STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Health & Living Community	118 Medical Dr 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident received supervision during incontinence care to prevent the resident from being rolled off the bed onto the floor for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B being hospitalized with an eight-millimeter frontal subdural hematoma.Findings include:During an interview, on 11/12/25 at 2:31 p.m., a family member of Resident B indicated she received a telephone call, on 10/1/25 at 6:00 a.m., Resident B had rolled out of bed when an aide was in the room. Typically, there were two staff members with her when care was provided due to Resident B's weight. She did not know where the other person was at the time of the fall. The resident was admitted to the hospital with a traumatic brain injury and bleeding on the brain.The clinical record for Resident B was reviewed on 11/13/25 at 11:50 p.m. The diagnoses included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis following a cerebral infarction which affected the left non-dominant side, and depression.An Occupation Therapy (OT) note, dated 9/30/25, indicated Resident B demonstrated left lateral leaning while in bed and required total assistance to reposition her hips and trunk to midline.A facility post-fall assessment, dated 10/1/25 at 5:50 a.m., indicated Resident B was lying in a supine position next to the bed after a witnessed fall. The resident was lying in bed prior to the fall. Staff were providing care to the resident, so she was partially clothed when she rolled out of the bed onto the floor. She was incontinent with urine. She received a skin tear to her bilateral arms and foot. She hit her head, so neuro checks were initiated, and she was sent to the hospital.A physician's progress note, dated 10/1/25 at 5:47 a.m., indicated Resident B had a witnessed fall earlier. She rolled out of bed during incontinent care in preparation for dialysis. She rolled over, rolled too far, and ended up on the floor. She attempted to grab the bed to prevent the fall and sustained three skin tears on her bilateral hands and feet with bleeding secondary to anticoagulation. She had a large skin tear observed on the right forearm and left hand. She also had a small skin tear on her right foot. She complained of back pain.A hospital neurosurgery consultation note, dated 10/1/25 at 9:15 a.m., indicated Resident B was brought into the hospital due to a fall at her facility. The resident indicated she was weak on her left side from a stroke. The facility staff rolled her but did not catch her and she rolled onto the floor. Imaging revealed a subdural hematoma (a type of bleeding inside the head where blood collects under the brain's outer covering. The blood collection could press against the brain and cause damage, was often life-threatening, and commonly resulted from a head injury). Neurosurgery was consulted. She complained of neck pain. Her CT (Computed Tomography) scan indicated she had an eight-millimeter-thick right frontal convexity subdural hematoma.A facility document, dated 10/2/25, indicated CNA 4 was educated on safe bed mobility assistance for residents. Staff were expected to provide proper bed mobility assistance using safe techniques to prevent resident falls and injuries. This included maintaining close supervision and ensuring bed height and the rails were adjusted as needed. Failure to follow the above expectations would result in progressive counseling, up to and including formal write-ups.A facility document, dated 10/2/25, indicated LPN 5 was educated on not leaving the room during care. Staff were expected to remain with the residents throughout the duration of care to ensure safety, provide assistance as needed, and maintain resident dignity. Leaving the resident during care was not acceptable and posed a risk of falls, injury, and emotional distress. Staff must complete the care task before exiting the room and ensure the residents were safe and comfortable prior to leaving the room. Failure to follow the above expectations would result in progressive counseling, up to and including formal write-ups.During an interview, on 11/12/25 at 11:43 a.m., the Executive Director (ED) indicated Resident B did not come back to the facility after her discharge from the hospital.During an interview, on 11/12/25 at 2:06 p.m., Speech Therapist 2 indicated Resident B's physical therapy evaluation indicated she was dependent on all activities of daily living care, which indicated she required a two-person physical assist for bed mobility. The evaluation recommended a Hoyer lift for transfers, which required a two-person physical assist. During an interview, on 11/12/25 at 2:24 p.m., CNA 3 indicated Resident B was a two-person physical assist for bed mobility due to the resident being unable to assist staff with turning. Each side of her bed was open to the room. She did have assist bars on her bed, which she was able to hold onto to steady herself. During an interview, on 11/12/25 at 3:07 p.m., CNA 4 indicated, on 10/1/25 at approximately 5:10 a.m., Resident B turned her call light on because she was incontinent with bowel and bladder and needed to be changed. CNA 4 and LPN 5 cleaned the resident up, but while cleaning her up, they noticed her bottom was excoriated. LPN 5 left the room to get some cream to treat her excoriated bottom. Resident B was lying on her left side facing the window. CNA 4 was on the