

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/02/2025
NAME OF PROVIDER OR SUPPLIER  Retreat at the Stratford, The		STREET ADDRESS, CITY, STATE, ZIP CODE  2460 Glebe St Carmel, IN 46032	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team (IDT) assessed to determine a resident was safe to self-administer medications for 1 of 1 resident reviewed for self-medication administration. (Resident D)</p> <p>Findings include:</p> <p>During an observation and interview, on 6/2/25 8:46 a.m., Resident D had a clear plastic medication cup, with pills, on her bedside table next to her meal tray. The resident indicated the staff left her medications in her room. She would take the pills.</p> <p>The clinical record for Resident D was reviewed on 6/2/25 at 10:29 a.m. The diagnoses included, but were not limited to, a fracture of the lower end of the left humerus (upper arm bone) and cirrhosis of the liver.</p> <p>An assessment for self-administration of medication completed by the interdisciplinary team (IDT), a physician's order and a comprehensive care plan for the self-administration of medications was not located in the clinical record.</p> <p>During an observation and interview, on 6/2/25 at 8:52 a.m., LPN 1 indicated the resident's medications were on her bedside table. The resident had wanted to eat before she took her medications. She did not know if Resident D had been assessed for self-administration of medications. She was supposed to stay with the residents while they took their medications.</p> <p>During an interview, on 6/2/25 at 12:51 p.m., the Care Services Administrator indicated the resident did not have an assessment, a physician's order or a care plan to self-administer medications.</p> <p>A current facility policy, titled Medication Self-Administration, undated and received from the Care Services Administrator on 6/2/25 at 3:00 p.m., indicated .A Medication Self-Administration Evaluation shall be completed for each resident who desires to self-administer medications .The Director of Health Services or designee will notify the attending physician of the evaluation results, and will obtain an order for the resident to self-administer medications</p> <p>3.1-11(a)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from verbal abuse and intimidation for 2 of 4 residents reviewed for abuse. (Resident B and C) The deficient practice was corrected on 5/25/25, prior to the start of the survey, and therefore was past noncompliance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an interview, on 6/2/25 at 8:56 a.m., Resident B indicated a staff member had been cross and impatient. She was unable to give the staff member's name (CNA 3). Resident B indicated she had slid down in her bed and CNA 3 accused her of doing it on purpose. She indicated she did not like the accusation.</li> <li>2. During an interview, on 6/2/25 at 9:00 a.m., Resident C indicated CNA 3 had been verbally rude to her and she filed a complaint. Her remote control had fallen between the wall and the bed. The bed needed to be moved to get the remote. CNA 3 threw her hands up and looked at me like I was crazy and said she don't move beds. Resident C indicated she then asked for some milk. CNA 3 went and got the milk, returned, opened the milk, slammed it down, and stormed out. Later in the evening, at 10-10:30 p.m., her roommate (Resident B) turned on the call light. CNA 3 had raised her voice and sounded belligerent toward Resident B. Resident C indicated she was afraid of CNA 3. She went to talk to Resident B to see if she was okay. Resident B told her she slid down in bed, needed help, and CNA 3 had started screaming. As Resident C was talking to Resident B, CNA 3 walked into their room. Resident C indicated she started walking to the door and had her hands on her walker when CNA 3 grabbed both of her wrists hard and pushed her back into her room. Resident C sat on her bed, picked up her phone to call her son, and CNA 3 grabbed her phone from her, put it on the chest of drawers, and stormed out. Resident C indicated she was shaking. Resident C contacted RN 4, and he informed her CNA 3 was gone for the night and the incident would be taken care of the next day. She indicated she was afraid CNA 3 would return with a gun, but RN 4 assured her she was safe, and CNA 3 could not get into the facility. The resident indicated she did feel safe now.</li> </ol> <p>The clinical record for Resident C was reviewed on 6/2/25 at 10:59 a.m. The diagnoses included, but were not limited to, left bundle branch block (electrical signals to the heart are blocked), atrioventricular block (electrical signal block from the upper chamber to the lower chamber of the heart) and atherosclerotic heart disease.</p> <p>A Basic Interview for Mental Status (BIMS) assessment, dated 5/26/25, indicated she was cognitively intact.</p> <p>A nursing progress note, charted late on 5/27/25 at 2:13 p.m., for the date of 5/23/25, indicated the nurse was called to Resident C's room. Resident C indicated she had been in an altercation with CNA 3. CNA 3 had taken the resident's phone away from her. The resident was upset and shaken but no injury was observed. RN 4 spoke with Resident C and her son and informed them CNA 3 was no longer in the facility. Resident C was asked to write down the details of what happened. RN 4 then spoke with Resident B, and she informed him CNA 3 was .gruff and was yelling at her . CNA 3 reported Resident C scratched her. There were no witnesses to the altercation. Resident C was assessed for injury and none were found.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility document, titled Coaching &amp; Counseling Form, received from the Care Service Administrator on 6/2/25 at 3:48 p.m., indicated, CNA 3 was terminated. The document failed to state a reason for the termination.</p> <p>A facility letter addressed to CNA 3 indicated effective 5/23/25 the CNA's position had been terminated due to committing resident abuse.</p> <p>During an interview, on 6/2/25 at 9:46 a.m., the Care Services Administrator indicated CNA 3 had been terminated from the facility. According to Resident C, CNA 3 grabbed her wrist. Resident C grabbed her phone and told CNA 3 she was going to report her. CNA 3 grabbed the phone, put it on the dresser, and left. RN 4 sent the CNA home and the next working day she was terminated. He indicated she was terminated for abuse. She had put her hands on a resident, snatched a phone from her, and the facility had a zero-tolerance policy.</p> <p>During a telephone interview, on 6/2/25 at 12:29 p.m., CNA 3 indicated when she entered the residents' room, Resident C was attempting to pull Resident B up in the bed. CNA 3 told Resident C it was not safe. Resident C was screaming and yelling. Resident C then grabbed the staff member, spat on her, and scratched her. RN 4 came to the room about five minutes after it happened. CNA 3 denied all allegations made and indicated she was going to leave the facility anyway.</p> <p>During an interview, on 6/2/25 at 1:20 p.m., RN 4 indicated he was called to Resident B and C's room by CNA 3. When he arrived at the room, Resident C was crying and upset. Resident C indicated CNA 3 had taken her phone. RN 4 indicated he asked CNA 3 to leave the room, and he reported the incident to the Care Service Administrator.</p> <p>A current facility policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021 and received from the Care Service Administrator on 6/2/25 at 3:00 p.m., indicated .Residents have the right to be free from abuse, neglect .This includes but is not limited to .verbal, mental .or physical abuse</p> <p>A current facility policy, titled Resident Rights, dated February of 2021 and received from the Care Service Administrator on 6/2/25 at 3:00 p.m., indicated .Federal and state laws guarantee certain basic rights to all residents of this facility .These rights include the resident's right to .be free from abuse</p> <p>The deficient practice was corrected by 5/25/25 after the facility implemented a systemic plan which included an investigation of the incident, education to the staff on resident abuse and reporting, residents were interviewed related to abuse, and CNA 3 was terminated.</p> <p>This citation relates to Complaint IN00460150.</p> <p>3.1-27(a)(1)</p> <p>3.1-27(b)</p>		