STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Restoracy of Carmel	616 Green House Way Carmel, IN 46032

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure new residents were correctly screened for tuberculosis and staff wore protective gowns for enhanced barrier precautions for 5 of 7 residents reviewed for infection control. (Resident 18, 40, 43, 66 and 54)Findings include:1. The clinical record for Resident 18 was reviewed on 2/19/26 at 2:35 p.m. The diagnoses included, but were not limited to, hypertensive encephalopathy, hypertensive heart disease with heart failure, and hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side. a. The Medication Administration Record (MAR), dated January 2026, indicated Resident 18 was given a tuberculin test on 1/6/26 at 11:27 p.m. The test was not read on 1/8/26 or 1/9/26 (48 to 72 hours after administration) due to the resident being out of the facility on leave of absence with his son. A nursing progress note, dated 1/9/26 at 5:29 p.m., indicated the tuberculin test was not read due to the resident being out of the facility. b. The MAR, dated January 2026, indicated the 2nd step test was administered on 1/20/26 at 10:52 p.m., and was read on 1/22/26 at 6:19 p.m. This was not 48 to 72 hours after administration. During an interview, on 2/20/26 at 10:30 a.m., the ADON (Assistant Director of Nursing) indicated a two (2) step tuberculosis test was needed at the time of admission and should be read within the 48-to-72-hour window, not too early or too late. 2. The clinical record for Resident 40 was reviewed on 2/19/26 at 10:01 a.m. The diagnoses included, but were not limited to, traumatic hemorrhage of the left cerebrum with unknown loss of consciousness, traumatic subdural hemorrhage, and paroxysmal atrial fibrillation. The MAR, dated February 2026, indicated a tuberculin test was administered on 2/8/26 at 6:10 p.m., and was read on 2/10/26 at 9:44 a.m. This was not 48 to 72 hours after administration. 3. The clinical record for Resident 43 was reviewed on 2/18/26 at 2:49 p.m. The diagnoses included, but were not limited to, Parkinson's disease, congestive heart failure, retention of urine, dysphagia, type 2 diabetes mellitus, and obstructive and reflux uropathy. The MAR, dated February 2026, indicated a tuberculin test was administered on 2/2/26 at 10:02 p.m., and was read on 2/4/26 at 5:30 p.m. This was not 48 to 72 hours after administration. The MAR, dated February 2026, indicated the second step tuberculin test was administered on 2/16/26 at 9:02 p.m., and was read on 2/18/26 at 5:02 p.m. This was not 48 to 72 hours after administration. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a wound care observation, on 2/19/26 at 11:02 a.m., Licensed Practical Nurse (LPN) 2 was not wearing a gown when completing the wound care for Resident 66's pressure ulcer. The clinical record for Resident 66 was reviewed on 2/19/26 at 2:48 p.m. The diagnoses included, but were not limited to, type 2 diabetes, chronic diastolic heart failure, and long- term use of insulin. The nursing progress notes indicated Resident 66 was diagnosed with a stage 3 pressure ulcer of the heel on 1/19/26. A physician's order, dated 1/19/26, indicated the resident required Enhanced Barrier Precautions due to a foley catheter. During an interview, on 2/20/26 at 10:38 a.m., the Assistant Director of Nursing (ADON) indicated staff were supposed to wear gowns during wound care for pressure ulcers. 5. During a catheter care observation for Resident 54, on 2/19/26 at 11:19 a.m., Qualified Medication Aide (QMA) 7 wore a cloth hospital gown for Personal Protective Equipment (PPE). The clinical record for Resident 54 was reviewed on 2/19/26 at 11:01 a.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy, benign prostatic hyperplasia, and other disorders of the kidney and ureter. A physician's order, dated 9/10/25, indicated Resident 54 required enhanced barrier precautions due to a suprapubic catheter. A current care plan, dated 9/10/25, indicated Resident 54 was on enhanced barrier precautions and the direct care staff were to utilize gowns and gloves for all personal care. During an interview, on 2/20/26 at 10:38 a.m., the Assistant Director of Nursing (ADON) indicated the facility was getting rid of all their reusable gowns and using disposable. The staff were supposed to be wearing disposable gowns when doing catheter care. A current facility policy, titled Screening Residents for Tuberculosis, dated 5/20/20 and provided by the Executive Director on 2/19/26 at 4:10 p.m., indicated . Admitting and readmitting residents will be tested for .TB disease within 3 days of admission, utilizing the tuberculin skin tests .adhere to the state regulations for screening of new admissions or readmissions related to the screening for tuberculosis infection and disease A current CDC healthcare education document, titled Tuberculin Skin Testing Information for Health Care Providers, downloaded from https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_ on 2/20/26 at 9:36 a.m., indicated .The skin test should be read between 48 and 72 hours after administration.The reasons for .false-negative reactions may include .incorrect method of giving the TST. A current facility policy, titled Enhanced Barrier Precautions, dated as approved 4/1/24 and received from the Executive Director on 2/19/26 at 9:10 a.m., indicated .Enhanced Barrier Precautions indications.Residents with chronic wounds and/or indwelling medical devices, even without a known MDRO infection or colonization. A. Chronic wounds include, but are not limited to, pressure ulcers, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diabetic foot ulcers, non-healing surgical wounds, and venous ulcers. B. Indwelling medical devices include central lines (including PICC), urinary catheter, feeding tubes.Enhanced Barrier Precautions will be utilized only during prolonged high-contact resident care activities. Examples include but not limited to.Device care or use: Central line (including PICC), urinary catheter.Wound care of chronic wounds. 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(e)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the physician was notified of a three (3) pound weight gain according to the physician's order for 1 of 3 residents reviewed for notification of change. (Resident 4)Findings include:The clinical record for Resident 4 was reviewed on 2/17/26 at 3:10 p.m. The diagnoses included, but were not limited to, heart failure, stage 3 chronic kidney disease, and type 2 diabetes.A care plan indicated Resident 4 was at risk for potential alteration of nutrition and weight status. Interventions included, but were not limited to, obtain and evaluate weights as ordered and notify the physician and family of any significant changes.A physician's order, with a start date of 10/3/24 and an end date of 1/7/26, indicated to weigh Resident 4 every Monday and Thursday and to notify the Nurse Practitioner (NP) for a weight increase of three (3) pounds.The following weights were documented in the clinical record:a. On 9/22/25, the weight was 239 pounds. On 9/25/25, the weight was 242.2 pounds. This was a gain of three (3) pounds or more.b. On 10/16/25, the weight was 241 pounds. On 10/20/25, the weight was 248.3 pounds. This was a gain of three (3) pounds or more.c. On 12/1/25, the weight was 227 pounds. On 12/3/25, the weight was 230.2 pounds. This was a gain of three (3) pounds or more.During an interview, on 2/19/26 at 9:51 a.m., Licensed Practical Nurse (LPN) 2 indicated the weight gain notification to the provider would be documented in the progress notes and she could not find the documentation in the clinical record.During an interview, on 2/19/26 at 3:38 p.m., the Director of Nursing (DON) indicated the facility could not find the notifications for Resident 4's weight gain and it should have been documented in a progress note. The facility could not find the documentation. A current facility policy, titled Weight and Height of Resident, dated as approved 5/20/20 and received from the Executive Director on 2/20/26 at 9:42 a.m., indicated .Report significant weight loss/weight gain to the nurse supervisor.Report other information in accordance with facility policy and professional standards of practice.3.1-5(a)(2)3.1-5(a)(3)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper discharge information was documented in the electronic health record for 3 of 6 residents reviewed for discharge. (Resident 5, 6 and 77)Findings include:1. The clinical record for Resident 5 was reviewed on 2/18/26 at 2:28 p.m. The diagnoses included, but were not limited to, repeated falls, traumatic subdural hemorrhage without loss of consciousness, and dementia.A nursing progress note, dated 1/6/26 at 8:00 p.m., indicated an order was received to send Resident 5 to the emergency room for an evaluation and treatment.A nursing progress note, dated 1/6/26 at 8:10 p.m., indicated an EMT (emergency medical technician) arrived at the facility to transport Resident 5 to the hospital.Resident 5 was discharged from the facility and admitted to the hospital from [DATE] to 1/9/26.The electronic health record did not contain documentation a report was called to the receiving facility, special instructions or precautions for ongoing care were provided, a copy of Resident 5's discharge summary, and a copy of the bed hold policy was provided to the resident at the time of discharge.2. The clinical record for Resident 6 was reviewed on 2/18/26 at 12:53 p.m. The diagnoses included, but were not limited to, unsteadiness on feet, multiple fractures of ribs on the right side, and laceration without foreign body of other part of head.A nursing progress note, dated 12/23/25, indicated Resident 6 was sent to the hospital for treatment.Resident 6 was discharged from the facility and admitted to the hospital from [DATE] to 1/5/26.The electronic health record did not contain documentation a report was called to the receiving facility, special instructions or precautions for ongoing care were provided, a copy of Resident 6's discharge summary, and a copy of the bed hold policy was provided to the resident at the time of discharge.3. The clinical record for Resident 77 was reviewed on 2/17/26 at 3:29 p.m. The diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, and amyotrophic lateral sclerosis (ALS).A nursing progress note, dated 1/19/26, indicated EMT arrived at the facility to transport Resident 77 to the hospital.Resident 77 was discharged from the facility to the hospital on 1/19/26.The electronic health record did not contain documentation a report was called to the receiving facility, special instructions or precautions for ongoing care were provided, a copy of Resident 77's discharge summary, and a copy of the bed hold policy was provided to the resident at the time of discharge.During an interview, on 2/18/26 at 1:44 p.m., the Executive Director (ED) indicated the facility did not utilize the electronic health records transfer/discharge assessment. The nurse would gather all information needed, call report to the receiving facility, document all required information in a progress note, and all appropriate paperwork would be sent with EMS (emergency medical service).During an interview, on 2/19/26 at 11:56 a.m., LPN (Licensed Practical Nurse) 2 indicated when a resident was transferred or discharged to the hospital the nurse would send a transfer sheet which would include: the resident's face sheet, medication list and when the medication was last administered, the resident's demographics, and the bed hold policy with EMS. LPN 2 indicated the facility did not have a specific assessment or document for what occurred with the resident, who report was given to, or where the resident was being transferred and the nurse should document the information in a progress note.During an interview, on 2/20/26 at 10:45 a.m., the Assistant Director of Nursing (ADON) indicated the protocol for discharging a resident would be to obtain an order from the physician for the resident to be sent to the hospital, call and inform the resident's family of the need and to get family approval for the transfer, contact EMS for transport and inquire where the resident would be transferred to, call report to the appropriate facility, print the resident's face sheet, medication list, POST form, bed hold and send all documents in the discharge packet to the hospital, then document all of this in a progress note.A current facility policy, titled Transfer or Discharge Documentation, dated 5/20/20 and received from the ED on 2/19/26 at 1:42 p.m., indicated .When a resident is transferred or discharged , details of this transfer or discharge will (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider.When a resident is transferred or discharged from the facility, the following information will be documented in the medical record.The basis for the transfer or discharge.That an appropriate notice was provided to the resident and/or legal representative.The date and time of the transfer or discharge.The new location of the resident.The mode of transportation.A summary of the resident's overall medical, physical, and mental condition.Disposition of personal effects.Disposition of medications.Others as appropriate or as necessary and.The signature of the person recording the data in the medical record.Should the resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider.The basis for the transfer or discharge.All special instructions or precautions for ongoing care.comprehensive care plan goals.All other necessary information, including a copy of the residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.3.1-12(a)(6)(A)(i)3.1-12(a)(6)(B)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASSAR) level I screen contained current mental health diagnoses and mental health medications for 1 of 2 residents reviewed for PASSAR. (Resident 75) The deficient practice was corrected on 2/12/26, prior to the start of the survey, and was therefore past noncompliance.Findings include:The clinical record for Resident 75 was reviewed on 2/19/26 at 8:48 a.m. The diagnoses included, but were not limited to, depression, anxiety, insomnia, and dementia.A PASSAR level I screen, dated 7/9/25, indicated no current or past mental health diagnoses were known or suspected. The current or past mental health medications were buspirone (an anxiety medication) and trazodone (used to treat insomnia and sometimes used to treat depression). The diagnosis for both medications was listed as unknown. The level I screen indicated there was no evidence of an intellectual/developmental disability or a serious behavioral health condition and if changes occurred or new information refutes the findings, a new screen must be completed.The PASSAR level I did not include accurate diagnoses of depression, anxiety or dementia and did not include accurate medication dosage or accurate prescribed mental health medications.A physician's order, dated 7/11/25 and discontinued 1/15/26, indicated Resident 75 received buspirone 5 milligrams (mg) twice a day related to anxiety. A physician's order, dated 7/21/25, indicated Resident 75 received duloxetine (an antidepressant medication) 60 mg related to depression.The care plans, dated 7/14/25, indicated Resident 75 received an antianxiety medication related to anxiety and an antidepressant medication related to depression.During an interview, on 2/19/26 at 12:19 p.m., the Executive Director (ED) indicated the facility had conducted an audit on PASSAR's earlier in the month (February) and found several level I screenings had not been updated.During an interview, on 2/19/26 at 3:27 p.m., the Social Service Director (SSD) indicated she had conducted an audit for level I PASSAR's to ensure all the information on the PASSAR's was correct and had found several which needed to be resubmitted.A current facility policy, titled Preadmission Screening and Resident Review (PASSR)/(LOC), dated 4/25/24 and received from the ED on 2/19/26 at 12:28 p.m., indicated .ensure all residents have the required screenings. This includes Level 1 PASSR, Level 2 PASSR, and Level of Care. It is the responsibility of the Business Office Manager, Social Service Director, MDS nurse, and/or designee to complete and/or track.ensuring new admission Level 1 PASSR are accurate.initiate a new Level 1, when a resident meets the qualifications.Level 1 completion procedure must be completed within 72 hours by the assigned or designated team member.Diagnosis-Assigned to Social Service Director.Mental Health Medications-Assigned to Social Service Director.This deficient practice was corrected by 2/12/26 after the facility implemented a systemic plan that included the following actions: an audit of all PASSARs were completed to ensure all information was correct, updated PASSARs were submitted if incorrect information was found, all new admission PASSARs are audited by the next business day to ensure the hospital or previous facility completed the PASSAR appropriately and are resubmitted if the previous facility information was incorrect, in-service education was conducted for all staff members responsible for ensuring PASSAR accuracy and completion.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure a medication cart was free of expired medications for 1 of 3 medication carts reviewed for medication storage and labeling. (Cottage 3)Findings include:The Cottage 3 medication cart was reviewed on 2/19/26 at 11:33 a.m. The following was observed:a. In the narcotic lock box, lorazepam (an antianxiety medication) with an unknown prescription filled date and a quantity of 30 out of 30 was past the expiration date of 1/15/26.b. In the narcotic lock box, lorazepam with an unknown prescription filled date and a quantity of 4 out of 30 was past the expiration date of 12/18/25.During an interview, on 2/19/26 at 11:33 a.m., QMA (Qualified Medication Aide) 7 indicated pharmacy audited the medication carts monthly and the nurses would also monitor for expired medications.During an interview, on 2/19/26 at 2:05 p.m., the Executive Director (ED) indicated the facility did not have a policy regarding medication cart audits.A current facility policy, titled Storage of Medications, dated 5/20/20 and received from the ED on 2/19/26 at 1:42 p.m., indicated .The facility stores all drugs and biologicals in a safe, secure, and orderly manner.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.A current facility policy, titled Pharmacy services, dated 5/20/20 and received from the ED on 2/19/26 at 1:42 p.m., indicated .Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice.3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure refrigerated food was not expired and refrigerators were maintained at proper temperatures for food safety for 2 of 6 refrigerators reviewed (Cottage 6) which supplied food to 2 of 6 cottages. (Cottage 1 and Cottage 6)Findings include:The kitchen in Cottage 6 was reviewed on 2/16/26 at 10:05 a.m. The following was observed:1. Refrigerator 2 which contained, but were not limited to, dairy products and mayonnaise.a. A tub of ricotta cheese with an expiration date of 2/13/26 was opened and less than half of the ricotta cheese remained in the container. Next to the opened and expired container was an unopened tub of Ricotta cheese with an expiration date not yet surpassed.b. An internal thermometer sat on the back of the top shelf and read fifty (50) degrees Fahrenheit.2. Refrigerator 3 which contained, but were not limited to, milk and condiments.a. An internal thermometer sat on the back of the top shelf and read forty-eight (48) degrees Fahrenheit.During an interview, on 2/16/26 at 10:09 a.m., the Dietary Manager (DM) indicated the meals prepared in Cottage 6 were served to both Cottage 6 and Cottage 1. The Dietary Manager observed the expiration date and internal temperatures and indicated the tub of ricotta cheese was past the expiration date and should be discarded. The elevated internal temperature was most likely due to the refrigerator doors being opened during breakfast clean up.After breakfast clean up and allowing the doors for Refrigerator 2 and Refrigerator 3 to remain closed, on 2/16/26 at 10:55 a.m., a second observation of the internal temperature was forty-six (46) degrees Fahrenheit in Refrigerator 2 and fifty-six (56) degrees Fahrenheit in Refrigerator 3.During an interview, on 2/16/26 at 10:58 a.m., [NAME] 6 indicated the internal temperature of the refrigerators should be thirty-five (35) to forty (40) degrees Fahrenheit.The refrigerator temperature log for Cottage 6, for February 2026, was missing a documented p.m. (evening/night) temperature on 2/15/26. A documented a.m. (morning) temperature on 2/16/25 for refrigerators 2 and 3 indicated the internal temperature of both refrigerators was thirty-six (36) degrees Fahrenheit.A current facility policy, titled Refrigerators and Freezers, undated and received from the Director of Nursing on 2/17/26 at 11:01 a.m., indicated .This community will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.Acceptable temperature ranges are 35 degrees Fahrenheit to 41 degrees Fahrenheit.employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.Supervisors will be responsible for ensuring food items in.refrigerators.are not expired.3.1-21(i)(1)3.1-21(i)(3)