AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER RETREAT AT THE STRATFORD, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG Bldg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. STREET ADDRESS, CITY, STATE, ZIP COD 2460 GLEBE ST CARMEL, IN 46032 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DE	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
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conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. The Retreat at the Stratford allegation of compliance. Submission of this response and Plan of Correction is NOT a legal	Blag	A E	do C	F 0/	200	This Discussion of Commenting was a	4 -	
accordance with 42 CFR 483.73. allegation of compliance. Submission of this response and Plan of Correction is NOT a legal				E 00	JUU	· ·	ents	
Survey Date: 04/04/23 Survey Date: 04/04/23 Submission of this response and Plan of Correction is NOT a legal		_	-					
Survey Date: 04/04/23 Plan of Correction is NOT a legal		accordance with 42	CFR 1 05./5.				nd	
		Survey Date: 04/04	1/23			•		
admission that a deficiency exists		Saivey Date. 04/04	, 				-	
Facility Number: 011151 or, that this Statement of		Facility Number: 0	11151			-		
Provider Number: 155794 Deficiencies was correctly cited,							d.	
AIM Number: NA and is also NOT to be construed						-		
as an admission against interest						as an admission against intere	est	
At this Emergency Preparedness survey, The by the residence, or any		At this Emergency l	Preparedness survey, The			ı		
Retreat at the Stratford was found not in employees, agents, or other		Retreat at the Stratford was found not in						
compliance with Emergency Preparedness individuals who drafted or may be		compliance with En	nergency Preparedness				be	
Requirements for Medicare and Medicaid discussed in the response or Plan		Requirements for M	ledicare and Medicaid			discussed in the response or F	Plan	
Participating Providers and Suppliers, 42 CFR of Correction. In addition,			lers and Suppliers, 42 CFR			of Correction. In addition,		
483.73. preparation and submission of this		483.73.					this	
Plan of Correction does NOT								
The facility has 18 certified beds. At the time of constitute an admission or		_						
the survey, the census was 11. agreement of any kind by the		the survey, the cens	us was 11.					
facility of the truth of any facts		Quality Davi	nnlated on 04/11/22	1				
Quality Review completed on 04/11/23 alleged or the correctness of any		Quanty Keview con	ipieted on 04/11/23			•	ıny	
conclusions set forth in this allegation by the survey agency.							N /	
allegation by the survey agency.						anoganon by the survey agent	у.	
E 0041 482.15(e), 483.73(e), 485.625(e)	E 0041	482.15(e). 483.73	(e), 485.625(e)					
SS=F Hospital CAH and LTC Emergency Power		` '	. ,					
Bldg §482.15(e) Condition for Participation:	Bldg	-	- ·					
(e) Emergency and standby power systems.	-	. ,	•					
The hospital must implement emergency and								
standby power systems based on the		-	· ·					
emergency plan set forth in paragraph (a) of		emergency plan s	et forth in paragraph (a) of					
this section and in the policies and								
procedures plan set forth in paragraphs (b)(1)								
(i) and (ii) of this section.		(i) and (ii) of this s	ection.					
§483.73(e), §485.625(e)				1				
(e) Emergency and standby power systems.		(e) Emergency an	d standby power systems.					

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

(X6) DATE

TITLE

Lorna Ray Care Services Administrator 05/06/2023

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

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 04/04/2023			LETED	
	PROVIDER OR SUPPLIE AT AT THE STRATI		2460	et address, city, state, zip c GLEBE ST MEL, IN 46032	OD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION
TAG	The [LTC facility implement emergy systems based of forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location required Care Facilities Collinterim Amendments TIA and TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure or build structure or build 482.15(e)(2), §48 Emergency generator the eminspection, testing requirements four Facilities Code, Norde. 482.15(e)(3), §48 Emergency generator the eminspection, testing requirements four Facilities Code, Norde. 482.15(e)(3), §48 Emergency generator the eminspection of the em	and the CAH] must gency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The gency and in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim and Tentative Interim and Tentative Interim and Interior in the American section and testing. Head LTC facility] must be regency power system grand [maintenance] and in the Health Care IFPA 110, and Life Safety IFPA 110, and Life Safety If IfPA 110, and Life Safety IfPA 110, and L	TAG	CROSS-REFERENCED TO THE ADEPICIENCY)	APPROPRIATE	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M3UT21

Facility ID: 011151

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	ľ	JILDING	NSTRUCTION	COM	e survey pleted 4/2023
NAME OF I	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZIP C LEBE ST	COD	
RETREA	T AT THE STRATE	FORD, THE			L, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		in accordance with 5 U.S.C.		IAG			DATE
	_	R part 51. You may obtain					
	, ,	the sources listed below.					
You may inspect a copy at the CMS							
	Information Resor	urce Center, 7500 Security					
	Boulevard, Baltimore, MD or at the National						
	Archives and Records Administration						
	(NARA). For information on the availability of						
	this material at NARA, call 202-741-6030, or						
	go to: http://www.archives.gov/federal_register/code						
	_of_federal_regulations/ibr_locations.html.						
	If any changes in this edition of the Code are						
	incorporated by reference, CMS will publish a						
	document in the Federal Register to						
	announce the changes.						
	(1) National Fire F	Protection Association, 1					
	Batterymarch Par	k,					
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
	. ,	th Care Facilities Code,					
		ed August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued	FPA 99, issued August 9,					
	2012.	TI A Jo, ISSUCU August 8,					
	(iv) TIA 12-4 to NI 2013.	FPA 99, issued March 7,					
		FPA 99, issued August 1,					
	2013.	-					
	(vi) TIA 12-6 to NI	FPA 99, issued March 3,					
	2014.						
	. ,	ife Safety Code, 2012					
	edition, issued Au						
	(VIII) TIA 12-1 to N 11, 2011.	NFPA 101, issued August					
	,	FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NF	FPA 101, issued October					
	22, 2013.						

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Event ID:

M3UT21 Facility ID: 011151

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2023	
	OF PROVIDER OR SUPPLIED			2460 G	ADDRESS, CITY, STATE, ZIP COD LEBE ST EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	ΤE	(X5) COMPLETION DATE
	(xi) TIA 12-4 to NI 22, 2013. (xiii) NFPA 110, S Standby Power S including TIAs to 2009 Based on record refailed to implement inspection, testing, found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all occupants Findings include: Based on records remaintenance Technesis Administrator on 0 12:15 p.m., no doct quality test for the for review. The fact Based on interview the fuel quality test generator could not be a seed on records remaintenance Technesis and the form of the fuel quality test generator could not be a seed on records remaintenance Technesis and the fuel quality test generator could not be a seed on records remaintenance Technesis and the fuel quality test generator could not be a seed on records remaintenance Technesis for maintenance Technesis for review set in service was a for a minimum of 3 load test document for March and April Technician stated the prior to 3/23 were considered.	Standard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system and maintenance requirements a Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could standard to a constant of an annual fuel diesel generator was available ility has 1 diesel fired generator. The time of records review, ing for the diesel fired the located. Eview and interview with the nician and Care Services 4/04/23 between 9:45 a.m. and attendance of the located. Eview and interview with the nician and Care Services 4/04/23 between 9:45 a.m. and 3/22 no documentation was very to show the diesel generator exercised at least once monthly, and on provided reflected tests all of 2023. The Maintenance the monthly generator tests conducted by the prior visor and did not know where	E 0		What corrective actions will be accomplished for those reside found to have been affected by deficient practice: Generator annual fuel quality will be conducted. Generator will have monthly 30 minute load to completed. Generator will have three-year 4 hour test completed. How the facility will identify off residents having the potential be affected by the same deficipractice and what corrective a will be taken: All residents have the potential be affected by the deficient practice. No further concerns noted. Facilities team will be educated on generator testing requirements. What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Director of Facilities or design will conduct monthly generato testing audits. Any issues identified will require a work or placed for repair. All logs will the audited monthly. How the corrective actions will monitored to ensure the deficipractice will not recur, I,e., where the deficient practice will not recurs.	test will test te ted. ner to ient iction al to es e r rder pe ent lbe ent	06/02/2023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			ETED	
		155794	B. W	NG		04/04/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LEBE ST		
DETDE A	T AT THE STRATE	OPD THE	CARMEL, IN 46032				
INC INCA	TAT THE SHATE	OND, THE	CARMILL, IN 40032				
(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 CROSS-REFERENCED TO THE APPRO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on records re-	view and interview with the			quality assurance program will	be	
	Maintenance Techn	ician and Care Services			put into place		
	Administrator on 04	1/04/23 between 9:45 a.m. and			The Director of Facilities or		
	12:15 p.m., the facil	ity provided documentation for			designee will bring audits to		
	testing of the emergency generator, however,				monthly QAPI Committee for		
	could not provide documentation of a three-year				review and recommendation u	ntil	
	4-hour test.			100% compliance is met. Any			
					recommendation made by the		
	This finding was acl	knowledged by the			committee will be followed up l	by	
	Maintenance Technician at the time of discovery			the Director of Facilities or			
		conference with the	de		designee.		
	Maintenance Techn	ician and Care Services					
	Administrator prese	nt.					
K 0000							
Bldg. 02							
	-	Recertification and State	K 0	000	This Plan of Correction represe	ents	
	-	as conducted by the Indiana			The Retreat at the Stratford		
	-	th in accordance with 42 CFR			allegation of compliance.		
	483.90(a).				Submission of this response a		
					Plan of Correction is NOT a le	_	
	Survey Date: 04/04	/23			admission that a deficiency ex	ists	
					or, that this Statement of		
	Facility Number: 0				Deficiencies was correctly cite	-	
	Provider Number:	155794			and is also NOT to be construe		
	AIM Number: NA				as an admission against intere	st	
					by the residence, or any		
	•	Code survey, The Retreat at			employees, agents, or other		
		und not in compliance with			individuals who drafted or may		
	-	articipation in Medicare, 42			discussed in the response or F	Plan	
		O(a), Life Safety from Fire and			of Correction. In addition,		
		the National Fire Protection			preparation and submission of	this	
) 101, Life Safety Code (LSC),			Plan of Correction does NOT		
		g Health Care Occupancies and			constitute an admission or		
	410 IAC 16.2.				agreement of any kind by the		
					facility of the truth of any facts		
	-	on the second floor of a			alleged or the correctness of a	ny	
		was determined to be of Type			conclusions set forth in this		
	II (111) construction	n and fully sprinkled. The			allegation by the survey agend	y.	

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Event ID:

M3UT21 Facility ID: 011151

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		JILDING	nstruction 02	(X3) DATE COMPL 04/04 /	ETED	
	PROVIDER OR SUPPLIER		2460 GL	ddress, city, state, zip cod .EBE ST L, IN 46032		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	(EACH DEFICIEN REGULATORY OR facility has a fire ala detection in the corr corridors, and hard- resident sleeping ro capacity of 18 and h of this visit. All areas where resi were sprinkled and services were sprink Quality Review con NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with a requires the use o	LSC IDENTIFYING INFORMATION To system with smoke idors, spaces open to the wired smoke detectors in all toms. The facility has a lad a census of 11 at the time dents have customary access all areas providing facility cled. The providing facility dents have customary access all areas providing facility cled. The providing facility dents have customary access all areas providing facility cled. The providing facility dents dents have customary access all areas providing facility cled. The providing facility dents dents have customary access all areas providing facility cled. The providing facility dents dents have customary access all areas providing facility cled.			TE	
	LOCKING Where special loci clinical security ne used, only one loci permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special loci safety needs of the					

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M3UT21 Facility ID: 011151

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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 02	(X3) DATE SURVEY COMPLETED 04/04/2023	
	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	release upon loss building is protect automatic sprinkle space is protected detection system at an attended los space); and both systems are arranupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servin contents in building an approved, superdetection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRANACCESS-CONTR LOCKING ARRANACCES	SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard logs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted les in buildings protected approved, supervised lection system and an used automatic sprinkler 2.4	V 0222	What correcting a sting a will be	
		on and Interview, the facility f 2 delayed egress locking	K 0222	What corrective actions will baccomplished for those reside	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		JILDING	DNSTRUCTION 02	(X3) DATE COMPL 04/04 /	ETED	
	OF PROVIDER OR SUPPLIEI		 2460 G	ADDRESS, CITY, STATE, ZIP COD LEBE ST EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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
TAG	arrangements were LSC 7.2.1.6.1(3) w process shall release egress within 15 se approved by the au upon application of required in 7.2.1.5. conditions: (a) The force shall continuously applie (c) The initiation of activate an audible door opening. (d) Once the lock happlication of force relocking shall be deficient practice of Findings include: Based on observating facility tour with the Care Services Admit 12:15 p.m. and 2:30 between the Skilled section on the 2nd second delayed egressed the irreversity was not initiated. Be observation, the Matimes to activate the delayed egress is not repaired. This finding was act Maintenance Technand again at the exited the exited the exited the control of the	installed in accordance with thich states an irreversible the the lock in the direction of conds, or 30 seconds where thority having jurisdiction, a force to the release device 10 under all of the following the required to exceed 15 lbf and be required to be ad for more than 3 seconds. If the release process shall signal in the vicinity of the as been released by the at to the releasing device, by manual means only. This could affect all residents. On and interview during a the Maintenance Technician and dinistrator on 04/04/23 between 00 p.m., the double door set of the nursing and Assisted Living floor, were equipped with a 15 the sess. When the exit doors were sole process to release the lock that are the time of a sintenance Technician tried 3 the delay egress and stated the of working and will need to be seen at the time of discovery the conference with the nician and Care Services	TAG	found to have been affected by deficient practice: The Director of Facilities or designees will ensure door with delayed egress locks is operational. How the facility will identify offeresidents having the potential be affected by the same deficient practice and what corrective as will be taken: All residents have the potential be affected by the deficient practice. Director of Facilities designee will audit exit doors and delayed egress locks on Skilled Unit to ensure all doors are operational. What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Director of Facilities or design will audit exit door with delayed egress locks. The Director of Facilities will identify any issue and create work order for reparting the corrective actions will monitored to ensure the deficient practice will not recur, I,e., who quality assurance program will put into place The Director of Facilities or designee will bring the results the audits to the monthly QAP Committee for review and recommendation. Any recommendation made by the committee will be followed up	th er to ent ction al to or with ed es e s not ee d es ir. l be ent at l be of	DATE

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

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		r í	JILDING	onstruction 02	(X3) DATE COMPL 04/04 /	ETED	
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD LEBE ST		
RETREA	AT AT THE STRATE	ORD, THE			EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	Administrator prese			IAG	the Director of Facilities or		DATE
	3.1-19(b)				designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer pattern of non-compliance is shown.	S	
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 02							
Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating							
		_					
	1 '	rated doors) or an					
		nguishing system in 3.7.1 or 19.3.5.9. When the					
		tic fire extinguishing system					
		e areas shall be separated					
	I	s by smoke resisting					
	The state of the s	ors in accordance with 8.4.					
	Doors shall be sel	_					
	_	and permitted to have					
		applied protective plates that					
		inches from the bottom of					
	the door.	and zone locations of					
		that are deficient in					
	REMARKS.	and are denoted in					
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	1	N/A					
		-Fired Heater Rooms					
	, ,	er than 100 square feet)					
	1	nance, and Paint Shops					
		ooms (exceeding 64					
	gallons) e. Trash Collection	n Pooms					
	(exceeding 64 gal						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		A. BUILD B. WING	OING	02	COMPL 04/04/		
	DER OR SUPPLIER	ORD, THE	24	460 GL	ddress, city, state, zip cod .EBE ST L, IN 46032		
	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
f. Co (ove g. L Haz Bass faild such prop defi resid vicin Find Bass facii Care 12:1 door self- This Mai and Mai	ombustible Stoer 50 square fe aboratories (if ard - see K322 ed on observation of a storage room perly working secient practice codents, as well as nity of the Laund dings include: ed on observation lity tour with the eservices Admin 15 p.m. and 2:30 r, equipped with eclose and latch intenance Technicagain at the exit	rage Rooms/Spaces et) classified as Severe e) n and interview, the facility over 10 hazardous area doors, as, were provided with lf-closing devices. This uld affect more than 5 staff and visitors in the dry. n and interview during a Maintenance Technician and mistrator on 04/04/23 between p.m., the laundry area corridor a self-closing device, failed to into the door frame. crowledged by the cian at the time of discovery conference with the ician and Care Services	K 0321		What corrective actions will be accomplished for those reside found to have been affected be deficient practice: The Director of Facilities or designees will ensure laundry equipped with a self-closing dwill latch to door frame by Jun 2023 How the facility will identify of residents having the potential be affected by the same defice practice and what corrective awill be taken: All residents have the potential be affected by the deficient practice. Director of Facilities designee will audit exit doors delayed egress locks on Skille Unit to ensure all doors are operational. What measures will be put in place or what systemic changes that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur: The Director of Facilities will that the deficient practice doe occur has a work of the practice	ents y the door evice ie 2, her to ient action al to or with ed rain ons The doors ect ency ssue	06/02/2023

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CENTERS FOI	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X)	X3) DATE SURVEY COMPLETED 04/04/2023	
	PROVIDER OR SUPPLIEF		2460 G	ADDRESS, CITY, STATE, ZIP COD GLEBE ST EL, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0345 SS=C Bldg. 02	in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are re 9.6.1.3, 9.6.1.5, N Based on record revialled to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual inspe	m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0345	immediately be requested via the concierge. How the corrective actions will be monitored to ensure the deficier practice will not recur, I.e., what quality assurance program will be put into place. The Director of Facilities or designee will bring the workords will be brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of non-compliance is shown. What corrective actions will be accomplished for those resident found to have been affected by deficient practice: The Director of Facilities or designees will ensure visual semi-annual inspection of fire	De nt	

more often if required by the authority having

must be visually inspected semi-annually:

jurisdiction. Table 14.3.1 states that the following

alarm system is conducted.

How the facility will identify other

residents having the potential to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>02</u>	COMPLETED
155794 B. WING	04/04/2023
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 2460 GLEBE ST	
RETREAT AT THE STRATFORD, THE CARMEL, IN 46032	
CARWILL, IN 40032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
a. Control unit trouble signals <u>be affected by the same deficie</u>	<u>ent</u>
b. Remote annunciators practice and what corrective ac	<u>ction</u>
c. Initiating devices (e.g. duct detectors, manual will be taken:	
fire alarm boxes, heat detectors, smoke detectors, All residents have the potential	i to
etc.) be affected by the deficient	
d. Notification appliances practice. No further concerns w	vere
e. Magnetic hold-open devices noted.	
This deficient practice could affect all building What measures will be put in	
occupants. <u>place or what systemic changes</u>	
the facility will makes to ensure	
Findings include: that the deficient practice does	<u>not</u>
occur:	
Based on records review and interview with the Director of Facilities or designed	
Maintenance Technician and Care Services will audit inspections twice a ye	ear
Administrator on 04/04/23 between 9:45 a.m. and (6 months apart) to ensure	
12:15 p.m., no documentation could be provided semi-annual inspection is	
regarding a visual semi-annual fire alarm system completed.	
inspection 6 months prior to the Annual How the corrective actions will I	
inspection dated 03/08/23. During the survey the monitored to ensure the deficient	
Maintenance Technician searched for the missing practice will not recur, I,e., what	
documentation but was unable to locate any quality assurance program will	<u>be</u>
further documentation. put into place	
The Director of Facilities or	,
This finding was acknowledged by the designee will bring the results of	l l
Maintenance Technician at the time of discovery the audits to the monthly QAPI	
and again at the exit conference with the Committee for review and	
Maintenance Technician and Care Services recommendation. Any	
Administrator present. recommendation made by the	
committee will be followed up b	ЭУ
3.1-19(b) the Director of Facilities or	
designee and the results will be brought to the next scheduled	=
QAPI committee meeting. This	
practice will continue for a	
minimum of 3 months or longer	r if o
pattern of non-compliance is	IIIa
shown.	
Silowii.	
K 0351 NFPA 101	
SS=F Sprinkler System - Installation	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED
		155794	B. WI	NG		04/04/	2023
				CTREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LEBE ST		
DETDE A		ODD THE					
KETKEA	T AT THE STRATE	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			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
Bldg. 02	Spinkler System -	Installation					
	2012 EXISTING						
	Nursing homes, ar	nd hospitals where required					
	by construction typ	oe, are protected					
	throughout by an approved automatic sprinkler system in accordance with NFPA						
	13, Standard for th	ne Installation of Sprinkler					
	Systems.						
	In Type I and II co	nstruction, alternative					
	protection measur	es are permitted to be					
	substituted for spri	inkler protection in specific					
	areas where state	or local regulations prohibit					
	sprinklers.						
	In hospitals, sprink	ders are not required in					
	clothes closets of	patient sleeping rooms					
		the closet does not exceed					
	•	sprinkler coverage covers					
	•	t as required by NFPA 13,					
	Standard for Instal	llation of Sprinkler					
	Systems.						
		19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		ation and interview, the facility	K 03	351	What corrective actions will be		06/10/2023
	-	tomatic extinguishing			accomplished for those resider		
	-	elevator machine rooms			found to have been affected by	<u>the</u>	
	-	d-floor residents. NFPA 13,			deficient practice:		
		matic sprinklers in elevator Il be of ordinary or intermediate			Facility will schedule installation	n ot	
		ASME/ANSI A17.1 permits			automatic sprinkler in elevator		
		or machine rooms when there is			room.		
	•	necting the main power supply			How the facility will identify oth		
		ator automatically upon, or			residents having the potential to		
		tion of water from the sprinkler			be affected by the same deficience		
		tor machine room. NFPA 101,			practice and what corrective a	<u> </u>	
		es in any occupancy where the			will be taken: All residents have the potentia	l to	
		ential fuel for fire is such that			be affected by the deficient	i iU	
		ontrol of fire is effectively			practice. Installation of sprinkle	ar .	
	accomplished by a t				head will be installed in elevate		
		n other than an automatic			room that services Skilled Nurs		
		ch as water mist, carbon				on ig	
	sprinkier system, su	en as water mist, carbon	I		Department		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	ľ í	JILDING	onstruction 02	(X3) DATE S COMPL 04/04/	ETED
	PROVIDER OR SUPPLIER		•	2460 GI	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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	spray, or a standard another type, that sy installed in lieu of a Such systems shall maintained in accor standards. Section extinguishing system required, supervised the activate the building deficient practice of and visitors using the Findings include: Based on observation facility tour with the Care Services Adm 12:15 p.m. and 2:30 room in the baseme which services the skilled nursing sect provided with auton Based on interview Maintenance Techna aforementioned eleprovided with auton This finding was ac Maintenance Technand again at the eximal Maintenance Technand again at the eximal again at th	m is installed in lieu of a d automatic sprinkler system, extinguishing system shall g fire alarm system. This buld affect all residents, staff he skilled nursing elevator. On and interview during a e Maintenance Technician and inistrator on 04/04/23 between 0 p.m., the elevator equipment and adjacent to elevator #1 residents of the second-floor ion of the facility, was not matic extinguishing protection. at the time of observation, the ician acknowledged the vator equipment room was not matic extinguishing protection. knowledged by the ician at the time of discovery to conference with the ician and Care Services			What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Director of facilities will add sprinkler head to inspection conducted every 6 months. As will be completed to ensure inspection is completed. How the corrective actions will monitored to ensure the deficient practice will not recur, I,e., whe quality assurance program will put into place. The Director of Facilities or designee will bring the results the audits to the monthly QAF Committee for review and recommendation. Any recommendation made by the committee will be followed up the Director of Facilities or designee and the results will be brought to the next scheduled QAPI committee meeting. This practice will continue for until pattern of non-compliance is shown.	udit libe ient iat libe by pe	

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	OF CORRECTION	IDENTIFICATION NUMBER 155794	UILDING	02	COMPL 04/04/	ETED
			2460 GL	DDRESS, CITY, STATE, ZIP COD LEBE ST		
RETREA	T AT THE STRATF	ORD, THE	CARIVIE	L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC 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)	TE	(X5) COMPLETION DATE
		can be promptly replaced. ce could affect all occupants				
	Findings include:					
	facility tour with the Care Services Admi 12:15 p.m. and 2:30 contained 2 spare sp	on and interview during a e Maintenance Technician and inistrator on 04/04/23 between p.m., the sprinkler riser room orinkler boxes that 1 of which orinklers which were loose and				
	and again at the exit	ician at the time of discovery conference with the ician and Care Services				
	3.1-19(b)					
K 0353 SS=F Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system	supply source				
	Provide in REMAR	RKS information on				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2023	
	PROVIDER OR SUPPLIER		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)	ΓE	(X5) COMPLETION DATE
	automatic sprinkle 9.7.5, 9.7.7, 9.7.8,	and NFPA 25	K O	353	What corrective actions will be		06/02/2023
	1. Based on record of facility failed to proof other evidence the shad been inspected LSC 4.6.12.1 requires system required for maintained in according requirements. Spring maintained in according the Inspection, Towards and Shading and the Inspections, tests, and components and shading the organization that requires that recording performed (e.g., instead the organization that results, and the date waterflow alarm dequarterly to verify the damage. NFPA 25, waterflow alarm deto, water motor gon 5.3.3.2 requires van switch-type waterflow affect all residents, facility. Findings include: Based on review of	review and interview, the vide written documentation or prinkler system components and tested for 1 of 4 quarters. The same and tested for 1 of 4 quarters. The same are same and tested for 1 of 4 quarters. The same are	K 0	353	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Facilities or designees will ensure sprinkle system inspections are conduct quarterly. Facilities team will be educated on sprinkler system inspections. How the facility will identify otheresidents having the potential be affected by the same deficit practice and what corrective a will be taken: All residents have the potential be affected by the deficient practice. Facilities team will schedule inspections of sprink systems to be conducted ever months. What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Director of Facilities or designed will audit inspections twice a year (6 months apart) to ensure semi-annual inspection is completed. How the corrective actions will monitored to ensure the deficient practice will not recur, I,e., what measures will not recur, I,e., what mea	nts y the r cted e er to ent ction I to ler y 6 es ent cee ear	06/02/2023
	Technician and Car 04/04/23 between 9	e Services Administrator on :45 a.m. and 12:15 p.m., 1 of 4 reports was missing. Reports			quality assurance program will put into place The Director of Facilities or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155794	B. W	ING		04/04/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DETDEA	T AT THE OTD ATE	CODD THE			LEBE ST		
RETREA	T AT THE STRATE	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 APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were provided for 3	quarters dated, 8/22/22,			designee will bring the results	of	
	12/29/22 and 3/8/23	3. During an interview at the			the audits to the monthly QAP		
	time of record revie	ew, the Maintenance			Committee for review and		
	Technician acknow	ledged there was no written			recommendation. Any		
	documentation avai	lable to show the sprinkler			recommendation made by the		
	system had been inspected for all 4 quarters of the				committee will be followed up	by	
	previous year.	-			the Director of Facilities or	•	
					designee and the results will b	е	
	This finding was ac	knowledged by the			brought to the next scheduled		
	_	nician at the time of discovery			QAPI committee meeting. This	;	
		t conference with the			practice will continue for a		
	_	nician and Care Services			minimum of 3 months or longe	r if a	
	Administrator prese	ent.			pattern of non-compliance is		
	•				shown.		
	2. Based on record	review and interview, the					
	facility failed to ma	intain 1 of 1 sprinkler system in					
	accordance with LS	SC 9.7.5. LSC 9.7.5 requires all					
	automatic sprinkler	systems shall be inspected					
	-	accordance with NFPA 25,					
	Standard for the Ins	spection, Testing, and					
	Maintenance of Wa	ter-Based Fire Protection					
	Systems. NFPA 25	i, 2011 edition, Table 5.1.1.2					
	indicates the require	ed frequency of inspection and					
	testing. NFPA 25, 5	5.2.4.1 states gauges on wet					
	pipe sprinkler syste	ms shall be inspected monthly					
	and gauges on dry s	systems (5.2.4.2) shall be					
	inspected weekly to	ensure normal water or air					
	pressure is being m	aintained. NFPA 25 13.3.2.1					
	states valves should	be inspected weekly, or					
	valves secured lock	s or supervised (13.3.2.1.1)					
	shall be permitted to	o be inspected monthly. This					
	-	ould affect all occupants.					
	-						
	Findings include:						
	-						
	Based on records re	eview and interview with the					
	Maintenance Techn	ician and Care Services					
	Administrator on 04	4/04/23 between 9:45 a.m. and					
		as no monthly inspection of the					
	-	ystem's gauges and valves					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794		ILDING	nstruction 02	(X3) DATE : COMPL 04/04/	ETED
	ROVIDER OR SUPPLIER T AT THE STRATF			2460 GL	DDRESS, CITY, STATE, ZIP COD LEBE ST L, 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0355 SS=F	monthly checks on a Inspection of Wet P blank. This finding was ac Maintenance Techn and again at the exit Maintenance Techn Administrator presentations of the property of t	ician at the time of discovery t conference with the ician and Care Services ent.					
Bldg. 02	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure all programmer given maintenance and year apart. NFPA 1 Fire Extinguishers, that fire extinguishers, that fire extinguishers at the time of hydro indicated by an insprinct indicated by an i	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility portable fire extinguishers were at periods not more than one 0, the Standard for Portable at Section 7.3.1.1.1 requires ers shall be subjected to rvals of not more than 1 year, static test, or when specifically	K 03	355	What corrective actions will be accomplished for those resider found to have been affected by deficient practice: The Director of Facilities or designee will schedule annual inspection of fire extinguishers. How the facility will identify oth residents having the potential to be affected by the same deficient practice and what corrective as will be taken: All residents have the potential be affected by the deficient practice. No further concerns who noted. What measures will be put in place or what systemic change the facility will makes to ensure	to ent ction I to vere	06/02/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 02	COMP	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIER		2460	ET ADDRESS, CITY, STATE, ZII I GLEBE ST MEL, IN 46032	P 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 C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY!	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	performed, identifies work, and identifies performing the work affect all residents. Findings include: Based on observation facility tour with the Care Services Adm 12:15 p.m. and 2:30 on the ABC fire ext 200-hall corridor lacurrent annual inspectant annual inspection to the throughout the facil Maintenance Techn fire extinguisher was extinguishers throughout the facil maintenance Techn fire inspected annual inspected annual inspected annual inspected annual inspected annual fire extinguishers throughout the facil maintenance Techn and again at the existinguisher throughout the facil maintenance Techn and again at the existinguishers throughout the facil maintenance Techn and again at the existinguishers throughout the facil maintenance Techn and again at the existinguishers.	knowledged by the ician at the time of discovery t conference with the ician and Care Services		that the deficient pra occur: Director of Facilities will audit fire extingu and will schedule ye maintenance How the corrective a monitored to ensure practice will not recu quality assurance pr put into place The Director of Facil designee will bring the the audits to the mor Committee for review recommendation. Ar recommendation ma committee will be fol the Director of Facilit designee and the resi brought to the next s QAPI committee me practice will continue minimum of 3 month pattern of non-comp shown.	or designee hisher monthly harly actions will be the deficient he results of he results of horthly QAPI w and hy hade by the flowed up by ties or sults will be scheduled heting. This he for a he ronger if a	
K 0363 SS=E Bldg. 02	than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin	corridor openings in other losures of vertical openings, s areas resist the passage made of 1 3/4 inch wood or other material in fire for at least 20 fully sprinklered smoke				

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

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	Ì	ILDING	nstruction 02	(X3) DATE : COMPL 04/04/	ETED
	ROVIDER OR SUPPLIER			2460 GI	DDRESS, CITY, STATE, ZIP COD LEBE 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)	ΓE	(X5) COMPLETION DATE
	passage of smoke to rooms containing combustible mater hardware. Roller is CMS regulation. The apply to auxiliary such flammable or commoderating is not expected and the door closed with a containing of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be lated the other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc. Based on observation failed to ensure 1 of impediment to closiframe and would resistance and w	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 03	363	What corrective actions will be accomplished for those reside found to have been affected by deficient practice: The Director of Facilities or	nts y the	06/02/2023
	Findings include:				designee will repair door hand room 266 to ensure that it clos		

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Event ID:

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

PRINTED: 05/11/2023 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155794	A. BUILDING 02 B. WING	COMPLETED 04/04/2023
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECTION PREFIX (FACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	(X5) EE COMPLETION DATE
	Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., the corridor door to Resident Room 266 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the Maintenance Technician agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b)	and latches positively to the frame. How the facility will identify residents having the potention be affected by the same despractice and what corrective will be taken: All residents have the potention be affected by the deficient practice. No further concern noted. What measures will be put in place or what systemic chart the facility will makes to ensith the facility will makes to ensith at the deficient practice do occur: Director of Facilities will trainstaff, in the proper regulation regarding the need for egreed oors to self close, and latch Management team will audit daily, quickly identify and concareas of concern. If the definities found to be a mechanical ine, the door does not latch the frame, a workorder will immediately be requested we concierge. How the corrective actions we monitored to ensure the definition practice will not recur, I,e., with quality assurance programs to put into place. The Director of Facilities or designee Workorders will be brought to the next schedule QAPI committee meeting. The practice will continue for a minimum of 3 months or long pattern of non-compliance is	other al to cicient caction tial to s were n nges ure pes not n all ns ss n. t doors crect ciency cissue o the dia the will be dicient what will be ed his ger if a

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 04/04/2023
	ROVIDER OR SUPPLIER		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 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
K 0372 SS=E Bldg. 02	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers where an is installed for smoth to the smoke barrier systems where an is installed for smoth to the smoke barrier system in REMAR Based on observation failed to ensure the passage of wire and smoke barriers wall the smoke resistance Section 19.3.7.5 requestion to be continuous from the smoke barrier to a second shall have a minimating. LSC Section to be continuous from the smoke barrier to a second shall have a minimating. LSC Section to be continuous from the smoke barrier to a second shall have a minimating to section the continuous from the smoke barrier to a second shall have a minimating to section the continuous from the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the continuous from the smoke barrier to a second shall have a minimating the same shall have a minimating the same shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the smoke barrier to a second shall have a minimating the s	all be constructed to a ance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.) hanical smoke control KS. on and interview, the facility penetrations caused by the for conduit through 1 of 2 s were protected to maintain e of each smoke barriers to be dance with LSC Section 8.5 minum ½ hour fire resistive 8.5.2.1 requires smoke barriers m an outside wall to an floor to a floor, or from a moke barrier, or by use of a 5. 8.5.6.2 requires penetrations ys, conduits, pipes, tubes, milar items to accommodate	K 0372	What corrective actions will be accomplished for those reside found to have been affected be deficient practice: The Director of Facilities or designee will seal penetration smoke barrier wall above the ceiling near the Salon door ex doors. How the facility will identify our residents having the potential be affected by the same defic practice and what corrective a will be taken: All residents have the potential be affected by the deficient practice. No further concerns noted. What measures will be put in place or what systemic change the facility will makes to ensure	ents by the s in drop cit her to ient action al to were

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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 02	(X3) DATE SURVEY COMPLETED 04/04/2023	
	PROVIDER OR SUPPLIER T AT THE STRATFORD, THE	2460 G	ADDRESS, CITY, STATE, ZIP COD SLEBE ST EL, 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	restricting the movement of smoke. This deficient practice could affect staff and at least 10 residents. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician and Care Services Administrator on 04/04/23 between 12:15 p.m. and 2:30 p.m., two unsealed penetrations were discovered in the smoke barrier wall above the drop ceiling near the Salon door exit doors. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present.		that the deficient practice does occur: Director of Facilities or designed will audit barrier walls quarterly ensure compliance. 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 Director of Facilities or designee will bring the results the audits to the monthly QAP Committee for review and recommendation. Any recommendation made by the committee will be followed up the Director of Facilities or designee and the results will be	ee y to I be ent at I be of I	
	3.1-19(b)		brought to the next scheduled QAPI committee meeting. This practice will continue for a minimum of 3 months or longe pattern of non-compliance is shown.	5	
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 5 wet locations were	K 0511	What corrective actions will be accomplished for those reside		
	provided with ground fault circuit interrupter		found to have been affected by		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MUI A. BUII B. WIN	LDING	nstruction 02	(X3) DATE COMPI 04/04	
NAME OF P	ROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD LEBE ST	-	
RETREA	T AT THE STRATE	ORD, THE			EL, IN 46032		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION	R.	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	r	TAG	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
		against electric shock. LSC			deficient practice:		
		ilities comply with Section 9.1.			The Director of Facilities or		
	•	electrical wiring and equipment			designee will replace outlet		
		PA 70, National Electrical Code.			is located within 1 foot of sin	k with	
		11 Edition at 210.8 Ground-Fault			a GFCI protected outlet.		
	_	Protection for Personnel,			How the facility will identify of		
	_	circuit-interruption for			residents having the potentia		
		provided as required in			be affected by the same defi		
	, , , , , , , , , , , , , , , , , , ,	C). The ground-fault			practice and what corrective	action	
	accessible location.	hall be installed in a readily			will be taken:	tial to	
		relling Units. All 125-volt,			All residents have the potent be affected by the deficient	และเง	
	` '	nd 20-ampere receptacles			practice. No further concerns	a woro	
		tions specified in 210.8(B)(1)			noted.	s were	
	through (8) shall ha				What measures will be put in	,	
		protection for personnel.			place or what systemic chan		
	(1) Bathrooms	rotection for personner.			the facility will makes to ensi	-	
	(2) Kitchens				that the deficient practice do		
	(3) Rooftops				occur:	00 1101	
	(4) Outdoors				Director of Facilities or design	inee	
	` '	(3) and (4): Receptacles that are			will audit all GFCI outlets to	,,,,,,	
	-	ole and are supplied by a			ensure compliance. Directo	r of	
	-	cated to electric snow-melting,			Facilities or designee will au		
		and vessel heating equipment			GFCI protected outlets quar		
		o be installed in accordance			ensure compliance.	-	
	with 426.28 or 427.	22, as applicable.			How the corrective actions w	<u>/ill be</u>	
	Exception No. 2 to	(4): In industrial establishments			monitored to ensure the defi	<u>cient</u>	
	only, where the cor	ditions of maintenance and			practice will not recur, I,e., w	<u>hat</u>	
	_	that only qualified personnel			quality assurance program v	<u>vill be</u>	
		sured equipment grounding			<u>put into place</u>		
		as specified in 590.6(B)(2)			The Director of Facilities or		
	_	or only those receptacle			designee will bring the result		
		bly equipment that would			the audits to the monthly QA	ŀΡΙ	
	_	ard if power is interrupted or			Committee for review and		
		t is not compatible with GFCI			recommendation. Any		
	protection.				recommendation made by th		
	` '	eceptacles are installed within			committee will be followed u	p by	
		outside edge of the sink.			the Director of Facilities or		
	_	(5): In industrial laboratories,			designee and the results will		
	receptacies used to	supply equipment where			brought to the next schedule	ea	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 02	(X3) DATE COMPL 04/04 /	ETED
	PROVIDER OR SUPPLIEF			2460 GL	DDRESS, CITY, STATE, ZIP COD LEBE ST L, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	removal of power whazard shall be perroged. GFCI protection. Exception No. 2 to patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet location (7) Locker rooms whacilities (8) Garages, service electrical diagnostic tools. NFPA 70, 517-20 Where the wet location to be interrupter (GFCI) preduce the contact relectrical insulation. This deficient pract 4 residents while in Findings include: Based on observation facility tour with the Care Services Adm. 12:15 p.m. and 2:30 sinks. The outlet location was not GFCI aforementioned receithe outlet was on a Technician at the tindid not believe the circuit. This finding was ac Maintenance Technical for the contact of the circuit.	would introduce a greater mitted to be installed without (5): For receptacles located in a sof general care or critical care facilities other than those protection shall not be required. Since the associated showering the bays, and similar areas where the equipment, electrical hand Wet Locations, requires alled equipment within the area of that are ground-fault circuit protection. Note: Moisture can resistance of the body, and is more subject to failure. Since could affect staff and up to the Pantry area. On and interview during a see Maintenance Technician and inistrator on 04/04/23 between 0 p.m., the Pantry area had 2 cated within 1 foot of the small protected. When tested, the septacle did not trip indicating GFCI circuit. The Maintenance me of observation stated he receptacle was on a GFCI knowledged by the sician at the time of discovery			QAPI committee meeting. This practice will continue for a minimum of 3 months or longe pattern of non-compliance is shown.	3	
	anu agam at me exi	t conference with the					

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	ILDING	<u>02</u>		COMPLETED	
		155794	B. WI	2023				
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER			2460 GI	LEBE ST			
RETREA	T AT THE STRATF	ORD, THE		CARME	EL, IN 46032			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION ician and Care Services		TAG	DEFICIENCIT		DATE	
	Administrator prese							
	Administrator prese	IIt.						
	3.1-19(b)							
K 0712	NFPA 101							
SS=F	Fire Drills							
Bldg. 02	Fire Drills							
		he transmission of a fire						
		imulation of emergency fire						
	conditions. Fire dri	ills are held at expected						
	and unexpected til	mes under varying						
		t quarterly on each shift.						
		r with procedures and is						
		re part of established						
		ills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms. 19.7.1.4 through 1	0.7.1.7						
		review and interview, the	K 0'	712	What corrective actions will be		06/02/2023	
		duct fire drills on each shift for	KU	/12	accomplished for those resider		00/02/2023	
		C 19.7.1.6 states drills shall be			found to have been affected by			
	-	on each shift to familiarize			deficient practice:	,o		
		urses, interns, maintenance			The facilities team was educat	ed		
		nistrative staff) with the			on Fire Drill policy and procedu	ure.		
	signals and emerger	ncy action required under						
	varied conditions. T	his deficient practice affects			How the facility will identify oth	<u>er</u>		
	all staff and resident	ts.			residents having the potential			
					be affected by the same deficient			
	Findings include:				practice and what corrective a	ction_		
	D 1 1				will be taken:			
		view and interview with the			All residents have the potentia	I TO		
		ician and Care Services 4/04/23 between 9:45 a.m. and			be affected by the deficient	Norc		
		owing shifts were missing			practice. No further concerns who noted.	were		
	-	completed fire drill:			What measures will be put in			
		drill in the First quarter of			place or what systemic change	29		
	2023.	and I have quarter of			the facility will makes to ensure			
		drill in the Fourth quarter of			that the deficient practice does			
	•	*	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>		COMPLETED	
		155794	B. W	ING		04/04/	2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			LEBE ST		
RETREA	T AT THE STRATE	FORD THE			EL, IN 46032		
		OND, THE		O7 ti tivil	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2022.				occur:		
					Director of Facilities or design	ee	
		cknowledged by the			will audit fire drills monthly to		
		nician at the time of discovery			ensure compliance.		
	_	it conference with the			How the corrective actions will		
		nician and Care Services			monitored to ensure the defici-		
	Administrator pres	ent.			practice will not recur, I,e., wh		
					quality assurance program wil	l be_	
					put into place		
		review and interview, the			The Director of Facilities or		
	•	nduct quarterly fire drills on			designee will bring the results		
		nd at unexpected times under			the audits to the monthly QAP	1	
	varying conditions. This deficient practice could				Committee for review and		
	affect all residents,	staff and visitors in the facility.			recommendation. Any		
	F' 1' ' 1 1				recommendation made by the		
	Findings include:				committee will be followed up	ру	
	Dagad on massands m	eview and interview with the			the Director of Facilities or	_	
		nician and Care Services			designee and the results will b		
		4/04/23 between 9:45 a.m. and			brought to the next scheduled		
		quarterly fire drills which were			QAPI committee meeting. This	5	
	-	d near the end of the month,			practice will continue for a minimum of 3 months or longe	r if o	
		y of the month. These			pattern of non-compliance is	ппа	
		llow fire drills to be conducted			shown.		
		nd unpredictable days.			SHOWH.		
	at on unexpected at	nd unpredictable days.					
	This finding was a	cknowledged by the					
	~	nician at the time of discovery					
		it conference with the					
	_	nician and Care Services					
	Administrator pres						
	riammouraver pres						
	3.1-19(b)						
	,						
K 0781	NFPA 101						
SS=E	Portable Space H	leaters					
Bldg. 02	Portable Space H						
		eating devices shall be					
		ealth care occupancies,					
		ed in nonsleeping staff and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/04/2023	
	ROVIDER OR SUPPLIER		2460	ET ADDRESS, CITY, STATE, ZIP COD OGLEBE ST MEL, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	OBE COMPLETION
TAG	employee areas w do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation failure to ensure 1 of were not used in the practice could affect visitors in the vicinity. Findings include: Based on observation facility tour with the Care Services Adm. 12:15 p.m. and 2:30 was in use in the Administrative at the time Services Administrative at the time Services Administrative used in the arrappliances were not removed the space of the	chere the heating elements degrees Fahrenheit (100 con and interview, the facility of 1 portable space heaters a facility. This deficient to up to 5 residents, staff and the facility of the Activities Area. The Maintenance Technician and inistrator on 04/04/23 between 0 p.m., a portable space heater activities Area. Based on the observations, the Care attor agreed a space heater was the allowed in the facility, and the heater. Removed by the ician at the time of discovery to conference with the ician and Care Services	K 0781		Il be sidents ed by the ducated e heaters vother tial to efficient ve action ential to the surre does not estimate the tany will be efficient what will be offer on. Any
				committee will be followed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155794	A. BUILDING <u>02</u> COMPLETH B. WING 04/04/20.				
		1337 94	D. W.	_		04/04/	72023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LEBE ST		
RETREA	T AT THE STRATE	FORD, THE			EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	REGULATORY O.	R LSC IDENTIFTING INFORMATION	+	TAG	the Administrator. Results will	he	DATE
					brought to the next scheduled		
					QAPI committee meeting. Thi		
					practice will continue for a		
					minimum of 3 months or longe	er if a	
					pattern of non-compliance is shown.		
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 02		s - Essential Electric					
	System Maintena	ince and Testing					
		other alternate power					
		ciated equipment is capable					
		ice within 10 seconds. If the on is not met during the					
		ocess shall be provided to					
		this capability for the life					
		l branches. Maintenance					
	and testing of the	generator and transfer					
		ormed in accordance with					
	NFPA 110.						
		re inspected weekly, oad 30 minutes 12 times a					
		intervals, and exercised					
		onths for 4 continuous hours.					
	· ·	nder load conditions include					
	a complete simula	ated cold start and					
		ual transfer of all EES					
	· ·	nducted by competent					
	1 °	enance and testing of stored					
		urces (Type 3 EES) are in NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
		stablished according to					
	i -	uirements. Written records					
	of maintenance a	nd testing are maintained					
		ble. EES electrical panels					
	and circuits are m	narked, readily identifiable,					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155794	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/04/2023
RETREA	ROVIDER OR SUPPLIER	ORD, THE	2460 C CARM	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Minimizing the pose emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 1. Based on record of facility failed to ma	(NFPA 99), NFPA 110,	K 0918	What corrective actions will be accomplished for those reside found to have been affected by	ents_
	12 months. Chapter requires monthly tenthe emergency elect accordance with NF Emergency and Star 8. NFPA 110 8.4.2 service to be exercisminimum of 30 min 99 requires a written performance, exercigenerator to be regular for inspection by the	sting of the generator serving rical system to be in PA 110, the Standard for andby Powers Systems, Chapter requires diesel generator sets in sed at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA in record of inspection, sing period, and repairs for the alarly maintained and available		deficient practice: Generator will have annual fur quality test will be conducted. Generator will have monthly of minute load test completed. Generator will have three-year hour test completed. How the facility will identify of residents having the potential be affected by the same deficient practice and what corrective a will be taken: All residents have the potential be affected by the deficient	el 30 ar 4 her to cient action
	Based on records re Maintenance Techn Administrator on 04 12:15 p.m., prior 03 available for review set in service was exfor a minimum of 3 load test documenta for March and April Technician stated the prior to 3/23 were c	view and interview with the ician and Care Services 1/04/23 between 9:45 a.m. and /22 no documentation was to show the diesel generator sercised at least once monthly, 0 minutes. The only monthly tion provided reflected tests a of 2023. The Maintenance we monthly generator tests onducted by the prior visor and did not know where was located.		practice. No further concerns noted. Facilities team will be educated on generator testing requirements. What measures will be put in place or what systemic change the facility will makes to ensure that the deficient practice does occur: Director of Facilities will adher the NFPA 110 requirements regarding testing of generator Weekly, Monthly, and annual inspections will be documented Any issues identified will requirements. How the corrective actions will	ges_re_es not re to rs. ed. uire a

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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 02	(X3) DATE SURVEY COMPLETED 04/04/2023	
	PROVIDER OR SUPPLIER		2460 0	ADDRESS, CITY, STATE, ZIP COD SLEBE ST EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR This finding was ac Maintenance Techn and again at the exit Maintenance Techn Administrator present and again at the exit Maintenance Techn Administrator present and again at the exit Maintenance Techn Administrator present and again at the exit Maintenance Techn Administrator present and again at the exit Maintenance Techn Administrator present and again at the exit Maintenance Technology (EACH ACT AND AGAINTENANCE	ician at the time of discovery conference with the ician and Care Services	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) monitored to ensure the defice practice will not recur, I,e., wh quality assurance program wi put into place The Director of Facilities or designee will bring audits to monthly QAPI Committee for review and recommendation of 100% compliance is met. Any recommendation made by the committee will be followed up the Director of Facilities or	DATE ient nat II be
	2012 Edition Section (Essential Electrical be inspected and test Section 6.4.4.1.1.3. maintenance shall be with NFPA110, Sta Standby Power Sys NFPA 110, Section shall be performed a approved by ASTM practice could affect	n 6.5.4.1.1.2 states Type 2 EES System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states e performed in accordance indard for Emergency and stems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests standards. This deficient		designee.	
	Maintenance Techn Administrator on 04 12:15 p.m., no docu quality test for the of for review. The faci Based on interview the fuel quality test generator could not This finding was ac Maintenance Techn and again at the exi				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155794		1 1	JILDING	NSTRUCTION 02	(X3) DATE COMPL 04/04 /	ETED	
	ROVIDER OR SUPPLIER			2460 GL	ddress, city, state, zip cod LEBE ST L, IN 46032		
(X4) ID PREFIX TAG	SUMMARY (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 APPROPE DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	3. Based on record a facility failed to ma Standby System in a Standard for Emerg Systems, Section 8. Health Care Faciliti NFPA 110 Section Emergency Power Sonce within every the assigned class is grepermitted to termina NFPA 99 Section 6 Type 2 essential eleshall be classified a	review and interview, the intain 1 of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least aree years. Where the eater than 4 hours, it shall be atte the test after 4 hours. 4.1.1.6.1 states that Type 1 and ctrical system power sources to Type 10, Class X, Level 1 is deficient practice could					
	Maintenance Techn Administrator on 04 12:15 p.m., the faci testing of the emerg could not provide d 4-hour test. This finding was ac Maintenance Techn and again at the exi	ician at the time of discovery t conference with the ician and Care Services					
K 0927 SS=E Bldg. 02	3.1-19(b) NFPA 101 Gas Equipment -	Transfilling Cylinders Transfilling Cylinders					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u> COMPLETE			LETED
155794		B. WING 04/04/2023			/2023		
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			LEBE ST		
DETDEA	T AT THE STRATE	OPD THE			EL, IN 46032		
KETKEA	I AI INE SIRAIF	ORD, THE		CARIVIE	EL, IN 40032		
(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
	Transfilling of oxy	gen from one cylinder to					
	another is in acco	rdance with CGA P-2.5,					
	Transfilling of Higl	h Pressure Gaseous					
	Oxygen Used for	Respiration. Transfilling of					
	any gas from one	cylinder to another is					
	prohibited in patie	nt care rooms. Transfilling					
	to liquid oxygen co	ontainers or to portable					
	containers over 50	psi comply with conditions					
	under 11.5.2.3.1 (NFPA 99). Transfilling to					
	liquid oxygen conf	tainers or to portable					
	containers under	50 psi comply with					
	conditions under 1	11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99	9)					
	Based on records re	eview and interview, the facility	K 0	927	What corrective actions will be	<u> </u>	06/02/2023
	failed to ensure staf	f was properly trained on			accomplished for those reside	ents_	
	trans-filling proced	ures in 1 of 1 oxygen storage			found to have been affected b	y the	
	room where oxyger	transferring takes place.			deficient practice:		
	NFPA 99 2012 edit	ion, 11.5.2.3.1 (4) the individual			Nursing staff will be educated	on	
	trans-filling the con	tainer(s) has been properly			trans-fill of liquid oxygen.		
		filling procedures. This			How the facility will identify otl	<u>ner</u>	
	deficient practice co	ould affect up to 10 residents in			residents having the potential	to	
	one smoke compart	ment.			be affected by the same defic	<u>ient</u>	
					practice and what corrective a	<u>iction</u>	
	Findings include:				will be taken:		
					All residents have the potentia	al to	
		eview and interview with the			be affected by the deficient		
		nician and Care Services			practice. No further concerns		
		4/04/23 between 9:45 a.m. and			noted.		
	_	mentation was available for			What measures will be put in		
		taff that trans-fill liquid oxygen			place or what systemic chang		
		ed. Based on interview at the			the facility will makes to ensur		
	time of observation				that the deficient practice doe	s not	
		d staff are trained during			occur:		
	orientation but was	unable to provide the training			Don or designee will audit nev		
	paperwork.				employee onboarding monthly	/ to	
					ensure that initial training and		
	This finding was ac				yearly education has been		
		nician at the time of discovery			conducted.		
		t conference with the			How the corrective actions wil	l be	
	Maintenance Techn	nician and Care Services			monitored to ensure the defici	<u>ent</u>	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 02	(X3) DATE COMPL		
THISTERN	or contection	155794	B. WING	<u>02</u>	04/04/		
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Administrator prese	ent.		practice will not recur, I.e., whe quality assurance program will put into place The Director of Nursing or designee will bring audits to monthly QAPI Committee for review and recommendation used to the committee will be followed up the Director of Facilities or designee.	<u>ll be</u> until		

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