PRINTED: 03/08/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05, 06			(X3) DATE SURVEY COMPLETED	
		155846	B. WING			R (02/2023	
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			•		STREET ADDRESS, CITY, STATE, ZIP CODE 616 GREEN HOUSE WAY CARMEL, IN 46032	,	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS		{K 0	000)}		
	Code Recertification at the exited on 01/11/23	t (PSR) to the Life Safety and State Licensure Survey 3 was conducted by the If Health in accordance with					
	Survey Date: 03/02/2	23					
	Facility Number: 013 Provider Number: 15 AIM Number: 201362	5846					
	found in compliance v Participation in Medic Subpart 483.90(a), Lit 2012 edition of the Na Association (NFPA) 1	are/Medicaid, 42 CFR fe Safety from Fire and the					
	06). Each building is a determined to be of T was fully sprinklered. alarm system with sm corridors, areas open hard-wired smoke det rooms. The entire fac	ype V (111) construction and Each cottage has a fire oke detection in the to the corridors and					
	were sprinklered and	ents have customary access all areas providing facility ered, with exception of a Iministration building.					
	Building 01 is identifie	ed as Cottage #2. The					

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

TITLE (X6) DATE

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.

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		155846	B. WING	B. WING		R 03/02/2023	
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	02/2023
RESTORA	CY OF CARMEL				CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page cottage has a capacit 12 at the time of this s	ry of 12 and had a census of	{K 0)00}			
{K 000}	Quality Review comp INITIAL COMMENTS		{K 0	00)			
	Code Recertification at the exited on 01/11/23	it (PSR) to the Life Safety and State Licensure Survey 3 was conducted by the of Health in accordance with					
	Survey Date: 03/02/2	23					
	Facility Number: 013 Provider Number: 15 AIM Number: 201362	55846					
	found in compliance we Participation in Medic Subpart 483.90(a), Li 2012 edition of the Na Association (NFPA) 1	Restoracy of Carmel was with Requirements for care/Medicaid, 42 CFR fe Safety from Fire and the ational Fire Protection 01, Life Safety Code (LSC), Health Care Occupancies					
	06). Each building is a determined to be of T was fully sprinklered. alarm system with sm corridors, areas open hard-wired smoke derooms. The entire fact had a census of 61 at	ype V (111) construction and Each cottage has a fire noke detection in the					
	An areas where resid	onto have customary access					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05, 06			(X3) DATE SURVEY COMPLETED	
		155846	B. WING			R 03/02/2023	
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL				616 GREE	DDRESS, CITY, STATE, ZIP CODE N HOUSE WAY , IN 46032	03/02/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 4.T.E.	ION
{K 000}	were sprinklered and services were sprinkl separate detached ac Building 02 is identifie	all areas providing facility ered, with exception of a dministration building. ed as Cottage #3. The ty of 12 and had a census of	{K 0	00}			
{K 000}	Code Recertification the exited on 01/11/2 Indiana Department of 42 CFR 483.90(a). Survey Date: 03/02/2 Facility Number: 013 Provider Number: 15 AIM Number: 20136. At this PSR survey, Found in compliance of Participation in Medic Subpart 483.90(a), Li 2012 edition of the Nassociation (NFPA) 1 Chapter 19, Existing and 410 IAC 16.2. The facility consists of 06). Each building is determined to be of T	it (PSR) to the Life Safety and State Licensure Survey 3 was conducted by the of Health in accordance with 23 2753 25846 2150 Restoracy of Carmel was with Requirements for care/Medicaid, 42 CFR ife Safety from Fire and the ational Fire Protection 01, Life Safety Code (LSC), Health Care Occupancies of six buildings (01 through a one-story cottage Type V (111) construction and Each cottage has a fire noke detection in the	{K 0	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 02 , 03 , 04 , 05 , 06		(X3) DATE SURVEY COMPLETED		
		155846	B. WING		R 03/02/2023		
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL			6	TREET ADDRESS, CITY, STATE, ZIP CODE 16 GREEN HOUSE WAY CARMEL, IN 46032	03/	02/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	All areas where reside were sprinklered and services were sprinkle separate detached and Building 03 is identified cottage has a capaciting at the time of this separate detached and Building 03 is identified cottage has a capaciting at the time of this separate detached and Indiana Peparate of the exited on 01/11/25 Indiana Department	tectors in the resident ility has a capacity of 72 and it the time of this survey. The time of	{K 0				
	The facility consists o	f six buildings (01 through					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 , 02 , 03 , 04 , 05 , 06		(X3) DATE SURVEY COMPLETED		
		155846	B. WING		R 03/02/2023		
NAME OF PR	ROVIDER OR SUPPLIER	100040		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	02/2023
RESTORACY OF CARMEL					16 GREEN HOUSE WAY		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	was fully sprinklered. alarm system with sm corridors, areas open hard-wired smoke der rooms. The entire fact had a census of 61 at All areas where reside were sprinklered and services were sprinkle separate detached ac Building 04 is identified cottage has a capacit 12 at the time of this separate detached ac Quality Review complinitial Comments. A Post Survey Revisi Code Recertification at the exited on 01/11/23 Indiana Department of 42 CFR 483.90(a). Survey Date: 03/02/24 Facility Number: 013 Provider Number: 15 Alm Number: 201362 At this PSR survey, Review compliance of the exited on 01/11/23 Provider Number: 15 Alm Number: 201362 At this PSR survey, Review complete the exited on 01/11/23 Provider Number: 15 Alm Number: 201362	a one-story cottage type V (111) construction and Each cottage has a fire to the corridors and tectors in the resident ility has a capacity of 72 and the time of this survey. The time of the time of this survey. The time of this survey. The time of the time of this survey. The time of the time of this survey. The time of this survey. The time of this survey. The time of the time of this survey. The time of the time of this survey. The time of the ti	{K 0				
	Subpart 483.90(a), Li	with Requirements for are/Medicaid, 42 CFR fe Safety from Fire and the ational Fire Protection					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01, 02, 03, 04, 05, 06	(X3	(X3) DATE SURVEY COMPLETED	
		155846	B. WING			R 03/02/2023	
NAME OF PROVIDER OR SUPPLIER RESTORACY OF CARMEL				STREET ADDRESS, CITY, STATE, ZIP C 616 GREEN HOUSE WAY CARMEL, IN 46032	ODE	03/02/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{K 000}	Chapter 19, Existing and 410 IAC 16.2. The facility consists of 06). Each building is determined to be of 1 was fully sprinklered, alarm system with sn corridors, areas oper hard-wired smoke de rooms. The entire fact had a census of 61 at All areas where resid were sprinklered and services were sprinkler	Health Care Occupancies of six buildings (01 through a one-story cottage Type V (111) construction and Each cottage has a fire moke detection in the a to the corridors and stectors in the resident cility has a capacity of 72 and at the time of this survey. Idents have customary access all areas providing facility ered, with exception of a dministration building. Led as Cottage #5. The try of 12 and had a census of urvey. Idented on 03/07/23 It (PSR) to the Life Safety and State Licensure Survey 3 was conducted by the of Health in accordance with	{K 0				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG 01, 02, 03, 04, 05, 06		(X3) DATE SURVEY COMPLETED		
		155846	B. WING			R 02/02/2022	
	ROVIDER OR SUPPLIER	100040		STREET ADDRESS, CIT 616 GREEN HOUSE W CARMEL, IN 46032	VAY	03/02/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)		
{K 000}	At this PSR survey, F found in compliance Participation in Medic Subpart 483.90(a), L 2012 edition of the N Association (NFPA) Chapter 19, Existing and 410 IAC 16.2. The facility consists of the Complex of the Compl	Restoracy of Carmel was with Requirements for care/Medicaid, 42 CFR ife Safety from Fire and the ational Fire Protection 101, Life Safety Code (LSC), Health Care Occupancies of six buildings (01 through a one-story cottage Type V (111) construction and Each cottage has a fire noke detection in the a to the corridors and tectors in the resident cility has a capacity of 72 and at the time of this survey. The same of this survey. The same of the survey of the	{K 0	00}			