STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF CARMEL	616 GREEN HOUSE WAY CARMEL, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00407963 and IN00411683. Complaint IN00407963-Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00411683-Federal/State deficiencies related to the allegations are cited at F686. Survey dates: June 29, 30, and July 3 and 5, 2023 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 2 Medicaid: 31 Other: 38 Total: 71 These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 12, 2023.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. Upon review of our submitted Plan of Correction, we request that a desk review considered to ensure our compliance with these citations.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bryan Lindsay | Administrator | 07/24/2023

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 continued program participation.

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure the physician's pressure ulcer orders were transcribed to the ETAR (Electronic Treatment Administration Record) and failed to ensure a resident's pressure ulcer treatment was completed as ordered by the physician for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Finding includes: An anonymous concern was emailed to the Indiana Department of Health office indicating Resident B's pressure ulcer was not cared for by the facility in an appropriate manner. The record for Resident B was reviewed on 7/3/23 at 11:00 a.m. Diagnoses included, but were not limited to, pressure ulcer left hip stage 4 (6/2/23), type II diabetes mellitus, pressure ulcer sacral region (5/8/23), urinary tract infection (UTI), dependence on wheelchair, cognitive communication deficit, and osteomyelitis (infection of a bone) (6/2/23). A care plan addressed the problem he had a pressure injury to the left ischium related to immobility, impaired bed mobility, obesity, sensory issues, edema, diabetes mellitus,	F 0686	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Facility failed to ensure the physician's pressure ulcer orders were transcribed to the ETAR (Electronic Treatment Administration Record) and failed to ensure a resident's pressure treatment was completed as ordered by the physician. **Corrective Action for resident(s) found to have deficient:** Medical Director notified of transcription error of pressure ulcer treatment for resident B, resulting in treatment not being	07/31/2023

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	friction/shear, osteomyelitis, and had a wound vac (a negative-pressure wound therapy, which used vacuum assisted closure using a suction pump, tubing and a dressing to remove excess drainage and to promote healing in acute or chronic wounds) per physician orders. Approaches included, but were not limited to, administer treatments as ordered and monitor for effectiveness. The admission physician's orders dated June 21, 2023, and ETAR (Electronic Treatment Administration Record) dated June 2023, were reviewed and the following orders were not transcribed onto the ETAR as ordered: a. Order date-6/3/23. Start date-6/5/23. NPWT (Negative-Pressure Wound Therapy) (wound vac) for stage 4 pressure ulcer: Left Ischium. Change black foam and drape every Monday and Thursday and PRN for soilage/dislodgement. If unable to form a seal, see PRN Vashe treatment. b. Order date-6/6/23. Start date-6/6/23. Vashe Wound Therapy External Solution (Wound Cleaners). Apply to Left Ischium ulcer. Cleanse ulcer to Left Ischium with wound cleanser or NS, pat dry, apply skin prep to peri wound then pack wound bed with Vashe soaked gauze, and cover with ABD pad and secure. The progress notes were reviewed, which included, but were not limited to, the following notes: a. On 6/2/23 at 1:20 p.m., Resident B was readmitted to the facility for skilled nursing care (dressing changes to his left Ischial wound) and rehabilitation. b. On 6/2/23 at 4:27 p.m., a wound vac was placed on the resident's left Ischial pressure wound.		completed per order, prior to survey exit. **Identify other residents having the same potential deficiency:** Resident's with pressure ulcers with treatments who are currently residing in the facility. All current residents have been audited by the Director of Nursing and Assistant Director of Nursing, ensuring all resident with pressure ulcers have treatment orders properly transcribed onto the ETAR, to allow nursing staff to visualize and perform the order. No other residents were identified as affected. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to the license nurses on the policy/procedures for transcribing pressure ulcer treatment orders appropriately onto the ETAR, by the day of compliance. PRN nurses will receive education prior to their first scheduled shift. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will audit all treatment orders for pressure ulcers by next business day for a minimum of 6 months until 100% of compliance is	

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	c. On 6/5/23 at 11:50 a.m., the resident was admitted to the facility after a hospital stay related to sepsis (a blood infection). He was admitted with a Stage 4 pressure ulcer to the left Ischium. New orders were received for a wound vac to the left ischial pressure ulcer and the wound center group to evaluate and treat. d. On 6/15/23, there was no documentation in the progress notes regarding the residents wound vac dressing being changed on this date, which was a Thursday. e. On 6/21/23 at 3:49 p.m., the resident was soiled when he was transferred from the wheelchair to the bed. His wound vac was not connected when he was transferred to the bed. There were no alerts sounding and the wound vac was at the correct settings providing suction. The aide notified the nurse the resident's wound vac was dislodged and there was "a lot" of drainage. The resident's wife told the nurse there was no dressing over the resident's wound, so the wound was just left open. The nurse viewed the wound, which had black foam in it. There was a large amount of sanguineous drainage (this type of drainage indicated the leakage of fresh blood produced by the open wound, which was typically associated with blood vessel damage) and a mild odor. The bed pad was changed and had an excessive amount of blood and a foul odor on it. The wife wanted the resident sent to the ER, so the nurse sent him to the ER. The resident was admitted to the hospital for an infection to the pressure ulcer to his left ischial area and pneumonia. A hospital ER record indicated, on 6/21/23 at 1:07 a.m., Resident B's wife was concerned the		maintained. Audit will ensure orders are transcribed properly on the ETAR to allow nursing staff to visualize and perform orders. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 7/31/23**	

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	resident's left perineal wound was not taken care of properly. She was concerned about his decubitus care, which she indicated it was draining/leaking around the wound vac for the last two days. He was admitted to the ER without a wound vac or wound packing in place to his ischial pressure ulcer. He had increased drainage from the wound. Wound notes from the hospital indicated the wife had noticed increased purulent drainage (sign of infection, made up of white blood cells trying to fight the infection and any bacteria pushed out of the wound and it may have an odor) from the wound along with worsening foul odor, the wound vac was not working or was being applied incorrectly at the facility. The wife indicated the wound vac had been off the resident for a day and she thought the wound might be infected. During an interview, on 7/3/23 at 1:50 p.m., the DON (Director of Nursing) indicated there were no orders on Resident B's ETAR to indicate the wound vac to his left Ischium was changed. She did not know why his wound vac orders did not show up on his ETAR. The facility did not send the wound vac to the hospital with the resident because they are rented pieces of equipment, but he should have had packing in the wound with a dressing covering the wound. The nurse sending him to the ER was most likely in a hurry and did not get time to check his wound dressing prior to sending him out 911. During an interview, on 7/3/23 at 3:42 p.m., the ADON (Assistant Director of Nursing) indicated she placed the wound vac orders into the computer on the ETAR on 6/5/23. She must have forgotten to click the TAR box before she submitted the orders, so the orders did not show			

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	up on the TAR for the nurses to know what the wound vac dressing orders were to change it as ordered by the physician. A current policy, titled "Wound Care," dated 5/2020 and provided by the DON (Director of Nursing) on 7/5/23 at 2:00 p.m., indicated "...Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: Verify that there is a physician's order for this procedure...." This Federal tag relates to Complaint IN00411683. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident with a diagnosis of dementia and who was identified as a high risk for falls was free from injury after she was left unattended on the toilet by a CNA for 1 of 3 residents reviewed for accidents. (Resident H) Finding includes: The record for Resident H was reviewed on 7/5/23 at 11:14 a.m. Diagnoses included, but were not limited to, Parkinson's disease, need for assistance	F 0689	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements	07/31/2023

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	with personal care, lack of coordination, unsteadiness on feet, urgency on urination, difficulty in walking, and abnormalities of gait and mobility. A Quarterly MDS (Minimum Data Set) assessment, dated 6/19/23, indicated the resident's BIMS (Brief Interview for Mental Status) assessment score was 7, which indicated she was severely cognitively impaired. She required an extensive assist of one person for transfers and toilet use. Her balance moving from a seated to standing position, moving on and off the toilet, from one surface to another, and walking with an assistive device was coded as 2 which meant she was not steady, and only able to stabilize with human assistance. Her active diagnoses included, but were not limited to, progressive neurological condition, Parkinson's disease, and dementia. Resident B's care plans were reviewed, which included, but were not limited to, the following care plans: The resident had a Care Plan, which addressed the problem she exhibited impaired cognitive function, impaired thought processes and short-term memory loss related to dementia without behaviors, Parkinson's Disease, hallucinations, delusional disorder, insomnia, history of transient ischemia attacks. (Initiated 7/25/2017). Approaches included, but was not limited to, 7/27/17-cue, reorient and supervise as needed. A care plan addressed the problem she had a history of falls and was at risk for falls with injury due to unsteadiness at times related to Parkinson's disease. Approaches included, but were not limited to, riser over the toilet, encourage resident to stay in common area when up and in wheelchair, offer assist to the bathroom upon		established by the state and federal law. **Alleged deficiency:** Facility failed to ensure a resident with a diagnosis of dementia and who was identified as a high fall risk was free from injury after she was left unattended on the toilet. **Corrective Action for resident(s) found to have deficient:** Executive Director had provided 1:1 education with the staff member who was involved in this incident, prior to survey entering. **Identify other residents having the same potential deficiency:** Resident's with a diagnosis of dementia and are identified as a high fall risk who are currently residing in the facility. All current residents have been audited by the Director of Nursing and Assistant Director of Nursing, ensuring all residents with dementia and are identified as a high fall risk are appropriately marked on the CNA's resident guide sheet. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to all nursing staff identifying residents who have a diagnosis of dementia and are identified as a high fall risk, on	

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	rising, before and after meals and at bedtime, assist to the bathroom nightly between 5 a.m. to 6 a.m., offer resident assistance to toilet every two hours when up in wheelchair. A care plan addressed the problem she had the potential risk for an ADL (Activity of Daily Living) self-care performance deficit related to dementia and Parkinson's disease. She required assistance due to impaired coordination/balance with lower body tasks. Approaches included, but were not limited to, Toilet use: the resident required limited assist by one staff for toileting, and transfer: the resident required assistance of one staff member with transfers to move between surfaces. Resident B's Morse Fall Scale score, dated 3/24/23, indicated her score was 65. The scoring indicated 45 or higher indicated a high risk for falls. She had previous falls on 2/23/23, 3/4/23, 3/8/23, and 5/1/23. On 5/3/23 at 8:08 p.m., she fell off the toilet. A progress note, dated 5/3/23 at 8:03 p.m., indicated Resident B was found on her bathroom floor with a laceration to her head. She was being toileted by CNA 1 when she left her unattended on the toilet to grab some missing supplies. CNA 1 instructed the resident to wait on the toilet seat with her wheelchair placed underneath the sink. When CNA 1 returned to the resident's bathroom, Resident B was found on the bathroom floor on her left side, with her pants down at her ankles and her pull-up was at her mid-thighs. Blood was noted on the bathroom floor due to a laceration (two centimeters long), as well as blood on each side of the corner of the wall. The laceration was cleansed, then steri-strips were applied.		their resident guide sheet. PRN nursing staff will receive education prior to their first scheduled shift. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will audit new admission and resident care sheet by the next business day, for a minimum of 6 months until 100% of compliance is maintained. Audit will ensure those with a diagnosis of dementia and identified as a high fall risk are identified for nursing staff. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 7/31/23**	

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	A progress note, dated 5/4/23 at 2:52 p.m., indicated the IDT (Interdisciplinary Team) met to discuss the fall which occurred on 5/3. Resident B was found on the floor in her bathroom with a laceration to her head. She was being toileted by CNA 1, then she left the resident unattended to gather supplies in another area other than the bathroom. When CNA 1 returned the resident was laying on the floor on her left side. The resident had a two-centimeter-long laceration to the middle of her forehead. Staff education given to CNA 1 on not leaving residents alone when on the toilet. A document, titled "Non-ulcer Weekly Skin Assessment," dated 5/3/23 at 3:50 p.m., indicated the resident had a laceration due to a fall, which measured 2.0 by 0.2 by 0.2 cm (centimeters), which was steri-stripped closed. It had a moderate amount of sanguineous (bloody) drainage. A current untitled and undated document, provided by the DON on 7/5/23 at 4:28 p.m., which indicated to the CNAs and nurses how to care for the residents listed Resident B's care on the sheet. The "Needs" section indicated to "Restroom often," but did not indicate to not leave the resident alone on the toilet. A document, titled "Teachable Moment," dated 5/4/23 and provided by the DON (Director of Nursing) on 7/5/23 at 1:20 p.m., indicated the ED (Executive Director) gave CNA 1 a teachable moment regarding she left a resident who was a high fall risk alone in the bathroom. The teachable moment indicated residents who were impulsive should not be left on alone on the toilet. CNA 1 indicated she knew residents should not be left alone on the toilet and it would not happen again. She had stepped out of the room to get supplies and did not think anything would happen. CNA 1			

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	was provided with education to ensure supplies such as gloves, wipes and briefs were available before helping the residents to the toilet. During an interview, on 7/5/23 at 3:17 p.m., the ED (Executive Director) indicated he gave CNA 1 a teachable moment for leaving Resident B alone on the toilet and she fell. During a phone interview, on 7/5/23 at 3:20 p.m., CNA 1 indicated on 5/3/23 at approximately 4:00 p.m., she left Resident B alone on the toilet to go to the next room to grab some wipes and when she got back to the bathroom, she found the resident on the floor with a cut to her forehead. She instructed the resident to sit on the toilet until she got back from the other room. She did not give her the call light to call for assistance. CNA 1 knew Resident B was a high fall risk and had fallen on previous occasions. She was given a teachable moment from the ED for leaving Resident B on the toilet alone. A current policy, titled "Falls-Clinical Protocol," dated 5/20/20 and provided by the DON on 7/5/23 at 2:00 p.m., indicated "...The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. a. Risk factors for subsequent falling include...musculoskeletal abnormalities...gait and balance disorders, cognitive impairment, weakness...confusion... and illnesses affecting the central nervous system...Cause Identification: 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall...Often, multiple factors in varying degrees contribute to a falling problem...After more than one fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling...If underlying			

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	causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reasons identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). Monitoring and Follow-Up...The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented...." This Federal tag relates to Complaint IN00407963. 3.1-45(a)(2)			