STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retreat at the Stratford, The	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 09676 Based on interview and record review, the facility failed to ensure ordered wound treatments were completed as ordered for 1 of 4 residents reviewed for wound treatment (Resident B). Findings include: Resident B's closed clinical record was reviewed on 4/02/24 at 12:02 p.m. Discharge diagnoses included, chronic atrial fibrillation, heart failure, and pacemaker placement. The resident had a 12/22/23 care plan need regarding the placement of a cardiac pacemaker. Review of the resident's Clinical Notes indicated the following: 12/22/23- The resident was admitted to the facility following the placement of a pacemaker. 12/28/23-The resident was admitted after a recent pacemaker implantation. The resident had an incision on her left upper chest. No redness was present at the wound site. 1/2/24-The resident returned from a follow-up visit with the cardiologist. The resident had a new order to clean incision daily with soap and water, no lotions, creams or powders to the incision site. Review of the Clinical Notes indicated the entries were identical on four days, and included the same typo and same wording. The identical notes were entered on the following dates and times: 12/27/23 at 8:59 a.m., 12/28/23 at 1:22 p.m., 12/29/23 at 2:16 p.m., 1/1/24 at 2:42 p.m. The entries read as follows, Res. here after hospital stay fro (sic) bradycardia with pacemaker implantation. Res. has incision on left upper chest steri strips in place dry intact some bruising noted no redness warmth or drainage noted. The typo was corrected on 1/2/24. Following the correction of the typo the identical entry was made on the following dates and times: 1/2/24 at 1:49 p.m., 1/3/24 at 7:35 p.m., 1/8/24 at 9:17 p.m. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the 14 day period of identical documentation, a 1/9/24 at 11:15 a.m., Addendum Note indicated the resident was having some redness around the left chest incision where the steri strips (wound closure strips) were present. The resident complained of pain and had a fever. The Medical Director was in the facility and assessed the area and indicated the resident needed to see her cardiologist as soon as possible. The resident went to the Cardiologist were she was placed on antibiotics for an infection at the pacemaker site. The resident had a 1/2/24, cardiology Ambulatory Visit Summary which contained an order to wash the pacemaker incision site with soap and water and pat dry, one time each day. The clinical record lacked documentation that the pacemaker incision site was washed and patted dry from 1/2/24, when the order was received, until 1/9/24, when the site was red and the resident had a fever. The resident had a 1/9/24 order for doxycycline hyclate 100 mg tablet (an antibiotic) - take one tablet two times a day for 10 days. A 1/11/24 at 3:34 p.m. Clinical Note indicated the resident had returned from a cardiology appointment and would need to go to the hospital for a pacemaker replacement. A 1/16/24 at 12:37 p.m., Clinical Note indicated RISK MEETING. The resident was started on antibiotics for an infection to the pacemaker site. A grievance was received. During an interview, on 4/2/24 at 2:47 p.m. Resident B's family indicated the following: The family took the resident to a cardiology appointment on 1/2/24. The doctor changed an oral medication and order the pacemaker site be washed with soap and water and patted dry each day. On 1/9/24 the facility called the family and said the Medical Director wanted the resident to see the cardiologist that day or go to the hospital. The family took the resident to the cardiologist that day. When the incision was observed at the cardiologist, the site was red all around the incision and down the arm. The wound was draining a green liquid. The cardiologist ordered a very strong antibiotic and wanted them to return in a couple days. When they returned to the cardiologist on 1/11/24, the decision was made to remove and replace the pace maker because the infection was not healing quick enough. The family spoke with the DON, who could not show any proof that the facility had routinely monitored the site nor washed the wound with soap as ordered. The resident did not return to the facility following the pacemaker replacement. During an interview on 4/3/24 at 9:45 a.m., the Administrator indicated the facility had developed a plan of correction to address the concerns expressed in the grievance made by Resident B's family regarding monitoring wounds and providing wound care as ordered. The Administrator provided paperwork regarding the concern and the facilities actions. The paperwork included a Grievance Form: and the corresponding documentation. A 1/10/24, Grievance Form indicated during a care conference Resident B's family expressed concern due to the resident's pacemaker site not being cleaned. The form indicated the Action taken and Date for this concern was as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/12/24-Nursing Inservice on charting and documentation for medication and treatment orders related to wound care, 1/13/24 Audit of all residents in house, 1/15/24 Resident Incident Reporting Form, (No date listed) QA review, 2/21/24 Nursing education on second (2nd) checks of orders. A current, 10/2010, facility policy titled, Wound Care, which was provided by the DON on 4/5/24 at 10:34 a.m. , indicated the following: .Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. . 6. All assessment data (i.e., wound bed color, size, drainage, etc) obtained when inspecting the wound The deficient practice was corrected by February 21, 2024, prior to the start of the survey, and was therefore past noncompliance. The facility had completed Nursing Inservices/education, completed audits, and taken the concern to the Quality Assurance Committee. This citation relates to complaint IN00426019. 3.1-37

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146 Based on observation, interview, and record review, the facility failed to ensure ongoing communication for continuation of care with the dialysis center for 1 of 1 resident reviewed for dialysis services (Resident 6) Findings include: During an interview on 4/02/24 at 1:54 p.m., Resident 6 was sitting in bed in her room watching TV. She indicated she went to dialysis and had a port to her left chest. Resident 6's clinical record was reviewed on 4/2/24 at 3:18 p.m. Current diagnoses included end stage renal disease (ESRD), dependence on dialysis, and congestive heart failure. The resident had a current April 2024 order for dialysis. The resident had a current care plan problem/need regarding a diagnosis of ESRD and receiving hemodialysis. The goal for this problem was Fluid balance will be maintained and resident will have no complications with hemodialysis through the next review. Approaches/interventions included: Interventions: monitor for complications from dialysis such as: hypoglycemia, hypotension, irritation to access site, and muscle cramps and Dialysis is at (dialysis facility name) on Tuesday, Thursday, and Saturday The clinical record for dialysis communication indicated, from January 2024 to April 2024, communication notes were not down loaded into the electronic medical record. The dialysis communication binder was reviewed on 4/3/24 at 10:02 a.m. Each Nurses Dialysis Communication Record: contained three (3) sections as follows: a. PRE- DIALYSIS ASSESSMENT b. DIALYSIS CENTER c. [NAME] POST DIALYSIS ASSESSMENT Review of communication records from 4/1/24 to 3/1/24 identified the following incomplete records: 4/1/24- Pre dialysis vitals only, 3/29, 3/27, 3/25, 3/22, 3/20, and 3/18 did not have any communication logs completed, 3/18/24- Pre dialysis vitals, dialysis vitals only, 3/15 and 3/13 did not have any communication log completed, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/24- Pre dialysis vitals only. 3/8 and 3/6 did not have communication logs completed, 3/4/24- Pre dialysis vitals, dialysis vitals. January and February 2024 also had missing log pages and or missing information. During an interview on 4/03/24 at 2:32 p.m., both the DON and Administrator indicated this was an ongoing problem with the dialysis center not wanting to fill this form out. The DON had many calls with the dialysis center administrator and this issue never resolved. This company is the most local one to the facility, and that's why they were still utilized. These points of contact happen by phone and there were not records of the conversation. The Administrator and DON indicated the facility sent this form with the resident for every visit. A current facility contract titled Long Term Care Facility Outpatient Dialysis Services Coordination Agreement, which was provided by the facility following the entrance conference on 4/1//24, indicated the following: .Interchange of Information: The Long Term Care Facility shall provide for the interchange of information necessary for the care of ESRD Residents, including a contact person at the Long Term Care Facility whose responsibilities included assisting with the coordination of Renal Dialysis Services for ESRD residents 3.1-37(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 09676 Based on observation, interview, and record review, the facility failed to ensure food was distributed under safe sanitary conditions for 14 of 14 residents who resided in the nursing home area of the facility. Findings include: During the lunch meal service observation on 4/3/24 from 11:54 a.m. to 12:38 p.m., the following concerns were identified: a. At 11:58 a.m., three meal trays were placed in the food service cart. During an interview on 4/3/24 at 11:59 a.m., Cook 3 indicated she had not taken the temperatures of the food prior to placing the three trays in the meal service cart. She was aware the temperature of all foods should be taken prior to placing any meal in the food service cart. b. At 12:03 p.m., Cook 3 was taking the temperatures of the food items on the steam table. She dropped the wrapper off of the alcohol wipe on the floor. She bent over an picked the wrapper up with her gloved hands. With the same soiled gloved hands, she continued to take temperatures of the food the steam table. c. At 12:19 p.m., Cook 3 was serving meals using her gloved hands to serve meals. With her gloved hands she touched, meal tickets, dishes, utensils counter tops, the bag containing hot dog buns, drawer handles, and other kitchen services. With the soiled gloved hands Cook 3 took a bun out of the bun bag. She opened the bun with the same gloves. While holding the bun in the palm of her same soiled gloved hand, she placed a sausage in the bun. d. At 12:21 p.m., she changed her gloves without washing her hands between doffing her soiled gloves and donning her new gloves. She then repeated the process of touching counter tops, meal tickets, utensils, counter tops, bun bags, drawer handles, and multiple other surfaces. Using her soiled gloved hands she opened a hot dog bun and held it in the palm of her hand while placing a sausage in the bun. At 12:25 p.m., she changed her gloves again without washing her hands between doffing and donning. She once again began the process of touching multiple surfaces and serving sausages in the bun. At 12:38 she changed gloves without washing her hands between doffing and donning new gloves. She again touched multiple surfaces with her gloved hands. She then used her soiled gloves to open a bun, holding it in her soiled palm, and serve a sausage in the bun. A current, 10/2017, facility policy, titled Preventing Forborne Illness Employee Hygiene and Sanitary Practice, which was provided by the Administrator on 4/4/24 at 10;00 a.m., indicated the following: .6. Employees must wash their hands . d, Before coming in contact with any food surface . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. After handling soiled equipment or utensils; g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination . 9. Food services employees will be trained in the proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent forborne illness. 10. Gloves are considered single -use items and must be discarded after completing the task This citation relates to complaint IN00417225.