STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155846	B. WING		02/26/2025
		<u> </u>		ADDRESS OF A STATE OF THE STATE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
DEOTOR	04 0V 0E 04 DA4EL			REEN HOUSE WAY	
RESTOR	RACY OF CARMEL		CARIMI	EL, IN 46032	
(X4) ID	SUMMARY	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	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
	This visit was for a	Recertification and State	F 0000	Disclaimer:	
	Licensure Survey.	This visit included the		This Plan of Correction consti	tutes
	1	omplaints IN00444413 and		this facility's written allegation	
	IN00444369.	•		compliance for the deficiencie	<b> </b>
				cited. However, submission of	
	Complaint IN0044	4413 - No deficiencies related to		Plan of Correction is not an	
	the allegations are			admission that a deficiency ex	kists
				or that one was cited correctly	<b> </b>
	Complaint IN0044	4369 - No deficiencies related to		This Plan of Correction is	
	the allegations are			submitted to meet requiremen	nts
				established by the state and	
	Survey dates: Febr	uary 19, 20, 21, 24, 25 and 26,		federal law.	
	2025.	3 - 7 - 7 7 7 7		1000.00.1000	
	Facility number: 01	13753			
	Provider number: 1				
	AIM number: 2013				
	2010				
	Census Bed Type:				
	SNF/NF: 70				
	Total: 70				
	10.001 70				
	Census Payor Type	•			
	Medicare: 5	•			
	Medicaid: 37				
	Other: 28				
	Total: 70				
	10 / 0				
	These deficiencies	reflect State Findings cited in			
		_			
	accordance with 410 IAC 16.2-3.1.				
	Quality review was	s completed on March 3, 2025.			
	Quality 10 view was	. completed on materials, 2023.			
F 0550	483.10(a)(1)(2)(b	)(1)(2)			
SS=D		Exercise of Rights			
Bldg. 00					
	Based on observati	on, interview and record	F 0550	Disclaimer:	03/20/2025
			1 0330		03/20/2023
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
		IDDIOGOTT EIER REI RESENTATIVE S S			
Chelsea K	nox		RN DON		03/18/2025

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

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continued program participation.

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	r í	UILDING	00	COMPLETED	
		155846	B. W	ING		02/26	
		<u> </u>		OTD PPT	ADDRESS CITY STATE ZIP COP		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
RESTO¤	ACY OF CARMEL				EL, IN 46032		
NESTUR				CARIVIE	L, IN 4000Z		
(X4) ID	SUMMARY	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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		failed to ensure urinary			This Plan of Correction consti		
	_	lignity covers in place for 2 of			this facility's written allegation		
		ed for dignity. (Resident 40 and			compliance for the deficiencie		
	52)				cited. However, submission of	f this	
					Plan of Correction is not an		
	Findings include:				admission that a deficiency ex		
					or that one was cited correctly	<b>/</b> .	
	_	vation, on 2/24/25 at 10:28 a.m.,			This Plan of Correction is		
		the TV area and his catheter			submitted to meet requiremen	nts	
	_	dignity cover (a cover which			established by the state and		
		ance of urine in the catheter			federal law.		
	bag).				Alleged deficiency, Foiled to		
	The clinical record	for Resident 40 was reviewed			Alleged deficiency: Failed to ensure urinary catheter bags		
		a.m. The diagnoses included,			dignity covers in place for 2 of		
		d to, benign prostatic			residents reviewed	3	
		obstructive and reflux			Tosiderits reviewed		
	uropathy, and hype				Corrective Action for resider	nt(s)	
	aropamy, and nype				found to have deficiency:	(3)	
	A physician's order	, with a start date of 1/22/23,			Dignity bags were provided fo	r	
		ent had a urinary catheter.			resident 40 and 52.		
		-					
	1	atheter care plan indicated to			Identify other residents havi	•	
	_	e resident to obscure visibility			the same potential deficienc	-	
		with a dignity cover as			Residents that have an indwe	-	
	appropriate.				foley catheter are at risk of ha		
					the same potential deficiency.	An	
	_	w, on 2/24/25 at 10:57 a.m.,			audit was completed on all		
		Nurse (LPN) 4 indicated the			residents that have a foley		
	catheter bag did no	t have a dignity cover.			catheter on 3/7/25 to ensure t	hey	
	2 Danie 1	2/20/25 / 10 22			have a dignity bag.		
	T	vation, on 2/20/25 at 10:23 a.m.,					
		at in the TV area and had a			Measures put into place or	£	
	I -	his chair and did not have a			systemic changes: Director of		
	dignity cover for hi	is urmary catheter.			Nursing or designee educated	ı alı	
	During on absorbes	ion, on 2/24/25 at 10:54 a.m.,			licensed nursing staff that all	~	
	~	it in the TV area and did not			catheters require a dignity bag	J.	
		er for his urinary catheter.			Plan to monitor performance	a to	
	nave a digility cove	of this urmary catheter.			maintain compliance: Directo		

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155846	A. BUILDING B. WING	00	COMPLETED 02/26/2025			
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 616 GREEN HOUSE WAY CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	on 2/21/25 at 10:55 but were not limited neuromuscular dysfi muscle weakness.  A physician's order, indicated the resider urinary retention.  During an interview 4 indicated the cather which needed to be  A current facility por Dignity," dated as a received from the D at 3:00 p.m., indicat standards of care the prohibited. Staff sha	plicy, titled "Quality of Life - pproved in May 2020, and irector of Nursing on 2/25/25 ed "Demeaning practices and at compromise dignity are all promote dignity and assist by: a. Helping the resident to		of Nursing or designee will aud resident with an indwelling fole catheter to ensure they have a dignity bag- 5 residents per wee x4 weeks, 3 residents per week x2 months, and 1 resident per week x3 months. If any compliance trends are identified they will be reviewed in QAPI meetings.	ey eek k			
F 0684 SS=D Bldg. 00	483.25 Quality of Care							
	failed to ensure staff orders regarding me of 2 residents review (Resident 19 and 7) Findings include: 1. The clinical recor on 2/21/25 at 11:42	d for Resident 19 was reviewed a.m. The diagnoses included, to, type 2 diabetes, heart	F 0684	Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.	of s this			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155846	B. W	ING		02/26/	/2025
				STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			REEN HOUSE WAY		
RESTOR	ACY OF CARMEL		CARMEL, IN 46032				
	JAN OF GARWILL				, n1 7000 <u>/</u>		
(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 APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	* *	with a start date of 5/14/24,			Alleged deficiency: Failed to		
		rdralazine (a medication to			ensure staff followed the		
		re) 10 milligrams (mg) every 4			physician's orders regarding		
		a systolic blood pressure			medication administration		
	(SBP) above 170.				Corrective Action for residen	at(c)	
	The medication administration record (MAR)				Corrective Action for resider found to have deficiency: Or		
	indicated the follow				for PRN hydralazine for reside		
		tolic blood pressure was 195.			19 was discontinued. Education		
	hydralazine was no	-			was provided to nursing staff		
	•	tolic blood pressure was 175.			administers medication regard		
	hydralazine was no	-			specific hold orders for reside	•	
	•	stolic blood pressure was 171.					
	hydralazine was no	•			Identify other residents havi	ng	
	-	estolic blood pressure was 179.			the same potential deficienc	_	
	hydralazine was no	t given.			An audit was completed on al	-	
					residents on 3/7/25 to determ	ine if	
	During an interview	y, on 2/24/25 at 11:41 a.m., the			they have hold orders on their	-	
	Director of Nursing	(DON) indicated the			blood pressure medications o	r	
	medication should l	have been given and			PRN blood pressure medicati	ons	
	documented in the	MAR.			and are at risk for the same		
					deficiency.		
	_	y, on 2/25/25 at 11:37 a.m., the					
		could not find any information			Measures put into place or		
		given. It should have been			systemic changes: Director of		
		MAR. 2. The clinical record for			Nursing or designee educated	d all	
		lewed on 2/21/25 at 1:14 p.m.			licensed nursing staff that		
	_	ided, but were not limited to,			administer medications regard	•	
	• •	omuscular dysfunction of the			hold orders and administering		
	bladder, and benign	prostatic hyperplasia.			PRN medications appropriate	ıy.	
	o A physisian's	lar with a start data of 1/21/25			Dian to manitor nonformation	. 4.	
		ler, with a start date of 1/31/25, cubitril-valsartan (a medication			Plan to monitor performance		
	_	ailure) every 12 hours for			maintain compliance: Director		
		nstructions to hold the			of Nursing or designee will au resident with hold orders on the		
		stolic blood pressure was			BP medications- 5 residents p		
	below 110.	sione blood pressure was			week x4 weeks, 3 residents p		
	0010W 110.				week x2 months, and 1 reside		
	The Medication Ad	ministration Record (MAR)			per week x3 months. If any	,, , t	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155846	B. W	ING		02/26/	/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8	616 GREEN HOUSE WAY					
RESTOR	ACY OF CARMEL		CARMEL, IN 46032					
(VA) ID	OID B (A D.Y.	CTATEMENT OF DEPICIENCIE	1	<u> </u>			(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
TAG		-valsartan was administered		IAU	compliance trends are identific		DATE	
		ood pressure below the			they will be reviewed in QAPI	<del>s</del> u,		
	1	-			meetings. Director of Nursing	or		
	ordered hold parameter on 1/31/25.				designee will audit resident wi			
	The MAR indicated	l sacubitril-valsartan was			PRN blood pressure medication			
					5 residents per week x4 week			
administered 3 times with the systolic blood pressure below the ordered hold parameter in					residents per week x2 months			
	February 2025.				and 1 resident per week x3	,		
					months. If any compliance trea	nds		
	b. A physician's ord	ler, with a start date of 9/4/24,			are identified, they will be revi			
		etoprolol succinate (a			in QAPI meetings.			
medication used to lower blood pressure) once a					Ç			
day for hypertension with instructions to hold the medication if the systolic blood pressure was								
	below 110 or if the	heart rate was below 55.						
		I metoprolol succinate was						
	_	(8) times with the systolic						
		w the ordered hold parameter						
		th the heart rate below the						
	ordered noid param	eter in January 2025.						
	The MAR indicated	l metoprolol succinate was						
		4) times with the systolic blood						
		ordered hold parameter and						
	1 ~	he heart rate below the ordered						
	hold parameter in F							
	•	•						
	During an interview	y, on 2/25/25 at 1:46 p.m., the						
	Director of Nursing	(DON) indicated a check mark						
	on the MAR indicat	ted the medication was						
	administered. While	e reviewing the MAR with the						
	DON, she indicated	the medications were						
		he systolic blood pressure						
		e below the ordered hold						
	parameter.							
		4						
		olicy, titled "Medication						
		neral Guidelines Policy," with						
	an approval date of	5/27/20 and received from the	1				İ	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846		JILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>02/26</b> /	ETED
	ROVIDER OR SUPPLIER			616 GR	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0880 SS=D Bldg. 00	DON on 2/26/25 at licensed nurse and/o each resident's medithe physician's order administered in according the attending physician's and administered in according the attending physician's and administered in according to the attending physician's and according to the attending physician and according to the attending and according to the accor	12:00 p.m., indicated "The or the QMA shall administer ications in accordance with rMedications are ordance with written orders of cian"  (e)(f) on & Control on, interview and record failed to ensure catheter bags dirty surface and catheters operly for 3 of 5 residents on control. (Resident 52, 7 and ret bag was resting on his st (a specialty wheelchair). were resting on top of the  (on, on 2/19/25 at 10:12 a.m., a ported the resident to the TV grable.  (d) the placement of the catheter in the placement of the catheter in the resident of the catheter in the placement of the pl	F 03		Disclaimer: This Plan of Correction constit this facility's written allegation compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by the state and federal law.  Alleged deficiency: Failed to ensure catheter bags were not touching a dirty surface and catheters were disposed of properly  Corrective Action for resident found to have deficiency: Catheter bags were disposed residents 7 and 44. Resident 5 catheter bag was adjusted to below his broda chair.	of sthis ists tts  tt  of for 52s nang	03/20/2025
		for Resident 52 was reviewed a.m. The diagnoses included,			Identify other residents having the same potential deficiency	-	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155846	UILDING	ONSTRUCTION  00	(X3) DATE COMPL <b>02/26</b> /	ETED
	PROVIDER OR SUPPLIER	<b>R</b>	616 GR	ADDRESS, CITY, STATE, ZIP COD REEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEPOTE THE PROPERTY OF THE PROPERTY	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	TE	(X5) COMPLETION
TAG	but were not limited neuromuscular dyst muscle weakness.  A physician's order	d to, chronic kidney disease, function of the bladder, and with a start date of 1/21/25, nt had a Foley catheter for	TAG	An audit was completed on all residents that have an indwellicatheter to ensure they have proper placement of their foley and that all other bags have be disposed of properly on 3/7/25	ing / bag een	DATE
	During an interview 4 indicated education for staff about the properties at 1:14 p.m. were not limited to, the bladder and ben	or, on 2/24/25 at 10:57 a.m., LPN on would need to be provided blacement of catheter bags.2. for Resident 7 was reviewed on a. The diagnoses included, but a neuromuscular dysfunction of high prostatic hyperplasia with		Measures put into place or systemic changes: Director on Nursing or designee educated licensed nursing staff regarding proper disposal of foley cathet bags and proper placement of foley bags on wheelchairs.	all g er	
	at 10:38 a.m., a use a trash can next to l indicated his cathet ago and the nurse c	ion and interview, on 2/19/25 d catheter drainage bag was in Resident 7's bed. Resident 7 er bag was leaking a few days hanged the catheter bag.		Plan to monitor performance maintain compliance: Director of Nursing or designee will autresident with foley catheters to ensure catheters are hanging properly and all other catheter bags have been disposed of properly - 5 residents per week weeks, 3 residents per week x months, and 1 resident per weeks x3 months. If any compliance	er dit o k x4 :2 eek	
	medical record to in had been changed a  3. The clinical reco on 2/21/25 at 1:42 plut were not limited dysfunction of the b  During an observat at 10:43 a.m., a cath brown sediment ins	mentation in the electronic ndicate Resident 7's catheter after 2/3/25.  In the diagnoses included, downward to the diagnoses included, downward to the diagnoses included, downward to the diagnoses included, and retention of urine.  In the diagnoses included, downward to the diagnoses included, and retention of urine.  In the diagnoses included, downward to the diagnoses included, and retention of urine.  In the diagnoses included, downward to the diagnoses included, and retention of urine.		trends are identified, they will reviewed in QAPI meetings.	pe	

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S			UILDING	nstruction 00	(X3) DATE COMPI 02/26	ETED	
	PROVIDER OR SUPPLIEF			616 GR	ADDRESS, CITY, STATE, ZIP COD EEN HOUSE WAY EL, IN 46032		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  DEGLE ATORY OF LIGHTENING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	ON BE PRIATE	(X5) COMPLETION
TAG	were hanging on a gastative described and been there for a been hanging in the from her doctor appears and appeared to have be drainage bags. RN 3 indicates appeared to have be drainage bags should after being changed. A current facility peand received from to 2/25/25 at 3:00 p.m. laws guarantee cert of this facility. The rights toa dignification and Cortical provides and sanitary environmental control Programare toProvide comand sanitary environmental current facility peand control programare toProvide comand sanitary environmental current facility per prevention and Cortical planSurveillance	grab bar located in Resident ident 44 indicated the larger ag hanging in her bathroom a month and the leg bag had bathroom since she returned pointment a week ago.  indicated Resident 44 left the grappointment on 2/11/25.  indicated Resident 44 left the grappointment on 2/11/25.  indicated Resident 44 left the grappointment on 2/11/25.  indicated Resident Rights, who is a seen used and all catheter and the catheter drainage bags been used and all catheter and be disposed of properly left.  indicated "Federal and state ain basic rights to all residents are rights include the resident's and existenceequal access to be licy, titled "Infection atrol," with an approval date of ad upon entrance, indicated has an Infection Prevention mThe objectives of the IPCC munity guidelines for a safe mentReview and help I waste management of the workplace to ensure that tices are observed"		TAG	DEFICIENCY		DATE

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