logs indicated there was no documented sanitizer concentration checks after 3/9/23 at 11:30 a.m., through 3/13/23.				dated. QAC will be checked d to ensure proper PPM. Any ite found out of compliance will be	aily ms	
	EC indicated there documentation for	w, on 03/13/23 at 11:30 a.m., the was no sanitizing log the sanitizer concentration 0 a.m., until the present day and			corrected and staff will be educated. Audits will be conducted weekly x 4 weeks, every 2 weeks for 2 months, the monthly until 100% compliance.	nen	
	compartment sink, quaternary ammoni was checked for co observed result of t per million).	vation of the 3 (three) on 03/13/23 at 11:33 a.m., the um compound (QAC) solution ncentration by the EC. The the QAC was 300 ppm (parts vation and interview with EC,			achieved. How the corrective actions will monitored to ensure the deficient practice will not recur, I.e., who quality assurance program will put into place The Administrator or designed bring the results of the audits the monthly CARL Committee.	ent at l be e will	
	J. During an ooser	ation and interview with EC,			the monthly QAPI Committee	IUI	ļ

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	COMP	LETED L/2023		
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPL	TION LD BE COPRIATE	(X5) COMPLETION DATE	
	on 03/13/23, the fol a) 11:10 a.m., a plas onions was noted. To open food item with b) 11:12 a.m., an oprice was noted. The and it was open. c) 11:14 a.m., an opnoodles was noted there was no date or noodles. d) 11:16 a.m., an opnoted with no open indicated the soda with the bottle. e) 11:22 a.m., a large noted with no date. bag of mixed green when opened. f) 11:23 a.m., a bag an open date. The Edate on the broccoling good in plaindicated it was open h) 11:25 a.m., multinoted with a missin in plastic with no open indicated the open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased with a missin in plastic with no open decreased dishwash record the results in decreased dishwash record the decreased dishwash record the results in decreas	lowing was observed: stic wrapped open bag of crispy The EC indicated it was an anout an open date. ben 5-pound bag of long grain EC indicated it was not dated ben 10-pound bag of spaghetti with no date. The EC indicated in the open bag of spaghetti ben 1 liter of club soda was date on the bottle. The EC was open, but no date was on ge open bag of mixed greens was The EC indicated the open is was supposed to be dated of broccoli was noted without in the open bag of quinoa (edible seeds) stic with no open date. The EC		review and recommendar recommendation made be committee will be followed the Executive Chef or deand the results will be brown the next scheduled QAPI committee meeting. This will continue until 100% compliance is achieved.	ion. Any y the d up by signee ught to		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155794		l í	ILDING	nstruction <u>00</u>	(X3) DATE S COMPL 03/14/	ETED		
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
R 0408 Bldg. 00	environmental surfa one of the following (parts per million) of compound (QAC) A current policy, tit Storage," received f p.m., indicated "F stored in a manner thandling practices bins will be remove labeled, and dated (containers must be during storage" 410 IAC 16.2-5-12 Infection Control - (c) Each resident schest x-ray complemenths prior to ad Based on interview to ensure a chest x-rays. (Refindings include: 1. The record for Ref 3/13/23 at 10:28 a.m not limited to, hyperhypothyroidism. A chest x-ray was m record. 2. The record for Ref 3/13/23 at 11:27 a.m.	led "Food Receiving and from the ED on 3/13/23 at 1:15 ood shall be received and hat complies with safe food Dry foods that are stored in d from original packaging, "use by" date)Other opened dated and sealed or covered (c) Noncompliance shall have a diagnostic eted no more than six (6) mission. and record, the facility failed ray was completed within 6 in for 3 of 7 residents reviewed exident 403, 405 and 406) esident 403 was reviewed on in. Diagnoses included, but were	R 04	108	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Nursing and Resident Care Director were educated on 3/31/2023 on polititles "Tuberculosis, Screening Resident for". Residents 406 had Chest X-rallocated in medical record. Residents 403 and 405 will be screened for TB as per policy. How the facility will identify oth residents having the potential be affected by the same deficipractice and what corrective awill be taken: All residents have the potential	nts y the icy y y ner to ent ction	04/28/2023	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/14/2023	
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE		2460 G	ADDRESS, CITY, STATE, ZIP COD GLEBE ST EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
	A chest x-ray was n record. 3. The record for Ro 3/13/23 at 11:35 a.r. not limited to, hype and dysphagia. A chest x-ray was n record. During an interview Vice President of C should have had a c provide a chest x-ra 406. A current facility por Tuberculosis Screen from the Vice Presi 3:50 p.m., indicated required to have a discount of the control			be affected by the deficient practice. RCD or designee audit all resident records for chest x-ray. Any resident the does not have a chest x-ray medical record will have a assessment completed as policy "Tuberculosis, Scree Residents for". What measures will be put place or what systemic charts the facility will makes to ensignee that the deficient practice doccur: Administrator or DON will a new resident charts within of admission to ensure resis have a completed TB assessment completed. Review will be ongoing. How the corrective actions monitored to ensure the depractice will not recur, I,e., quality assurance program put into place Administrator or designee which into the monthly QAPI Committer review and recommendation recommendation made by committee will be followed the RCD or designee and the results will be brought to the scheduled QAPI committee meeting. This practice will continue until 100% complication to compliance will the monthly until 100% compliance will continue unti	will r a nat y in the TB per ning in nges sure oes not udit 1 week dents ssment will be ficient what will be vill its to ee for n. Any the up by he e next e
R 0410	410 IAC 16.2-5-12 Infection Control -			achieved.	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILDING 00 COMPLETED B. WING 03/14/2023			ETED		
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE				2460 GL	DDRESS, CITY, STATE, ZIP COD EBE ST L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
Bldg. 00	completed within to admission or upon forty-eight (48) to a result shall be reconsidered induration with the by whom administ (f) For residents we documented negative result during the parameter that the parameter that is negative performed within the after the first test. It testing will depend with tuberculosis. (g) All residents with the tuberculin shave a chest x-ray laboratory examinate a diagnosis. Based on interview failed to ensure a 2-administered to 5 of tuberculosis testing. and 407) Findings include: 1. The record for Ref 3/13/23 at 12:05 p.m. not limited to, demedepressive disorder. The record indicated tuberculosis test and completed.	the have not had a tive tuberculin skin test receding twelve (12) and tuberculin skin testing two-step method. If the ve, a second test should be one (1) to three (3) weeks. The frequency of repeat I on the risk of infection the have a positive reaction win test shall be required to very and other physical and actions in order to complete and record review, the facility step tuberculosis test was to residents reviewed for (Residents 401, 403, 404, 406, and the physical and the physical step tuberculosis test was to residents reviewed for (Residents 401 was reviewed on the Diagnoses included, but were centia, insomnia, and major	R 041	10	What corrective actions will be accomplished for those resider found to have been affected by deficient practice: The Director of Nursing and Resident Care Director were educated on 3/31/2023 on polititles "Tuberculosis, Screening Resident for". Residents 403, 406 and 407 has First step PPD initiated on 3/30/23. How the facility will identify oth residents having the potential to be affected by the same deficient practice and what corrective active will be taken: All residents have the potential	ction	04/28/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		r í	UILDING	onstruction 00	(X3) DATE COMPL 03/14/	LETED	
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE			STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OF 3/13/23 at 10:28 a.i. not limited to, hype hypothyroidism. A 2-step tuberculos resident's record. 3. The record for R 3/13/23 at 11:15 a.i. not limited to, hype A 2-step tuberculos resident's record. 4. The record for R 3/13/23 at 11:35 a.i. not limited to, hype and dysphagia. A 2-step tuberculos resident's record. 5. The record for R 3/13/23 at 11:50 a.i. not limited to, major hypertension, and in A 2-step tuberculos resident's record. During an interview	ELSC IDENTIFYING INFORMATION m. Diagnoses included, but were relipidemia, and distest was not located in the esident 404 was reviewed on m. Diagnoses included, but were retension. distest was not located in the esident 406 was reviewed on m. Diagnoses included, but were retension, depression, anorexia, distest was not located in the esident 407 was reviewed on m. Diagnoses included, but were retension, depression, anorexia, distest was not located in the esident 407 was reviewed on m. Diagnoses included, but were redepressive disorder, msomnia. distest was not located in the			be affected by the deficient practice. RCD or designee wil audit all resident records for a initial TB test. Any resident that does not have an up in the medical record will have a TB assessment completed as per policy "Tuberculosis, Screenin Residents for". What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Administrator or DON will aud new resident charts within 1 w of admission to ensure resident have a completed TB assessment and signs and symptoms of THOW the corrective actions will monitored to ensure the deficient practice will not recur, I,e., when quality assurance program will put into place Administrator or designee will bring the results of the audits the monthly QAPI Committee review and recommendation. The recommendation made by the	l n n at	
	should have had a t completed and she documentation. A c Tuberculosis Scree from the Vice Presi 3:50 p.m., indicated tuberculin skin test	Elinical indicated the residents wo-step tuberculosis testing could not provide the current policy, titled "Resident ning," undated and received dent of Clinical on 3/13/23 at 1"All residents will have a accomplished through use of termal method (5 TU PPD)			committee will be followed up the RCD or designee and the results will be brought to the n scheduled QAPI committee meeting. This practice will continue until 100% compliand achieved.	ext	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULT A. BUILI B. WING	DING	ONSTRUCTION 00	(X3) DATE COMPI 03/14		
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE			2	460 G	ADDRESS, CITY, STATE, ZIP COD LEBE ST EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	D	PROVIDER'S PLAN OF CORRECTION	ſ	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)	W.(1)	DATE
		e time of admission or within					
		ior to admission, unless there is					
		ory of a positive skin testThe					
		requested to administer the					
		and record the results on the					
		nThe Mantoux skin test will					
		y qualified nursing staff upon					
		esident does not have					
		a test completed within three (3)					
		mission or a documented					
		e skin testThe two-step					
	method will be use	ed for the baseline testingAll					
	Mantoux administ	ration and results will be					
	documented on the	e Resident Tuberculosis					
	Screening Record.	This includes test results					
	administered by ex	xternal clinics or health care					
	providers"						

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