

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Restoracy of Whitestown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6712 Restoracy Drive Whitestown, IN 46075	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents were afforded privacy during medical assessments and personal care for 5 of 5 residents reviewed for privacy (Residents 3, 8, 28, 65, and 25). Findings include: 1. On 2/10/26 at 11:40 a.m., the Physician Assistant (PA) approached Resident 3 while she was asleep in a chair in a common area. Without ensuring the resident was awake, without requesting permission, and without providing privacy, the PA pulled the collar of the resident's shirt to the side to assess bruising on the resident's left shoulder. The assessment occurred in a common area where privacy was not provided.</p> <p>On 2/10/26 at 11:43 a.m., PA approached Resident 8 in the main activity room, where other residents were present, and asked the resident about her pain level. Resident 8 indicated, her pain was really bad. The PA then assessed the resident by checking her pulse and visually examining her physical condition while she remained in the main activity room, without offering or providing privacy.</p> <p>2. On 2/11/26 at 10:57 a.m., the PA was asked to assess Resident 28's leg for a suspected rash. The PA approached the resident in the main activity room, where six other residents were present, and without asking if the resident would like privacy or relocating the resident to a private area, pulled up the resident's pant leg and examined and palpated the resident's skin.</p> <p>On 2/11/26 at 10:58 a.m., the PA then approached Resident 3, who was asleep in her chair in the common area, and pulled the collar of her shirt to the side to assess bruising without waking the resident, requesting permission, or providing privacy.</p> <p>3. On 2/11/26 at 11:03 a.m., Certified Nursing Assistant (CNA) 7 approached Resident 65 in the main activity room. Without offering privacy or relocating the resident, she wiped the shirt sleeves of the resident's sweater, (which was soiled with spilled food crumbs and wet from excessive drool that dripped from her mouth). She continued to wipe down her face and hands, then removed the Resident's sweater by pulling it up and over her head, which in turn, pulled the back of her shirt up exposing the sides of her breast and briefs sticking out from her pants.</p> <p>4. On 2/12/26 at 12:16 p.m., Licensed Practical Nurse (LPN) 8 and CNA 6 stood in the dining room where multiple residents were gathered as they waited on lunch and discussed resident weights. At one point, CNA 6 indicated, the weight on the new guy, in the presence of other residents, without ensuring privacy of resident health information.</p> <p>On 2/13/26 at 10:30 a.m., the above observations were shared with the Director of Nursing (DON) who indicated even in Memory Care, staff should strive to ensure residents were at least offered privacy before exams and not discuss medical records/conditions in front of other residents.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 155858	If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Restoracy of Whitestown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6712 Restoracy Drive Whitestown, IN 46075	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an observation, on 2/10/26 at 12:00 p.m., the Physician's Assistant (PA) assessed Resident 25 in the dining room. There were seven other residents, and two visitors, present at the time of the assessment. The PA touched Resident 25's lower legs, and stated, You feel a little swollen, can I see your feet? The PA placed a stethoscope on the resident's back and chest.</p> <p>Resident 25's record was reviewed on 2/11/26 at 12:28 p.m. Diagnoses on the resident's profile included, but were not limited to, Alzheimer's disease (a progressive, irreversible brain disorder that destroys memory and thinking skills) unspecified.</p> <p>A nurse's note, dated 2/10/26, indicated the resident was evaluated by the PA for increased weight and swelling to the lower extremities.</p> <p>On 2/12/26 at 2:50 p.m., the DON provided a copy of current facility policy titled, Resident Rights, dated 5/20/2020. The policy indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to. t. Privacy and confidentiality.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Restoracy of Whitestown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6712 Restoracy Drive Whitestown, IN 46075	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with dementia (Resident 37) received person-centered care and services to honor Resident 37's expressed preference to leave the dining room table for 1 of 3 residents reviewed for dementia care. Findings include: Throughout the survey period, Resident 37 was observed to be pleasantly confused, non-verbal, and independent in her activity pursuits which mostly consisted of independently ambulating in her wheelchair up and down the hallway outside of her room. She was also observed to prefer sitting away from the dining room table, and watching her peers, staff, and visitors instead of participating or engaging with them. During a continuous observation on 2/12/26, from 12:20 p.m., until 12:50 p.m., the following was observed: Resident 37 and ten of her peers were observed gathered in the dining room while they waited for lunch. Resident 37 was observed to exhibit behaviors consistent with attempting to leave the dining room table and relocate herself independently in her wheelchair, back to the hallway, or away from the gathered crowd. Resident 37 pushed herself backwards, turned around, and wheeled away from the group back into the hallway outside of her room. Certified Nursing Assistant (CNA) 7 went to Resident 37 and returned her to the table, at which time, Resident 37 immediately began trying to remove herself from the table again. This continued for several minutes as she repeatedly attempted to leave the table by maneuvering her wheelchair away, but CNA 7 continued to relocate the Resident back to the table. At one point, Resident 36 appeared to become irritated with Resident 37 and indicated to her, you need to stay here, you don't want to leave this place. Resident 36 used Resident 37's wheelchair arm rest to jerk her back to the table. As Resident 36 continued to encourage Resident 37 to stay at the table, CNA 7 indicated her thanks to Resident 36 for trying to keep Resident 37 at the table. When Resident 37 went to move away from the table on another attempt, Resident 36 put her hand over Resident 37's arms and pulled her back to the table, which prompted Resident 50 to reach over and shoo away Resident 36's touch and indicated, Don't pull on her like that, you're going to hurt her arm. Resident 36 let go, and Resident 37 left the table. CNA 7 returned Resident 37 to the table. Then proceeded to stand in the resident's path, blocking her from being able to get in between the table and the kitchen island. CNA 7 indicated, you can't get past me [name] I know you can't move me. CNA 7 stood, blocking the residents path for several minutes as she flipped through TV channels. As soon as CNA 7 moved, Resident 37 immediately left the area and went back to the hallway outside of her room. CNA 6 returned Resident 37 back to the table, and when Resident 37 attempted to leave the table, CNA 6 also physically blocked Resident 37's path. Throughout these observations, Resident 37 consistently demonstrated her preference to leave the dining room table. Staff repeatedly physically blocked her exit, allowed another resident to physically handle and redirect her, and did not implement person-centered dementia care approaches to accommodate her expressed preference to be away from the dining table. On 2/13/26 at 10:30 a.m., the above observations were shared with the Director of Nursing (DON) who indicated she would review the resident's care plans and record, but staff should not allow other residents to intervene with redirection and should not force a resident to be at the table if it was their desire to leave. On 2/12/26 at 1:00 p.m., Resident 37's record was reviewed. She was a long term care resident who resided in a secure memory care house. She had diagnoses of dementia and anxiety. An annual Minimum Data Set (MDS) assessment, dated 11/24/25, indicated she was severely cognitively impaired. Resident 37's comprehensive care plans were reviewed and lacked person-centered interventions to address her preference for being away from the dining room table, or individual approaches to offer when she was exhibiting signs of anxiousness or anxiety. The</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Restoracy of Whitestown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6712 Restoracy Drive Whitestown, IN 46075	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>record lacked documentation of staff attempts to intervene or address her peers from redirecting her to prevent resident-to-resident altercations. On 2/13/26 at 11:05 a.m., the DON provided a copy of current but undated facility policy titled, Dementia- Clinical Protocol. The policy indicated, ,for the individual with confirmed dementia, the IDT [interdisciplinary team] will identify a resident-centered care plan to maximize remaining function and quality of life. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. 3.1-37</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Restoracy of Whitestown, The		STREET ADDRESS, CITY, STATE, ZIP CODE 6712 Restoracy Drive Whitestown, IN 46075	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interview and record review, the facility failed to ensure staff performed appropriate hand hygiene and used infection control practices between resident contact and during resident assessments. This deficient practice had the potential to affect 3 of 3 residents randomly observed, (Residents 28, 3 and 65). Findings include: On 2/11/26 at 10:57 a.m., the Physician's Assistant (PA) was asked to assess Resident 28's leg for a suspected rash. The PA examined the resident's leg by pulling up the resident's pant leg and palpating the resident's skin without performing hand hygiene or wearing gloves. On 2/11/26 at 10:58 a.m., immediately after touching Resident 28, the PA approached Resident 3 and touched the resident's clothing and skin to assess bruising without performing hand hygiene between residents. On 2/11/26 at 10:59 a.m., immediately after contact with Resident 3, the PA approached Resident 65 and wiped the resident's nose and mouth with a tissue without performing hand hygiene between residents. On 2/11/26 at 11:03 a.m., Certified Nursing Assistant (CNA) 7 used a wet washcloth to wipe off Resident 65's soiled sweater (which had bits of food crumbs and spots of wetness from her excessive drooling). She first wiped off the sleeves of the sweater, then using the soiled cloth, wiped off the resident's hands, then moved to her face. On 2/13/26 at 10:30 a.m., the above observations were shared with the Director of Nursing (DON) who indicated, it was best practice to perform hand hygiene in-between resident contact. On 2/12/26 at 2:50 p.m., the DON provided a copy of current facility policy titled, Handwashing/Hand Hygiene, dated 5/20/2020. The policy indicated, use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. before and after direct contact with residents. 3.1-18(l)</p>		