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	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Restoracy of Carmel	616 Green House Way 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47346 Based on interview and record review, the facility failed to ensure an advance directive was reviewed, obtained, or updated to reflect admitted residents' current wishes for 1 of 1 resident reviewed for advance directives. (Resident 213) Finding includes: The record for Resident 213 was reviewed on [DATE] at 11:30 a.m. Diagnoses included, but were not limited to, dementia, anxiety, aphasia (loss of ability to understand or express speech), and respiratory failure (develops when the lungs can't get enough oxygen into the blood). A Hospital History and Physical progress note, dated [DATE] at 7:33 p.m., indicated Resident 213 had an order for Do Not Attempt Cardiopulmonary Resuscitation (DNR)/Do Not Intubate (DNI). A Palliative Care Consult note, dated [DATE] at 4:21 p.m., indicated Resident 213's code status was reviewed, and he requested a DNR/DNI. A Hospital Internal Medicine progress note, dated [DATE] at 5:00 p.m., indicated his code status was a DNR/DNI. Resident 213's Physician Orders for Scope and Treatment (POST), dated [DATE], indicated his wishes were a DNR/DNI. The POST had not been signed by a physician. A Nursing Admission assessment, dated [DATE] at 1:31 p.m., indicated Resident 213 was admitted from the hospital and had an admitting diagnosis of dementia. The admission assessment lacked indication code status was reviewed. A care plan, dated [DATE], indicated he was a Full Code, and the staff were to initiate CPR (life saving measures) accordingly. A Plan of Care Note, dated [DATE] at 4:55 p.m., indicated a care plan meeting was held. There was no discussion regarding Resident 213's advanced care directive or code status. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 213's record lacked indication he had an order, the banner at the top of his EMR (electronic medical record) screen and face sheet lacked any indication of what code status Resident 213 wanted if his heart stopped beating and/or he stopped breathing. During an interview, on [DATE] at 9:36 a.m., the Social Service Director (SSD) indicated there was no code status on the EMR banner and no order for code status. A full code was indicated in the care plan. There were no progress notes from nursing or social services with the discussion of the care plan. The hospital records indicated DNR/DNI. There was a discrepancy in his code status, and it needed to be addressed. During an interview, on [DATE] at 12:36 p.m., the Assistant Director of Nursing (ADON) indicated the admission staff should have reviewed the code status with the family and the resident and completed the physician's order for scope of treatment (POST). Staff should review the banner, order, or miscellaneous records for a code status. A facility policy, titled Advanced Directive, dated [DATE], indicated the plan of care for each resident will be consistent with the resident's his or her documented treatment preferences or advanced directive. 3XXX,d+[DATE](f)(4)(ii) 3XXX,d+[DATE](f)(5)

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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. 37727 Based on interview and record review, the facility failed to notify the physician of a change in a resident's condition which resulted in a facility acquired pressure ulcer for 1 of 3 residents reviewed for notification of change. (Resident 53) Finding includes: During an interview, on 11/28/22 at 1:27 p.m., the resident indicated she had a pressure area on her bottom which she had acquired at the facility. The record for Resident 53 was reviewed on 11/30/22 at 2:00 p.m. Diagnoses included, but were not limited to, pressure ulcer of sacral region, morbid obesity, and diabetes mellitus. A document, titled Braden Scale for Predicting Pressure Score Risk, dated 03/15/22, indicated the resident was at high risk for the development of a pressure sore. A quarterly MDS (Minimum Data Set) assessment, dated 09/06/22, indicated the resident required the physical assist of one person for bed mobility. A current care plan, initiated 10/20/22, indicated the resident was at risk to develop a pressure ulcer. A health status note, dated 11/2/22 at 2:23 a.m., indicated the nurse was notified by the CNA, Resident 53 had reddened areas to the top of her right and left buttock measuring 1.4 cm (centimeters) in length by 0.7 cm in width. The nurse applied skin prep (a treatment to help the skin from opening) and educated the resident about the importance of turning on her side to relieve the pressure from her buttock. It did not indicate the physician was made aware of the new reddened areas. A significant change MDS assessment, dated 11/10/22, indicated the resident had developed a sacral pressure sore. During an interview, on 12/07/22 at 3:51 p.m., the Medical Director indicated he was not notified the resident had a reddened area to her coccyx and it was his expectation to be notified of any clinical change in a resident's condition. A current facility policy, titled Notification of a Significant Change in Condition, undated and provided by the Director of Nursing on 12/02/22 at 1:00 p.m., indicated .The elder's physician will be notified promptly when the elder experiences a significant change in condition A current policy, titled Nurse Notification to Physician, undated and provided by the Director of Nursing on 12/02/22 at 1:00 p.m., indicated .It is the responsibility of the Licensed Clinical Support Team to notify the elder's physician when the elder's clinical condition may require or requires physician intervention (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(a)(2) 3.1-5(a)(3)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47346 Based on interview and record review, the facility failed to identity injuries of unknown origin as possible abuse for 3 of 11 residents in Cottage 3 reviewed for injuries of unknown origin. (Resident 27, 5 and 46) The immediate jeopardy began on November 2, 2022, when Resident 27 was found to have a bruising on the right side of the forehead. On 11/8/22, Resident 5 was noted to have discoloration and a skin tear. On 12/2/22, Resident 46 was noted to have several bruises on her left arm. The Director of Nursing was notified of the immediate jeopardy on 12/5/22 at 4:02 p.m. The immediate jeopardy was removed on 12/07/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The record for Resident 27 was reviewed on 12/5/22 at 11:00 p.m. Diagnoses included, but was not limited to, Alzheimer's disease, depression, anxiety, and dementia. A care plan, dated 3/24/20, indicated Resident 27 had an activity of daily living (ADL) self-care performance deficit related to her Alzheimer's disease, dementia, and decline in mobility. Interventions included, but were not limited to, provide skin inspection weekly and observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The Quarterly Minimum Data Set (MDS) assessment, dated 11/18/22, indicated Resident 27 had a severe cognitive impairment and demonstrated no behaviors. She required supervision with walking, transfers, and eating. She required limited assistance for personal hygiene, bed mobility, toilet use, dressing, and locomotion on the unit. The Treatment Administration Record (TAR), dated 10/31/22, indicated Resident 27 was scheduled to have a shower on Monday and Thursday with a head-to-toe assessment in the evening on Monday and Thursday. A shower and a head-to-toe assessment was completed on 10/31/22. Resident 27's skin observation task, dated 11/1/22 to 11/27/22, lacked indication bruising was noted. A Nurse Progress note, dated 11/2/22 at 5:47 p.m., indicated the nurse was notified a bruising on the right side of Resident 27's forehead. The area was assessed by the nurse and described as dark purple-blackish area in color and measured 4 cm (centimeter) by 3 cm. The nursing team was made aware. The progress note lacked indication family, or the provider was notified, an investigation was completed, or the care plan was updated. A Skin Observation assessment, dated 11/3/22 at 10:58 p.m., indicated Resident 27 had no new skin issues. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's progress note, dated 11/3/22 at 2:28 p.m., indicated Resident 27 was seen for an acute visit for a bruise on her forehead. She had a bruise on the right side of the forehead and was an unwitnessed injury. The contusion measured 4 cm by 3 cm and Resident 27 had not been taking blood thinners. During an interview, on 12/5/22 at 10:18 a.m., the Assistant Director of Nursing (ADON) indicated staff needed to have education on documentation, communication, and assessment of an injury of unknown source. They resident was at risk for a potential delay in treatment by not reporting concerns as soon as the injury happened or was observed. A Nursing Assistant was terminated in Nonmember related to concerns about rough care and an increase in bruising was found. 2. The record for Resident 5 was reviewed on 12/5/22 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, depressive disorder, chronic obstructive pulmonary disease, and chronic kidney disease. A care plan, dated 12/3/22, indicated Resident 5 had a history of developing bruising, skin tears, and abrasions easily and sometimes from unknown causes. She was at risk for future falls, bruising, and skin tears due to fragile skin and unsteadiness at time. Interventions included, but were not limited to, remove wander guard, complete a new elopement assessment, and put the wander guard around the walker if it was still appropriate in attempt to prevent further skin breakdown, and staff were to encourage the resident to reposition if sitting with legs cross for too long in attempt to prevent further bruising. A Quarterly Minimum Data Set (MDS) assessment, date 9/26/22, indicated the resident had demonstrated no behaviors, and had a severe cognitive impairment. She required supervision for walking, transfers, and eating. She required limited assistance for personal hygiene, bed mobility, toilet use, dressing, and locomotion on the unit. The Treatment Administration Record (TAR), dated 11/22, indicated for the staff to complete a skin assessment weekly on Tuesday in the morning, and complete a skin observation assessment on Thursday. Staff were to document any abnormal findings. A skin observation task, dated 11/8/22 at 11:59 p.m., indicated Resident 5 had discoloration and a skin tear. A skin observation, dated 11/9/22 at 10:00 a.m., indicated she had the following bruising: a. On the back of right hand was a bruise which measured 2 centimeters (cm) x 2 cm. b. On the right elbow was a bruise which measured 2.5 cm by 1 cm. c. On the left iliac crest was a bruise which measured 7 cm by 3 cm. d. On the front left knee was a bruise which measured 5 cm x 2 cm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse progress note, dated 11/9/22 at 10:15 a.m., indicated Resident 5 had bruising on her right inner wrist and bicep, the left side of her abdomen, and her left inner thigh which was light reddish-purple in color. Her skin was intact. Resident 5 was unable to explain what occurred due to her cognition. The nurse progress note lacked indication the physician was notified, or the bruise of unknown origin was investigated. A physician's progress note, dated 11/9/22 at 4:09 p.m., indicated Resident 5 was seen for a pain management visit. The progress note indicated she had no rash. The record lacked indication the resident had falls around the time the bruising was found. During an interview, on 12/2/22 at 3:29 p.m., the Director of Nursing (DON) indicated a family member had reported concerns regarding rough care from staff to the residents. On 11/22, a Nursing Assistant was terminated because of concerns related to rough care. During an interview, on 12/2/22 at 3:32 p.m., the Administrator indicated he would report immediately if he was notified of an injury of unknown source. Staff should be reporting immediately to the nurse, DON, or Administrator any concerns related to an injury of unknown source. During an interview, on 12/2/22 at 4:00 p.m., the Assistant Director of Nursing (ADON) indicated no education was provided to staff on investigating or reporting injuries of unknown source after the concerns were found on 11/9/22. No investigation was completed and an update to Resident 5's care plan had not been completed for the 11/9/22, injury of unknown source. During an interview, on 12/5/22 at 9:44 a.m., with the DON and ADON, they indicated staff were educated on 12/2/22 related to reporting of incidents of abuse, neglect, and injuries of unknown sources. The DON indicated she had a concern staff was not reporting the incident immediately when it was found, the lack of documentation, and not completing an assessment. Staff should have followed up the chain of command to the ADON, DON, or Administrator when concerns were found. The DON indicated her expectation for staff when an injury was identified was to complete a skin assessment, notify the family and provider, and communicate to the management staff. 3. The record for Resident 46 was reviewed on 11/29/22 on 11:00 a.m. Diagnoses included but were not limited to, dementia, delusional disorders, major depressive disorder, anxiety, macular degeneration, Parkinson's disease, and psychotic disorder. A care plan, dated 10/23/22, indicated Resident 46 had a behavior problem with physical aggression during brief changes by hitting, spiting, and biting related to dementia, depression, and psychosis due to Parkinson. Interventions, included but were not limited to, administer medications as ordered, monitor and document for side effects and effectiveness, anticipate and meet the resident's needs, assist the resident to develop more appropriate methods of coping and interacting, encourage the elder to express feelings appropriately, explain all procedures to the elder before starting and allow the elder to acknowledge an understanding or accept, intervene as necessary to protect the rights and safety of others, approach the resident calmly and speak in a respectful tone of voice, divert attention and remove from a situation and take to an alternate location as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly MDS assessment, dated 12/1/22, indicated she had severe cognitive impairment and demonstrated no physical behaviors. The MDS further indicated she was an extensive assistance of one staff of all activities of daily living. A skin observation task, dated from 11/24/22 to 12/2/22, indicated no issues were found on Resident 46 skin. Physician's orders included, but were not limited to, on 7/16/22, staff were to provide a weekly skin assessment from head to toe every Thursday. On 12/3/22, staff were to clean the skin tear with normal saline, apply bacitracin (antibiotic ointment) and leave open to air. A Skin Observation, dated 12/1/22 on 12:11 a.m., indicated Resident 26 had bruising on left forearm. A progress note, dated 12/2/22 at 7:50 a.m., and created on 12/2/22 at 11:27 a.m., indicated the nurse received a phone call to notify her Resident 46 had several bruises on her left arm. The wound was cleansed, and a bandage applied. The second bruise, close to the left elbow measured 7 cm by 5 cm and was described as dark purple in color. During the dressing change, Resident 46 was described as uncomfortable, and she grimaced during the wound cleaning. The bruise closest to her wrist measured 7.5 cm x 3 cm and had a skin tear which measured 2 cm by 1 cm and was described as dark purple and lighter purplish pink areas. A small area above the left elbow measured 1 cm by 1 cm was described as red in color. A progress note, dated 12/2/22 at 3:35 p.m., indicated the nurse was notified by the Nursing Assistant Resident 46 was combative with care overnight when she was checked and changed to see if she was incontinent. Resident 46 was startled by the Nursing Assistant and had grabbed her chest area. The Nursing Assistant released the grip of Resident 46 to change her brief. The nurse notified the Nurse Practitioner. A progress note, dated 12/2/22 at 4:21 p.m., indicated the nurse obtained an order for both skin tears to be cleaned with normal saline, apply bacitracin, and to leave the skin tears open to air. The Power of Attorney and DON were notified. A progress note, dated 12/2/22 at 6:12 p.m., indicated the staff, the DON, and the Executive Director were notified of the bruising and skin tear to the resident's left arm. The nurse assessed the area and investigated what transpired when bruise and skin tear occurred. The Nurse Practitioner was notified of what occurred and orders were put in place for the skin tear. The resident had a history of being combative during care at times. Resident 46 was startled when the CNA went in to give care around 2:00/2:30 a.m., and she grabbed the CNA's chest area. The CNA then removed the grip the resident had on her breast. This was reported to the staff nurse and the management followed up on all concerns at this time. A Social Service progress note, dated 12/2/22 at 7:10 p.m., and created on 12/2/22 at 7:14 p.m., indicated the Social Service Director (SSD) was sitting with the resident when the Nursing Assistant attempted to put a sleeve on the resident's arm with the bruising and wound, but the resident refused. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/3/22, the Nursing Assistant indicated at 2:17 p.m., the resident had a red, bruised, scratched, discolored, and open area. During an interview, on 12/01/22 at 8:59 a.m., the Executive Director indicated the facility had identified a concern regarding increased bruising which were unexplained. During an interview, on 12/1/22 at 10:30 a.m., Nursing Assistant (NA) indicated she had observed bruising on residents which was not on the resident the day before when she worked. She had not received any recent education on abuse or reporting injuries of an unknown source, since before 11/22. During an interview, on 12/2/22 at 12:20 p.m., the Memory Care Coordinator indicated she had reported many times to the ED and the DON concerns about rough care, bruising, and injuries of unknown sources which had occurred in Cottage 3 and Cottage 4. During an interview, on 12/02/22 at 3:03 p.m., the DON indicated she had concerns regarding the unexplained bruising on residents. Her expectation was for staff to report concerns regarding bruising or injuries to the nurse, nurse manager, DON, or ED immediately. When she started her employment, skin assessments were completed to monitor or check for bruising. The facility had not completed any audits, observations, or investigations regarding the unexplained bruising. She was aware of three or four other incidents of bruising or injuries of unknown source. During an interview, on 12/2/22 on 4:25 p.m., the DON indicated education was not provided and she was going to start training now. A copy of education on abuse, care planning, investigation was requested. The DON indicated the staff had no education except when hired on abuse, or dementia. Education was not provided on abuse or reporting after the incidents. She was unsure if the cooks were educated on dementia. The week she was hired, around 11/9/22, a staff member was let go due to rough care. A current facility policy, titled Prevention of Elder Abuse, Neglect, and Misappropriation of Elder Property Policy, dated 2016, indicated each elder living in this community had the right to be free from abuse, neglect, and misappropriation of their property. All reported incidents will be immediately investigated. The Immediate Jeopardy that began on 11/2/22 was removed on 12/7/22 when the facility completed a head-to-toe skin assessment on all residents and interviewed all cognitively intact residents for any concerns of mistreatment. The facility in-serviced all staff on the Abuse Policy, body areas which were considered vulnerable or areas of concern, and the Elder Justice Law. 3.1-27(a)(1) 3.1-27(a)(3)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47346 Based on interview and record review, the facility failed to ensure injuries of an unknown origin were reported to the Indiana State Department of Health (ISDH) for 3 of 3 residents reviewed for reporting allegations. (Resident 27, 5, and 46) Findings include: 1. The record for Resident 27 was reviewed on 12/5/22 at 11:00 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety, and dementia. A progress note, dated 11/2/22 at 5:47 p.m., indicated Resident 27 had bruising to the right side of her forehead and the nurse assessed the bruise. The progress note lacked indication the bruising of unknown source was investigated. A review of Resident 27's medical record lacked indication the injuries were reported to the state agency or investigated immediately after the injury occurred. 2. The record for Resident 5 was reviewed on 12/5/22 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, depressive disorder, chronic obstructive pulmonary disease, and chronic kidney disease. A progress note, dated 11/9/22 at 10:15 a.m., indicated Resident 5 had bruising to her right inner wrist, under her arm, the left side of her abdomen, and her left inner thigh. The progress note indicated the bruising was assessed and the family was notified. A review of Resident 5's medical record lacked indication the injuries were reported to the state agency or investigated immediately after the injury occurred. 3. The record for Resident 46 was reviewed on 11/29/22 on 11:00 a.m. Diagnoses included, but were not limited to, dementia, delusional disorders, major depressive disorder, anxiety, macular degeneration, Parkinson's disease, and psychotic disorder. A progress note, dated 12/2/22 at 7:50 a.m., and created on 12/2/22 at 11:27 a.m., indicated the nurse received a phone call to notify her Resident 46 had several bruises on her left arm. The wound was cleansed, and a bandage was applied. The second bruise, close to the left elbow measured 7 cm (centimeters) by 5 cm and was described as dark purple in color. During the dressing change, Resident 46 was described as uncomfortable, and she grimaced during the wound cleaning. A progress note, dated 12/2/22 at 3:35 p.m., indicated the nurse was notified by the Nursing Assistant, Resident 46 was combative with care overnight when she was checked and changed to see if she was incontinent. The resident was startled by the Nursing Assistant and had grabbed her chest area. The Nursing Assistant released the grip of Resident 46 to change her brief. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 46's record lacked indication the injuries were reported to the state agency or investigated immediately after the injury occurred. During an interview, on 12/2/22 at 4:25 p.m., the Director of Nursing (DON) indicated education was not provided and the injuries were not reported after the injuries of unknown source were found. The week she was hired, around 11/9/22, a staff member was let go due to rough care. During an interview, on 12/5/22 at 3:15 p.m., the Executive Director (ED) indicated the concern for reporting the injuries was a communication issue with staff not reporting the bruising or injuries of an unknown source to the right person. Injuries of unknown origin which could not be explained should be reported immediately. A current facility policy, titled Investigating Injuries of Unknown Origin, dated 2016, indicated an injury shall be classified as an injury of unknown source when both conditions are met: a. The resident is unable to explain how the injury occurred or the injury was not observed by a team member or visitor. b. The injury is suspicious because of the extent or the location or the injury is in an area not vulnerable to trauma, or the number of injuries observed at a particular time or incidences of injury that occurred over time cannot be explained. Injuries of unknown causes will be investigated to determine if abuse or neglect could be a contributing factor. 3.1-28(c) 3.1-28(d) 3.1-28(e)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. 47346 Based on interview and record review, the facility failed to thoroughly investigate injuries of unknown origin as possible allegations of abuse and report to the state agency potentially preventing further injury to a resident for 3 of 11 residents reviewed for injuries of unknown origin. (Resident 27, 5 and 46) The immediate jeopardy began on November 2, 2022, when Resident 27 was found to have a bruising on the right side of the forehead. On 11/8/22, Resident 5 was noted to have discoloration and a skin tear. On 12/2/22, Resident 46 was noted to have several bruises on her left arm. The Director of Nursing was notified of the immediate jeopardy on 12/5/22 at 4:02 p.m. The immediate jeopardy was removed on 12/07/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings Include: 1. The record for Resident 27 was reviewed on 12/5/22 at 11:00 p.m. Diagnoses included, but was not limited to, Alzheimer's disease, depression, anxiety, and dementia. A progress note, dated 11/2/22 at 5:47 p.m., indicated Resident 27 had bruising to the right side of her forehead and the nurse assessed the bruise. The progress note lacked indication the bruising of unknown source was investigated. 2. The record for Resident 5 was reviewed on 12/5/22 at 12:00 p.m. Diagnoses included, but were not limited to, dementia, depressive disorder, chronic obstructive pulmonary disease, and chronic kidney disease. A progress note, dated 11/9/22 at 10:15 a.m., indicated Resident 5 had bruising to her right inner wrist, under her arm, the left side of her abdomen, and her left inner thigh. The progress notes further indicated the bruising was assessed and family was notified. A review of Resident 5's medical record lacked indication the unexplained bruising was investigated. 3. The record for Resident 46 was reviewed on 11/29/22 on 11:00 a.m. Diagnoses included but were not limited to, dementia, delusional disorders, major depressive disorder, anxiety, macular degeneration, Parkinson's disease, and psychotic disorder. A progress note, dated 12/2/22 at 7:50 a.m., and created on 12/2/22 at 11:27 a.m., indicated the nurse received a phone call to notify her Resident 46 had several bruises on her left arm. The wound was cleansed, and a bandage was applied. The second bruise, close to the left elbow measured 7 cm by 5 cm and was described as dark purple in color. During the dressing change, Resident 46 was described as uncomfortable, and she grimaced during the wound cleaning. (continued on next page)

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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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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 12/2/22 at 3:35 p.m., indicated the nurse was notified by the Nursing Assistant, Resident 46 was combative with care overnight when she was checked and changed to see if she was incontinent. The resident was started by the Nursing Assistant and had grabbed her chest area. The Nursing Assistant released the grip of Resident 46 to change her brief. Resident 46's record lacked indication the injuries were reported or investigated immediately after the injury occurred. During an interview, on 12/01/22 at 8:59 a.m., the Executive Director (ED) indicated the facility had identified an increase in unexplained bruising in Cottage 3. If an injury or bruising of unknown origin was found, the staff should immediately report the concern to the nursing staff and follow the chain of command. The injury of unknown source should be investigated to determine the cause and to ensure the resident safety. During an interview, on 12/1/22 at 10:30 a.m., a Nursing Assistant (NA) indicated she had observed bruising on residents which was not on the resident the day before when she worked. She had not received any recent education on abuse or reporting injuries of an unknown source, since before 11/22. During an interview, on 12/2/22 at 12:20 p.m., the Memory Care Coordinator indicated she had reported many times to the ED and the DON regarding concerns about rough care, bruising, and injuries of unknown origin which had occurred in Cottage 3 and Cottage 4. During an interview, on 12/02/22 at 3:03 p.m., the DON indicated she had concerns regarding the unexplained bruising on residents. Her expectation was for staff to report concerns regarding bruising or injuries to the nurse, nurse manager, DON, or ED immediately. When she started her employment, skin assessments were completed to monitor or check for bruising. The DON indicated the facility had not completed any audits, observations, or investigations regarding the unexplained bruising. She was aware of three or four other incidents of bruising or injuries of an unknown source. During an interview, on 12/2/22 on 4:25 p.m., the DON indicated education was not provided and she was going to start training now. A copy of education on abuse, care planning, investigation was requested. The DON indicated the staff had no education except when hired on abuse, or dementia. Education was not provided on abuse or reporting after the incidents. She was unsure if the cooks were educated on dementia. The week she was hired, around 11/9/22, a staff member was let go due to rough care. During an interview, on 12/5/22 at 3:15 p.m., the ED indicated concerns for bruising of an unknown source should be investigated to rule out concerns for abuse. The concern was with the communication from staff and the reporting of bruising or injuries of an unknown source. A current facility policy, titled Investigating Injuries of Unknown Origin, dated 2016, indicated an injury shall be classified as an injury of unknown source when both conditions are met: a. The resident is unable to explain how the injury occurred or the injury was not observed by a team member or visitor. b. The injury is suspicious because of the extent or the location or the injury is in an area not vulnerable to trauma, or the number of injuries observed at a particular time or incidences of injury that occurred over time cannot be explained. Injuries of unknown causes will be investigated to determine if abuse or neglect could be a contributing factor. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy that began on 11/2/22 was removed on 12/7/22 when the facility completed a head-to-toe skin assessment on all residents and interviewed all cognitively intact residents for any concerns of mistreatment. The Executive Director reviewed the Division of Long-Term Care Reporting Policy and the facility Abuse Investigation and Reporting Policy. Education was provided to the Director of Nursing, Assistant Director of Nursing, Memory Care Facilitator, and Social Service Director. 3.1-28(c) 3.1-28(d) 3.1-28(e)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47346 Based on record review and interview, the facility failed to ensure staff accurately coded the Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for MDS. (Resident 213) Finding includes: The record for Resident 213 was reviewed on 12/1/22 at 11:30 a.m. Diagnoses included, but were not limited to, dementia, respiratory failure, dysphagia, anxiety, and aphasia (loss of ability to understand or express speech). A physician's order, dated 11/17/22, indicated Resident 213 had an order for a regular diet, mechanical soft texture, and thin regular consistency. An admission Minimum Data Set (MDS) assessment, dated 11/22/22, indicated Resident 213 was admitted to the facility after an acute hospital stay. He was on tube feedings while in the facility and received 25 percent or less of total calories and 500 less fluids through his tube feeding. An admission progress note, dated 11/17/22 at 7:07 p.m., indicated Resident 213 ate less than 25 percent of his meals with an assist of one staff. During an observation, on 11/30/22 at 12:30 p.m., Resident 213 was seated, at the dining room table, in his wheelchair. He was eating his lunch; no tube feeding was connected. During an interview, on 11/29/22 at 3:30 p.m., the Executive Director (ED) indicated the MDS assessment was coded incorrectly for Resident 213. The MDS Coordinator marked the wrong column regarding tube feedings while in the facility. He had a nasal gastric tube while in the hospital but did not when he admitted to the facility. The MDS assessment was inaccurately coded. The facility followed the RAI (Resident Assessment Instrument) manual for all assessments. 3.1-31(c)(5)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37727 Based on interview and record review, the facility failed to document targeted behaviors in the comprehensive care plan for a resident receiving an antipsychotic medication for delusional behaviors for 1 of 5 residents reviewed for comprehensive care plans. (Resident 22) Finding includes: The record for Resident 22 was reviewed on 12/01/22 at 12:08 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, delusional disorder, depression, and mood disorder. A current physician's order, dated 03/07/22, indicated the resident was taking risperidone (an antipsychotic) 1 mg (milligram) two times a day for psychotic disorder. A current care plan, initiated in 06/29/22, indicated the resident was prescribed an anti-psychotic medication related to a psychotic disorder with hallucinations. Interventions included, but were not limited to, observe and document occurrence of targeted behavior symptoms. The specific targeted symptoms were not indicated in the care plan. During an interview, on 12/06/22 at 12:18 p.m., the Social Service Director indicated it was her responsibility to initiate behavior care plans for resident's including the use of antipsychotic medication for behaviors. A behavior care plan should indicate the resident's specific targeted behaviors. Resident 22's anti-psychotic care plan should have indicated her specific delusions or hallucination behaviors she exhibited. 3.1-35(a) 3.1-35(b)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47346 Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADLs), related to shaving, for 1 of 1 resident reviewed for ADL care. (Resident 213) Finding includes: During an observation, on 11/29/22 at 1:40 p.m., Resident 213 had quarter inch long, gray, and white-colored facial hair which spread from ear to ear and on his upper lip. During an observation, on 11/30/22 at 8:30 a.m., Resident 213 had quarter inch long, gray, and white-colored facial hair which spread from ear to ear and on his upper lip. In Resident 213's room, there were many pictures of him, and all the pictures had a clean-shaven face of Resident 213. During an observation, on 12/2/22 at 2:25 p.m., Resident 213's hair was disheveled, and he had quarter inch long, gray, and white-colored facial hair which spread from ear to ear and on his upper lip. The record for Resident 213 was reviewed on 11/30/22 at 3:00 p.m. Diagnoses included, but were not limited to, dementia, respiratory failure, aphasia, and limited mobility. An admission Minimum Data Set (MDS) assessment, dated 11/22/22, indicated he had a severe cognitive impairment, and demonstrated no behaviors. He required extensive assistance of two staff for ADLs and personal hygiene. He was totally dependent on two staff for bathing. A Care Area Assessment (CAA), dated 11/22/22, lacked indicated Resident 213 was triggered for activity of daily living (ADL). The record lacked indication Resident 213 had refused or was offered to have his beard and mustache hairs shaved. During an interview, on 12/1/22 at 10:10 a.m., the Memory Care Coordinator indicated it was her expectation for the CNA (Certified Nursing Assistant) to provide shaving as needed for Resident 213. During an interview, on 12/1/22 at 3:30 p.m., the Director of Nursing (DON) indicated it was her expectation for the CNA providing ADL care to provide grooming which included shaving on the bath days or as needed. During an interview, on 12/2/22 at 2:25 p.m., a family member indicated Resident 213 had been a director of a business for many years, and his appearance was important to him. He always had a clean-shaven face and would dress neat. During an interview, on 12/2/22 at 3:00 p.m., Nursing Assistant 4 indicated she had not asked or offered Resident 213 if he preferred to be shaved when she assisted with his morning care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/1/22 at 3:30 p.m., the DON indicated they did not have a policy related to shaving. 3.1-38(a)(3)(D)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 47346 Based on observation, interview and record review, the facility failed to provide meaningful activities, staff engagement, and assistance with activities for residents who were dependent on staff for activity involvement for 6 of 6 residents reviewed for activities. (Resident 4, 5, 25, 30, 46, and 213) Findings include: 1. During an observation, on 11/28/22 from 2:28 p.m., to 3:00 p.m., Resident 4 was found seated in the chair, in the living room common area, with other residents. The television was on and no interactions from staff or residents were observed. The record for Resident 4 was reviewed on 11/28/22 at 3:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and major depressive disorder. A care plan, dated 12/13/19, indicated Resident 4 was dependent on staff to meet her emotional, intellectual, physical, and social needs related to her cognitive deficits and dementia. Resident 4 required set up assistance from staff with group and independent activities. A Significant Change in Status Minimum Data Set (MDS) assessment, dated 1/16/22, indicated she had a severe cognitive impairment, demonstrated no behaviors, and required limited assistance with her activities of daily living. Her preferences indicated it was very important to be around animals and go outside when the weather was nice. She found it somewhat important to listen to music, do things as a group, and to do her favorite activities. A Care Area Assessment (CAA) for Resident 4 lacked indication activities were triggered. Resident 4's record lacked indication a Life Enrichment Participation Review had been completed. A Review of Resident 4's activity task record indicated she participated mainly in group activities which consisted of watching television or movies. 2. During an observation, on 11/28/22 from 10:34 a.m., to 10:50 a.m., Resident 5 was seated in common area, near the fireplace, with other residents. The television was on, but no staff were engaged. During an observation, on 11/28/22 at 1:42 p.m., Resident 5 was seated in common area, near the fireplace, with other residents. The television was on, but no staff were engaged. During an observation, on 11/29/22 from 1:30 p.m., to 1:45 p.m., Resident 5 was seated in common area, near the fireplace, with other residents. The television was on, but no staff were engaged. A care plan, dated 3/11/21, indicated staff were to encourage her to participate in favorite activities of her choosing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment, dated 1/15/22, indicated Resident 5 had a severe cognitive impairment and required limited assistance for her ADLs. A CAA lacked indication Resident 5 trigger for activities. A Life Enrichment Assessment, dated 11/4/22, indicated Resident 5 enjoyed participating in one to one, individual, group, and event activities. A review of Resident 5's activity task record indicated the activities documented were movies and television on all events except for six occasions. 3. During an observation, on 11/28/22 at 11:15 a.m., Resident 25 was observed seated, in the living room common area with the television on, with six other residents and no staff interactions. During an observation, on 11/28/22 at 2:59 p.m., Resident 25 appeared to be sleeping with his eyes closed, seated in his wheelchair, in the living room area. A movie was playing on the television. No interaction from staff were observed with the residents. The record for Resident 25 was reviewed on 12/1/22 at 8:30 a.m. Diagnoses included, but were not limited to, encephalopathy, dementia, major depressive disorder, and repeated falls. A care plan, dated 4/7/22, indicated he had behaviors and was at risk for elopement, wandered aimlessly and went to the front door after family left. The care plan indicated to distract Resident 25 with structured activities, television, and conversation. A CAA, dated 4/7/22, indicated it was very important for Resident 25 to have books, magazines, and newspapers to read. It was somewhat important for him to do group activities, do his favorite activities, listen to music he liked, and to be around animals. A Social Services Initial Assessment, dated 4/7/22, indicated Resident 25 had grown up on a farm, worked in trucking, and was a security guard. His family wanted staff to know he liked to read the newspaper, liked sports and social interactions, and having a job or duty to do. A Life Enrichment Annual Participation Review, dated 10/6/22, indicated Resident 25 enjoyed participating in one to one, individual, group, and event activities. His interests included watching television, westerns, sports, listening to music, outdoor time, and visiting with family. Resident 25 was very social and liked to converse with peers. A quarterly MDS assessment, dated 10/7/22, indicated Resident 25 had a severe cognitive impairment, and demonstrated no behaviors. He required extensive assistance from staff to complete activities of daily living. An activity task record, dated 8/8/22 to 12/7/22, indicated the activities Resident 25 attended was movies and television on all occasions except for two which included gardening and coloring. 4. During an observation, on 11/28/22 from 10:34 a.m., to 10:50 a.m., Resident 30 was seated in her wheelchair, in the common area near the fireplace, with other residents. The television was on, but no staff were engaged. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 11/30/22 from 1:00 p.m., to 2:35 p.m., Resident 30 was seated in her wheelchair, in the common area near the fireplace, with other residents. The television was on, but no staff were engaged. The record for Resident 30 was reviewed on 11/29/22 at 2:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, chronic obstructive pulmonary disease, and bipolar. A care plan, dated 3/19/20, indicated Resident 30 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to dementia. She benefited from working with her hands and was sensitive to loud noises. Interventions included, but were not limited to, ensure the activities for the resident were compatible with her physical and mental capabilities, known interest and preferences, and invite her to the scheduled activities. An annual MDS assessment, dated 2/7/22, indicated Resident 30 had a severe cognitive impairment and required extensive assistance from staff in all activities of daily living. Her preferences indicated it was very important for Resident 30 to participate in her favorite activities and listen to music. She found it somewhat important to go outside when weather was good, do things in groups, and to have books, newspapers, and magazines. A CAA, dated 2/7/22, indicated Resident 30 was rarely understood due to her progression of her Alzheimer's disease, and was unable to ask for assistance as desired. Resident 30 was not triggered for activities. During an interview, on 11/30/22 at 1:12 p.m., a family member indicated she was concerned with the lack of engaging activities for Resident 30. The Activity Director did not participate or provide activities for Cottage 3 and Cottage 4. 5. During an observation, on 11/28/22 at 10:34 a.m., Resident 46 was seated in her wheelchair, in the common area near the fireplace, with other residents. The television was on, but no staff were engaged. During an observation, on 11/28/22 from 1:05 p.m., to 2:35 p.m., Resident 46 was seated in her wheelchair, in the common area near the fireplace, with other residents. The television was on, but no staff were engaged. The record for Resident 46 was reviewed on 11/29/22 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, psychotic disturbance, mood disturbance, and anxiety. An admission MDS assessment, dated 5/13/22, indicated Resident 46 had a severe cognitive impairment. It was very important for Resident 46 to participate in religious services, go outside when the weather was good, do her favorite activities, and to be around pets. It was somewhat important for her to read books, newspaper, magazines, listen to music, or keep up with the news. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 9/13/22, indicated Resident 46 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Interventions included, but were not limited to, ensure the activities for Resident 46 were compatible with physical and mental capabilities, known interest, and preferences, invite the resident to scheduled activities, and the resident needed one to one bedside in room visits and activities if unable to attend out of room events. A Life Enrichment Participation assessment, dated 10/23/22 on 3:32 p.m., indicated Resident 46 enjoyed participating in one to one, individual, group, and event activities. She relied on family and staff to anticipate and meet all her wants and needs. She enjoyed music, outdoor time, and watching some television. A CAA, dated 11/22/22, indicated Resident 46 required assistance with all activities of daily living including bed mobility, transfers, toileting, and eating. Resident 46 was not triggered for activities. 6. During an observation, on 11/30/22 at 9:00 a.m., Resident 213 was seated in his wheelchair, in the common area near the fireplace, with other residents. The television was on, but no staff were engaged. During an observation, on 12/2/22 at 2:08 p.m., Resident 213 was seated in his wheelchair, in the common area with seven other residents. He was looking across the room. The television was on, but no staff were engaged. During an interview and observation, on 12/2/22 at 12:15 p.m., Resident 213 was seated in his wheelchair, with his family member and another male resident, in the library of the cottage. The family member indicated Resident 213 worked as a director for a company and had many interactions with people during his career. He found a lot of enjoyment with interactions especially with men. Resident 213 needed engaging activities with staff and other residents. The family member did not feel like having the television on was an engaging activity. The record for Resident 213 was reviewed on 12/1/22 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, cognitive communication deficit, anxiety, and aphasia. An admission MDS assessment, dated 11/22/22, indicated Resident 213 had a severe cognitive impairment. It was somewhat important for Resident 213 to participate in religious services, go outside when the weather was good, do his favorite activities, and to be around pets. It was not very important to read books, newspapers, magazines, or listen to music. A CAA, dated 11/22/22, indicated Resident 213 required assistance with all activities of daily living including bed mobility, transfers, toileting, and eating. Resident 213 was on psychotropic medications for dementia, depression, and anxiety. He was not triggered for activities. A Life Enrichment Participation assessment had not been completed on Resident 213. An activity task record, dated 11/17/22 to 12/8/22, indicated all activities Resident 213 participated in or were provided by the staff were movies and television except for one day which was a manicure. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A plan of care progress note, dated 12/1/22, indicated a care plan meeting was held, and family voiced concerns on dietary, therapy, medication, and socialization. The Memory Care Coordinator indicated she would create a more robust schedule of activities which would stimulate cognition and upper body strength. During an interview, on 11/30/22 at 1:30 p.m., a family member indicated she was concerned with the lack of engaging activities for Resident 213. The staff appeared to walk by the residents and not engaged with them. She had not observed staff interacting with the residents except for when care need to be completed. An activity calendar for Cottage 3 and Cottage 4, dated 11/22, indicated the following: a. On 11/28/22, activities were to include music, current events, table talk, special events, refresh/rejuvenate, and evening news. b. On 11/29/22, activities were to include music, holiday program, manipulatives, tea/talk, puzzles, manicures, and refresh/rejuvenate. c. On 11/30/22, activities were to include table talk, history of America, manicures, fall stories, music, refresh/rejuvenate, and classic television. During an interview, on 11/30/22 at 9:45 a.m., the Memory Care Coordinator indicated no activity calendars had been displayed recently for the residents. The Activity Director did not provide activities for the residents in Cottage 3 and Cottage 4 who have a diagnosis of dementia. Some of the staff were more engaging with the residents than others. The main activities were television and music throughout the day. It was difficult for nursing staff to complete their daily activities of living for the residents and provide the activities. During an interview, on 11/30/22 at 10:47 a.m., Nursing Assistant (NA) 4 indicated family members had complained about the lack of activities, engagement from staff, and activities which met the resident's interest. The main activity used was television even though residents rarely watch it. During an interview, on 11/30/22 at 10:54 a.m., the Mental Health Provider indicated it was very important for residents with dementia and Alzheimer's disease, especially those residents in Cottage 3 and Cottage 4, to have engaging activities such as reminiscing, staff engagement, and tactile activities. Residents with dementia could use music to help with long term memory and to reactivate certain areas of the brain. Television could be used occasionally and for a limited time but not a primary activity throughout the day. Activities were important to have during the day to decrease behaviors in residents with dementia, and it also helped residents to sleep at night. A current facility policy, titled Programming for Residents with Cognitive impairments and other Special Needs, undated, indicated activity programs are provided for the maintenance and enhancement of each resident's quality of life while promoting physical, cognitive, and emotional health. The facility would offer meaningful programs for residents with cognitive impairments which use reality and sensory awareness techniques. This Federal tag relates to Complaint IN00393166. (continued on next page)

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	155846	A. Building B. Wing	12/08/2022

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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-33(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47346 Based on interview and record review, the facility failed to identify a change of condition, ensure the physician's order was followed, and ensure the physician was notified of a change of condition for 1 of 2 residents reviewed for quality of care. (Resident 48) Finding includes: The record for Resident 48 was reviewed on 11/29/22 at 10:15 a.m. Diagnoses included, but were not limited to, dementia, malignant left breast cancer, chronic obstructive pulmonary disease, diabetes, and irritable bowel. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/22, indicated the resident had a severe cognitive impairment and demonstrated no rejection to care. Resident 48 required an extensive physical assistance of one staff with all activities of daily living. She took no anticoagulant during the assessment. A progress note, dated 10/18/22, indicated the nurse was called to Cottage 4 by a Nursing Assistant (NA) due to the elder had a skin tear to her lower right shin. The skin tear was bright red and non-bleeding. Due to the resident's cognitive state, she was unable to describe how she obtained the skin tear. The skin tear measured 3.5 cm (centimeters) by 1.5 cm. It was cleansed with normal saline, bacitracin was applied to the area, and covered with a foam dressing. The wound had no signs or symptoms of infection. Skin observation task notes, dated 10/17/22 to 10/20/22, lacked indication Resident 48 had any skin conditions, tears, bruises, or redness. A skin observation assessment, dated 10/21/22 at 12:00 a.m., indicated Resident 48 had no new skin issues. A skin observation task, dated 10/21/22 at 6:21 a.m., indicated Resident 48 had redness but lacked indication where the redness was located. A physician's progress note, dated 10/26/22 at 10:55 a.m., indicated Resident 48 was seen for an acute visit related to a skin tear of right leg and staff report a bandage had been in place since 10/18/22. The skin inspection of the right lower extremity discovered a skin tear with slough present at the right lateral border, and the skin tear on the left forearm was scabbed with steri-strips. A progress note, dated 10/26/22 at 4:54 p.m., indicated Resident 48 was seen by the Nurse Practitioner (NP) with new orders for immediate labs of a complete metabolic panel, and a complete blood count (a lab test to check for infections). The NP ordered Medihoney to the right lower extremity skin tear twice a day, and leave open to air. A skin observation assessment, dated 10/31/22, indicated Resident 48 had a right anterior leg skin tear and measured 2.5 cm by 1.5 cm by 0.1 cm. The skin tear had granulation tissue, and xeroform was applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders, entered on 11/24/22 at 11:05 p.m., indicated for staff to complete a weekly skin assessment which included a complete visual head-to-toe skin assessment every day shift on Thursday, and to complete the skin observation under assessments and document any abnormal findings in the progress notes. The medical record lacked indication the provider, family, Director of Nursing, or the Executive Director was notified of the injuries, an investigation was completed for an injury of unknown source, the care plan was updated, or the staff were educated. There was a lack of assessment from 10/18/22 to when the provider examined the wound on 10/26/22, when slough was found on the right lower extremity skin tear. A review of Resident 48's Medication Administration Record (MAR) indicated documentation was being completed for dressing changes to the left and right forearm but lacked documentation dressing changes were completed to the right lower extremity. During an interview, on 12/2/22 at 3:20 p.m., the Assistant Director of Nursing (ADON) indicated Resident 48 had not been provided with wound care from 10/18/22 to 10/26/22, when the nurse practitioner had been asked to see the resident regarding the skin tear. The skin tear did have slough on the edges and there was a concern for infection. Staff should have provided wound care and requested wound care orders from the provider. A current facility policy, titled Wound Care, undated, indicated staff should ensure there was a physician's order for wound care and to document in the resident's record the type of wound care, the date and time wound care was given, any change in the resident's condition, and all assessment data obtained when inspecting the wound. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47346 Based on observation, interview, and record review, the facility failed to ensure there was adequate supervision to prevent accidents when kitchen cleaning chemicals and chemicals in the medication room were unlocked and unsecured and failed to ensure the metal fireplace was supervised while in use for 2 of 6 cottages reviewed for supervision to prevent accidents. (Cottage 3 and 4) Findings include: 1. a. On 11/28/22 at 10:42 a.m., during an initial kitchen tour of Cottage 3, the half door was open six inches. Under the two-compartment sink, a half full bottle of Lysol toilet bowl cleaner and a bottle of Dawn Dish soap was found unsecured and unlocked. At 10:48 a.m., the cabinet next to the dishwasher contained the following: a. Two one-gallon bottles of crystal dry rinse aide. b. A gallon bottle of [NAME] pot and pan detergent. c. A gallon bottle of Sanitizer Es. d. A bottle of Dawn Dish soap. b. During an observation, on 11/28/22 at 2:55 p.m., the fireplace in Cottage 3 was on. The black metal surround of the fireplace measured 2 inches wide on the two sides and the top was hot to the touch. An infrared thermometer found the temperature of the metal to be 157.7 degrees. Six residents were observed seated, in the living room common area, with no staff in direct view of the residents. During an observation and interview, on 11/28/22 at 3:16 p.m., the Maintenance Director indicated the metal surround temperature was 145.7 degrees. During an interview, on 11/30/22 at 9:45 a.m., the Memory Care Coordinator indicated the residents were not always supervised in the common areas when the staff were providing care to other residents or were on their break. The residents were at risk for injuries related to the hot temperatures of the fireplace surround. 2. a. On 11/28/22 at 11:34 a.m., during an initial kitchen tour of Cottage 4, the half door was open and unsecured. The cabinet next to the dishwasher contained the following: a. A one-gallon bottle of crystal dry rinse aide. b. A one-gallon bottle of [NAME] pot and pan detergent. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A one-gallon bottle of Sanitizer Es. d. A bottle of Dawn Dish soap. e. A one-gallon bottle of high temperature aide. On 11/28/22 at 12:05 p.m., a spray bottle of Champion Spring Air Freshener -Clean Linen was observed on the mantel of the fireplace in the living room of Cottage 4. During an interview, on 11/28/22 at 11:15 a.m., the Dietary Manager (DM) indicated chemicals were in the kitchen, in a cabinet, which was unlocked and unsecured. The staff did not have keys for the cabinets to lock the doors. During an interview, on 11/28/22 at 3:04 p.m., Nursing Assistant (NA) 4 indicated the spray bottle of air freshener was on the mantel of the fireplace in the living room of Cottage 4. She indicated all chemicals should be locked up and secured away from the residents for their safety. b. During an observation, on 11/29/22 at 8:59 a.m., the Cottage 4 medication room was found unlocked and unsecured with the doors open. A bottle of drug buster, a spray bottle with pink colored liquid, and a one-gallon bottle of hand sanitizer was sitting on the floor under the counter. During an interview, on 11/29/22 at 9:15 a.m., the Director of Nursing (DON) indicated the chemicals were in the room and they should be locked up and secured away from the residents who have dementia. During an interview, on 11/30/22 at 9:45 a.m., the Memory Care Coordinator indicated the residents were not always supervised in the common areas when the staff were providing care to other residents or were on their break. The residents were at risk for injuries related to the unsecured chemicals. Residents have gone into the kitchen because the door was not secured and not always locked. A review of the facility maintenance requests lacked indication a report was made regarding the cabinet locks not working. The Array Safety Data Sheet (SDS) for Concentrated Liquid Dish Machine Detergent, dated 6/6/14, indicated the detergent was classified as hazardous for skin corrosion and acute toxicity for oral ingestion, and to seek immediate medical attention if exposed to the eyes, skin, ingestion, or inhalation. The Array SDS for Warewash Detergent, dated 1/15/15, indicated the detergent was classified as hazardous for skin corrosion and acute toxicity for oral ingestion, and to seek immediate medical attention if exposed to the eyes, skin, ingestion, or inhalation. The Array SDS for Chlorine Sanitizer, dated 7/7/20, indicated the detergent was classified as hazardous for skin corrosion and acute toxicity for oral ingestion, and to seek immediate medical attention if exposed to the eyes, skin, ingestion, or inhalation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Material Safety Data Sheet (MSDS), dated 10/31/09, indicated Lysol Toilet Bowl Cleaner was classified as hazardous for exposure to eye, skin, inhalation, and ingestion, and to seek immediate medical attention if exposed to the eyes, skin, ingestion, or inhalation. The Champion Spray Air Freshener [NAME] and Gamble MSDS, dated 2/20/13, indicated it may be hazardous if exposed to eye, skin, inhaled, or ingested, and to seek medical attention immediately if swallowed, exposed to eyes, or inhaled. A current facility policy, titled Storage Areas, Maintenance, undated, indicated cleaning supplies must be stored in areas separate from food storage rooms and must be stored as instructed on the labels of such product. A current facility policy, titled Poisonous and Toxic Materials, undated, indicated when poisonous and toxic materials will be stored on shelves. The policy lacked indication the chemicals should be secured away from residents. A current facility policy, titled Physical Environment, undated, indicated plant operations would conduct weekly safety inspections of each small home environment and maintain preventative maintenance log inspections for all equipment used in the homes. 3.1-45(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37727 Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated and a nebulizer mask and oxygen tubing were stored in a sanitary manor for 1 of 3 residents reviewed for respiratory care. (Resident 7) Finding includes: During an observation, on 11/29/22 at 11:47 a.m., Resident 7's nasal cannula and oxygen tubing were wrapped around the oxygen concentrator (a medical device which supplies extra oxygen), a non-rebreathing mask with the tubing attached was sitting on top of her bed side table both uncovered and undated. The record for Resident 7 was reviewed on 11/30/22 at 1:30 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, hypoxia (lack of oxygen), and diabetes mellitus. A current physician's order, dated 9/13/22, indicated the resident was to receive oxygen to keep her oxygen levels greater than 90%. A current physician's order, dated 6/16/22, indicated to change the resident's oxygen tubing every Sunday on the night shift. A current care plan, initiated 10/25/22, indicated the resident had an altered respiratory status related to respiratory failure and required oxygen as needed. During an interview, on 11/29/22 at 11:47 a.m., LPN 11 indicated the resident's oxygen tubing and mask should be dated and contained in a bag. A current facility policy, titled Oxygen Policy and Procedure, undated and provided by the Director of Nursing on 12/02/22 at 3:04 p.m., indicated .Label storage bag that will store tubing, cannula, and/or mask .Oxygen tubing, nasal cannula, and/or mask will be labeled with date replaced or contained in a bag indicating the date 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47346 Based on observation, interview and record review, the facility failed to appropriately treat a resident's pain consistent with professional standards of practice for 1 of 1 resident reviewed for pain management. (Resident 37) Finding includes: During an observation, on 11/28/22 at 11:25 a.m., to 11:40 a.m., Resident 37 was seated in the dining room, in his wheelchair, leaning forward rubbing his knees roughly. He lowered his eyebrows and squinted his eyes. Resident 37 indicated Yes, I hurt when asked if he had pain. Staff were observed to walk by him and did not interact with the resident or provide intervention for his pain. The record for Resident 37 was reviewed on 11/28/22 at 11:45 a.m. Diagnoses included, but were not limited to, dementia, anxiety, osteoarthritis, and low back pain. A history and physical progress note, dated 6/13/21, indicated Resident 37 had arthritic changes in his upper and lower extremities. A physician progress note, dated 6/21/21, indicated Resident 37 was seen for complaints of back pain. A Care Area Assessment, dated 4/20/22, indicated Resident 37 was not triggered for pain. A hip and pelvis X-ray, dated 8/31/22, indicated the resident had degenerative changes in his left hip and pelvis. A care plan, dated 10/15/22, indicated Resident 37 had a risk for pain related to arthritis, back pain, and general discomfort. Interventions included, but were not limited to, encourage elder to try different pain-relieving methods such as positioning, relaxation, quiet environment with low light, bathing, warm or cool cloth, back rub, and soft music, administer analgesia per orders, anticipate his need for pain relief and respond immediately to any complaint of pain, monitor and document for side effects of pain medication, notify the physician if interventions were unsuccessful, observe and report to the nurse any signs of non-verbal pain: changes in breathing. A Quarterly Minimum Data Set assessment, dated 11/7/22, indicated Resident 37 received opioids and was on a scheduled pain medication regimen. A physician progress note, dated 11/7/22, indicated Resident 37 was seen and had completed he had pain in his knee. Physician's orders included, but were not limited to, tramadol 50 milligrams (mg) tablets, give 25 mg by mouth three times a day for pain, Tylenol 1000 mg by mouth three times a day for osteoarthritis of the knee, and Biofreeze gel 4 percent (%) was to be applied to the back and bilateral knees topically every six hours as needed for pain related to osteoarthritis of knee. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 37's Medication Administration Record, dated 11/22, indicated he did not receive his scheduled Tramadol for his pain on the following 11 occurrences: a. At 8:00 a.m., on 11/26/22 and 11/27/22. b. At 2:00 p.m., on 11/8/22, 11/9/22, 11/12/22, 11/22/22, 11/23/22, 11/25/22, and 11/26/22. c. At 8:00 p.m., on 11/26/22 and 11/27/22. A nurse progress note, dated 11/27/22 at 5:58 a.m., indicated the pharmacy was called for a refill of Tramadol. A nurse progress note, dated 11/28/22 at 8:00 p.m., indicated Resident 37 was out of Tramadol and the pharmacy was notified and authorization was given to pull from the emergency kit. A provider progress note, dated 12/1/22, indicated Resident 37 was seen for a refill of his Tramadol which he took for knee pain. He reported he had muscle aches, muscle weakness, back pain, and swelling in the extremities. During an interview, on 11/29/22 at 3:19 p.m., the Director of Nursing (DON) indicated the nursing staff should follow the physician's orders, administer medication as directed, and when a medication was not available staff should have notified the pharmacy, the DON, and the physician. During an interview, on 12/1/22 at 4:00 p.m., the Assistant Director of Nursing indicated the resident had not received his tramadol and it was not available. A current facility policy, titled Mediation Administration General Guidelines Policy, dated 5/27/20, indicated the facility would provide appropriate care and services to manage the resident's medication regimen to avoid negative outcomes. 3.1-37(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37727 Based on observation, interview and record review, the facility failed to assess, obtain a physician's order, care plan, and provide maintenance inspections for side rails for 2 of 2 residents reviewed for accident hazards. (Resident 21 and 51) Findings include: 1. During an observation, on 11/30/22 at 8:25 a.m., Resident 21 was observed in her bed, awake, with her bilateral grab bars elevated. During an observation, on 12/01/22 at 9:07 a.m., Resident 21 was observed in her bed with her bilateral grab bars elevated. During an observation, on 12/06/22 at 8:40 a.m., Resident 21 was observed in her bed, awake, with her bilateral grab bars elevated. The record for Resident 21 was reviewed on 11/29/22 at 3:53 p.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and fracture of her right fibula (bone in lower leg). A side rail assessment, dated 04/09/19, indicated the resident was assessed for the use of side rails as well as an informed consent was obtained from the resident's responsible party. A physician's order, a care plan, or any maintenance inspections for the side rails were not found in the resident's record. 2. During an observation, on 11/28/22 at 11:46 a.m., Resident 51 was lying in bed, dressed, with her grab bar away from the wall elevated. During an observation, on 11/30/22 at 9:04 a.m., Resident 51 was in bed, watching television, with the grab bar away from the wall elevated. During an observation, on 12/01/22 at 11:41 a.m., Resident 51 was in bed with the grab bar away from the wall elevated. The record for Resident 51 was reviewed on 11/30/22 at 9:44 a.m. Diagnoses included, but were not limited to, fracture of lower vertebra, dementia, and stroke. An assessment, consent, physician's order, care plan, or any maintenance inspections for the side rails were not found in the resident's record. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/02/22 at 8:53 a.m., the Director of Nursing (DON) indicated Resident 21 did not have an order, care plan or maintenance inspections and Resident 51 did not have an assessment, order, care plan, consent, or maintenance inspections for side rail use and they should have had. A current facility policy, titled Bed Safety, undated and provided by the Director of Nursing on 12/02/22 at 3:00 p.m., indicated .a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential risks .d. Ensure that bed rails are properly installed .to ensure proper fit .6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use .7. If side rails are used .assessment of the resident, consultation with the attending physician, and input from the resident or the resident's legal representative prior to their user .9. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails 3.1-45(a)(1)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37727 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on site for 8 hours a day for 3 of 30 days reviewed for RN coverage from November 01, 2022, to November 30, 2022. (November 12, 28, and 29, 2022) Finding includes: During a review of the schedule for licensed staff, on 12/08/2022 at 9:20 a.m., documentation of the hours worked lacked evidence of a RN for 8 consecutive hours for November 12, 2022, November 28, 2022 and November 29, 2022. During an interview, at that time, the Director of Nursing reviewed the documents and indicated there was no RN coverage, for 8 consecutive hours on those dates. A policy was requested on 12/09/22 at 3:25 p.m., and 5:14 p.m., but was not provided. 3.1-17(b)(3)

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Restoracy of Carmel	616 Green House Way Carmel, IN 46032

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37727 Based on observation and interview, the facility failed to provide current daily staff postings for residents and visitors to view in 2 of 5 cottages observed for sufficient nurse staffing. (Cottage 1 and Cottage 2) Finding includes: During the survey dates, of 11/28/22 through 12/05/22, the daily staff posting information located in both Cottage 1 and Cottage 2 were observed to remain dated 11/29/22 and not updated with current dates throughout the survey dates. During an interview, on 12/08/22 at 10:05 a.m., the Staffing Coordinator indicated it was her responsibility to post the daily staff information and it should be kept up to date in each cottage. A current facility policy, regarding daily staff posting in the facility, was requested on 12/09/2022 at 3:25 p.m. During an interview, on 12/09/22 at 5:14 p.m., the Assistant Director of Nursing indicated the facility did not have a written policy. 3.1-13(g)(4)(B)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 47346 Based on interview and record review, the facility failed to reassess a resident's medication regimen who had been prescribed a prophylaxis antibiotic for a history of urinary tract infections (UTI) for 1 of 2 residents reviewed for unnecessary medications. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 11/30/22 at 2:45 p.m. Diagnoses included, but were not limited to, dementia and chronic kidney disease. A history and physical, dated 12/21/20, indicated Resident 5 had orders for Keflex (an antibiotic) for UTI prophylaxis. A physician's order, dated 2/23/21, indicated Resident 5 was to receive Keflex 250 milligram (mg) capsule by mouth in the morning for UTI prophylaxis. A care plan, dated 3/2/21, indicated Resident 5 was on antibiotic therapy prophylaxis. Interventions included, but were not limited to, administer the antibiotic medication as ordered by physician, monitor and document side effects and effectiveness every shift, and observe, document, and report as needed signs and symptoms of secondary infection related to antibiotic therapy. A social service note, dated 3/23/22 at 2:11 p.m., indicated a care conference was held; medications and care plans were reviewed and updated. Nursing explained to the family, Resident 5 had not had signs or symptoms of a UTI. During an interview, on 11/30/22 at 3:21 p.m., the Nurse Practitioner indicated Resident 5's antibiotic had been prescribed to her since her admission to the facility for a history of UTI. Resident 5 had not had a UTI in more than a year and the antibiotic should be discontinued. During an interview, on 12/1/22 at 3:59 p.m., the Consultant Nurse indicated no antibiotic stewardship had been done for months. The facility had not been tracking infections or antibiotics to determine if the medication was appropriate. During an interview, on 12/2/22 at 3:45 p.m., the Consulting Pharmacist indicated the medication should be reviewed by the provider to determine whether a prophylaxis medication was available for a resident on a daily antibiotic. A current facility policy, titled Mediation Administration General Guidelines Policy, dated 5/27/20, indicated the facility would provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medication and minimize negative outcomes. 3.1-48(a)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47346 Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than five percent based on medication errors observed during 2 of 26 opportunities for errors resulting in a medication error rate of 7.69 percent. (Residents 10 and 42) Findings include: 1. During a medication administration observation, on 11/29/22, at 8:40 a.m., QMA 1 prepped the medications for Resident 10. QMA 1 put the medications into a plastic sleeve and used the medication crusher to crush the medication. She then mixed the medication into vanilla pudding. QMA 1 indicated Resident 10 had an order to crush her medications. The record for Resident 10 was reviewed on 11/28/22 at 3:10 p.m. Diagnoses included, but were not limited to, urgency of urination, hallucinations, delusional disorder, Parkinson's disease, dementia, mood disturbance, and anxiety. A review of Resident 10's Medication Administration Record, on 11/29/22 at 8:45 a.m., indicated she received the following medication which should not have been crushed: a. Oxybutynin Chloride Extended Release 24 Hour 10 mg (milligram), one tablet by mouth for urgency of urination. This medication was an extended-release tablet and should not be crushed. 2. During an observation, on 11/30/22 at 8:45 a.m., QMA 1 prepped the medications for Resident 42 and placed them in a plastic sleeve. She then crushed the medications and mixed them in vanilla pudding. QMA 1 proceeded to spoon the medication mixed into pudding into Resident 42's mouth. The record for Resident 42 was reviewed on 11/30/22 at 8:45 a.m. Diagnoses included, but were not limited to, mood disorder, and depression. A care plan, dated 2/20/22, indicated Resident 42 was prescribed antidepressant medications related to insomnia, mood disorder with depressive features, and anxiety. Interventions included, but were not limited to, administer antidepressant medications as ordered by physician. A physician's order, dated 6/6/22, indicated Resident 42 may have his mediations crushed (or open capsules) if therapeutically acceptable and mixed into a food source. Resident 42's Medication Administration Record, indicated on 11/30/22, he received the following medication which should not have been crushed: a. Wellbutrin SR tablet extended release 12-hour 150 mg, one tablet by mouth for mood disorder. During an interview, on 11/30/22 at 8:45 a.m., QMA 1 indicated she had an order for the medications to be crushed so she was able to crush the medications. She did not respond when asked what medications could not be crushed. She indicated she could contact the nurse or director of nursing if she had questions. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/29/22 at 9:17 a.m., the Director of Nursing (DON) indicated medications should be given as directed by the physician. If staff had a question whether a medication could be crushed, they should review the medication, contact the DON or pharmacy for clarification. During an interview, on 11/29/22 at 1:51 p.m., the DON she indicated medications which are extended released or sustained release should not be crushed and staff should have reviewed the medication, information or contacted the pharmacy for a liquid form. During an interview, on 12/2/22 at 3:45 p.m., the Consulting Pharmacist indicated medications which are extended released or sustained release should not be crushed to ensure the medication was absorbed by the body as intended. A facility policy, titled Crushing Medication, undated, indicated medication shall be crushed only when it was appropriate and safe to do so, consistent with physician orders. Nursing staff or the consulting pharmacist should contact the physician who gives an order to crush a drug the manufacture states should not be crushed for example long acting or enteric coated medications. 3.1-48(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47346 Based on observation, interview and record review, the facility failed to ensure medications were secure and inaccessible to residents and staff in 2 of 6 cottages reviewed for medication storage. (Cottage 3 and Cottage 4) Findings include: 1. During an observation, on [DATE] at 11:00 a.m., with the Dietary Manager, a round white tablet, identified as Tylenol was found on the floor in Cottage 3, six feet from the dining tablet. The medication on the floor was given to Qualified Medication Aide (QMA) 1. During an observation, on [DATE] at 11:50 a.m., with the Memory Care Coordinator (MCC), a small orange colored tablet was found on the floor in the dining room near Room L which was found to be Paroxetine Hydrochloride Extended Release 37.5 milligrams. The tablet was given to QMA 1 by the MCC. The MCC indicated the medication should have been picked up immediately and destroyed because the residents had a lack of safety awareness. During an observation, on [DATE] at 8:48 a.m., to 8:54 a.m., QMA 1 picked up medication off the medication cart which was in the common area near the fireplace. The medication cart was unlocked and unsecured as she walked away. One resident was observed seated in the living room. Two visitors and a facility staff member were touring Cottage 3. Cook 7 was observed in the kitchen with her back to the common area. Two residents were observed seated at the dining table. During an observation, on [DATE], at 8:55 a.m., the medication/nurse's room in Cottage 3 was found with the white glass door opened all the way. The cabinet door labeled number 5 was unlocked and unsecured. The cabinet door pulled opened and inside the cabinet was a large gray colored box. The gray box was labeled as an Emergency Kit. The green zip tie was found intact on the container. The QMA 1 verified the medication med room door and cabinet were unlocked and unsecured and a resident could get into the room. She indicated the residents in Cottage 3 had diagnoses of dementia and had poor safety awareness. The medication cart should be locked and secured prior to walking away. She did not have the keys to the cabinet, was not able to lock and secure the cabinet, and it had been like that for a while. During an interview, on [DATE] at 12:00 p.m., QMA 1 indicated some of the residents in Cottage 3 would spit out the medication or pretend to take the medication and drop them on the floor. When asked if the medications should be picked up when found, QMA 1 indicated it was the responsibility of the night shift nursing assistants to sweep and mop the floor. The day shift nursing assistants should vacuum the carpets. The medication cart was opened because she forgot to lock it prior to walking away. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation, on [DATE], at 9:00 a.m., the medication/nurse's room in Cottage 4 was found with the white glass door opened all the way. The cabinet door labeled number 5 was unlocked and unsecured. The cabinet door pulled opened and inside the cabinet was a large gray colored box. The gray box was labeled as an Emergency Kit. The green zip tie was found intact on the container. During an observation and interview, on [DATE] at 9:15 a.m., the Director of Nursing indicated the medication/nurse's room was found unlocked with the white glass door wide open. The cabinet labeled number 5 and number 7 were unlocked and pulled right open. Inside the cabinet 5 was a large gray colored box and she indicated it was an Emergency Kit. The Emergency Kit had a green zip tie found intact on the kit. The residents in Cottage 4 had diagnoses of dementia and had poor safety awareness and could be at risk for ingesting medication. During the observation, with the DON, the following were in the unlocked and unsecured cabinets: Inside the Cabinet labeled number 5 in Cottage 4 the following medications were on the shelf near the Emergency kit: a. a 473 ml bottle of valproic acid. b. a bottle of Coppertone sunscreen. c. a bottle of Miralax. d. a 12-ounce bottle of Antigas. e. a bottle of regaloid powered 538 grams. f. an expired bottle of Promed liquid protein, half full with a use by date of [DATE]. g. 5 lovenox 40 mg syringes. h. a bottle of oral rinse. Inside Cabinet labeled number 7 the following were found unlocked and unsecured: a. a 237 ml bottle of Cetaphil lotion. b. a bottle of baby shampoo. c. three tubes of aspercream. d. eight patches of aspercream/lidocaine (pain relieving patches). e. a tube of Resitcare 5 % cream. f. a tube of AD ointment g. a tube of Desitin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. five tubes of Calmoseptine. i. six tubes of Biofreeze. j. a tube of Bacitracin ointment. k. a tube of nystatin. l. a tube of cortisone cream. m. a tube of medihoney. n. a tube of recitcare ointment. The Pharmacy Ekit Contents document had an expiration date of [DATE] and indicated each of the Ekits contained more than 197 different medications. During an interview, on [DATE] at 9:20 a.m., the Executive Director indicated the doors to the medication room should be locked until the locks on the cabinet doors could be replaced. Medications should be secured to ensure the residents could not get into them. During an interview, on [DATE] at 4:41 p.m., the Consulting Pharmacist indicated medication should be locked and secured. Medications which were unsecured could be accidentally ingestion especially with residents with cognitive impairment. 3XXX,d+[DATE](m) 3XXX,d+[DATE](n)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47346 Based on observation, interview and record review, the facility failed to properly handle and store potentially hazardous foods in a manner which was intended to prevent the spread of food borne illnesses, maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination, label and date containers of refrigerated products when opened and failed to wear a hair restraint which completely covered hair and beard while food was being prepped in 6 of 6 cottages reviewed for kitchens. (Cottage 3, 4, 1, 2, 5, and 6) Findings include: 1. During an initial tour of Cottage 3's kitchen, on 11/28/22 at 10:42 a.m., the following were observed: a. The white refrigerator/freezer in the storage room had a gallon which was half full of sweet pickle relish dated 9/29/22. b. The black refrigerator/freezer in the main kitchen had a large tube of ground beef sitting directly on the bottom shelf with no pan underneath. To the left side of the tube of ground beef, was a large area of dried blood which measured 2.5 inches by 10 inches and smeared to the front in a L shaped mark. The whole tube of ground beef was defrosted and did not have a sticker to indicate a pull date or use by date. c. a container of a vinegar coleslaw which was opened and had a dated of 10/20, marked on top of the lid. d. a container of sour cream had a date of 11/10, marked on top of the lid. e a container of cottage cheese had a date of 11/10, marked on top of the lid. f. a bottle of sweet baby rays, opened, 1/3 full, and was undated sitting on a shelf on the door. g. a container of hazelnut spread with a date of 6/8/22, was marked on top of the lid. h. an opened bottle of honey was undated. i. a jar of grape jelly was opened and had a date of 9/16. j. a jar of almond butter, was opened and had a date of dated 7/27. 2 During an initial tour of Cottage 4's kitchen, on 11/28/22 on 11:15 p.m., the following one-gallon containers of salad dressing were observed opened, and in a reach-in cooler: a. Buttermilk Ranch dressing with a received date of 10/26/22. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation of Cottage 4's kitchen, on 11/28/22 at 11:34 a.m., the Dietary Manager was observed not wearing a hairnet or a beard guard when he entered the kitchen. A 32-gallon gray trash can was found outside the kitchen next to the half door, directly across from a resident's room. The trash can container was full of garbage, food waste, and metal cans. During an interview, on 11/28/22 at 11:35 a.m., the Dietary Manager indicated staff should be washing their hands, wearing hair nets and beard guards to keep hair out of food. Staff should put them on prior to walking into the kitchen. The garbage should not be outside the kitchen and should be taken out when full to the outside garbage dumpster. This was a safety and health issue for residents. Staff were putting containers into the refrigerator after they were opened, and not putting dates on them. All containers should have a received date and an open date to ensure items were discarded appropriately. Staff needed to do a better job at labeling food and ensuring the kitchen was kept clean. 37727 4. During an observation in Cottage 1 kitchen, with Cook 9 and 10 in attendance, on 11/28/22 beginning at 10:35 a.m., the following items were noted: a. The bottom cupboard shelves had scattered crumbs throughout. b. The canned foods did not have any date indicating when they were received. c. The Dietary Supervisor walked through the kitchen, at 11:12 a.m., without a hair net. His hair was extended beyond the ball cap he was wearing in the back. He indicated at that time he should have worn a hair net. 5. During an observation of the Cottage 2 kitchen, with the Dietary Manager and Registered Dietician in attendance, on 11/29/21 beginning at 12:36 p.m., the following items were noted: a. In freezer 1, there were several bags of frozen vegetables which were frozen solid, crunched when pick up, and had freezer burn. b. In freezer 2, there was an unidentifiable plastic bag of crumbled meat which was discolored with freezer burn. At that time, the Dietary manager indicated when the meat was put in the freezer it should have been labeled and dated and if something appears to be freezer burn it should be thrown away. 02799 6. During a tour of the kitchen in Cottage 5, on 12/01/2022 at 2:39 p.m., with the Dietary Manager (DM) and the Registered Dietitian, the following was observed: a. In a black refrigerator/freezer, 2 packages of link sausages, with an open date of 11/15/2022, were observed in the freezer compartment. The package was loosely wrapped in plastic cling wrap which had come loose at the end of the package. A large amount of ice crystals was observed inside the bag around the sausages. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. In a black refrigerator/freezer, a gallon size plastic bag contained frozen Swai (fish) found in the freezer compartment. The undated plastic bag was open to air and ice crystals were in and around the fish portions. The microwave was observed to have dried, brown food splatter on the ceiling and the right side of the heating compartment. A flat griddle on the center island was heavily soiled with black, burnt, and stuck on food debris. During an interview, with the DM (Dietary Manager), he indicated the griddle was used for preparing eggs in the morning. 7. During a tour of the kitchen in Cottage 6, on 12/01/2022 at 3:34 p.m., with the Dietary Manager (DM) and the Registered Dietitian, the following was observed: a. 2 bags of cubed squash and 2 bags of carrots were observed in the freezer compartment. Both unopened bags were observed to have a large buildup of ice crystals on the inside of the bag and all items appeared discolored. A policy related to kitchen was not provided before exit. 3.1-21(i)(1) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47346 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections, failed to handle, store, process, and transport linens to prevent the spread of infection, ensure the laundry rooms and washing machines were kept clean and in good repair, and to ensure proper infection control measures were followed related to hand hygiene during direct resident care observations including feeding, wound care, and medication administration. This had the potential to affect 64 of 64 residents who resided in the facility. Findings include: 1. During an interview, on 12/1/22 at 2:32 p.m., the Nurse Consultant indicated the facility had a management change over and did not have an infection control program in place. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) had not completed the program for infection preventionist. She had not found any documentation over the last year to indicate the facility had been providing infection surveillance. During a review of the facility document, titled Resident Infection Tracker, lacked indication from 1/1/22 to 12/1/22, the facility had been tracking infections throughout the facility. A review of the QAPI plan, on 12/1/22 at 2:45 p.m., with the Nurse Consultant, the QAPI plan dated 11/1/22, identified areas of concern related to no infection control system in place, no antibiotic stewardship program, or covid vaccine program. The root cause was due to the lack of tools to document and track infections, lack of education, and a frequent turn over in management and floor staff. The goal of the QAPI plan was to establish an infection control program, antibiotic program and covid vaccine program. 2. During an observation, on 11/28/22 at 10:43 a.m., a bath towel, pillowcase, and gown were found directly on floor. The floor was observed to have dirt and dust under the linens. During an observation, on 11/28/22 at 10:53 a.m., a bath towel, pillowcase, and top sheet were found directly on floor. The floor was observed to have dirt and dust under the linens. During an interview, on 11/28/22 at 2:00 p.m., the Memory Care Coordinator indicated the linens should not be on the dirty floor. Staff should be cleaning the floor and ensure all linens were on the shelves. 3. During a continuous observation, on 11/28/22 from 11:59 a.m., to 12:37 p.m., Certified Nursing Assistant (CNA)6 was observed to walk over to the wall and grab a red colored four wheeled walker and push it over to the table between two residents. He sat down on the walker and picked up a fork near Resident 49 and proceeded to pick up bites of spaghetti and feed the resident. CNA 6 than grabbed a fork next to Resident 30 and provided bites of spaghetti. CNA 6 had his hand touching his hair on the side of his head. CNA 6 put his arm down and grabbed a cup with his left hand and helped Resident 49 take a drink. CNA 6 did not perform hand hygiene throughout the process of feeding Resident 30 or Resident 49. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 11/28/22 at 12:40 p.m., CNA 6 indicated he was not aware he did not perform hand hygiene during the meal service. During an interview, on 11/29/22 at 1:45 p.m., the DON indicated staff should be performing hand hygiene before, during, and after providing feeding assistance to a resident. Staff should not rest their head on their arm or hands during the meal service. During an interview, on 12/1/22, at 2:30 p.m., the Consultant Nurse indicated her expectation was for staff to perform hand hygiene as needed and before providing care such as medication pass or feeding. Staff should perform hand hygiene before feeding or in between feeding residents. The staff should avoid touching their face or hands while providing care or passing medications. 4. During an observation, on 11/29/22 at 8:40 a.m., Qualified Medication Aide (QMA) 1 had prepped medication for Resident 10. After mixing the crushed medication into pudding, she grabbed the cup and a spoon. She then walked over to Resident 10's room, along the way scratched her stocking hat on three different occasions. QMA 1 was observed to walk into Resident 10's room, directly into the bathroom where Resident 10 was seated on the toilet with her pants and brief down to her thighs and administered the medication mixed in pudding. QMA 1 handed Resident 10 a glass of water and she took a drink. QMA 1 was not observed performing hand hygiene before, during, or after administering the medication. During an interview, on 11/29/22 at 8:50 a.m., QMA 1 indicated she forgot to perform hand hygiene before giving the medications and giving medications in the bathroom while a resident was using the toilet may not be the best place. During an interview, on 11/29/22 at 1:51 p.m., the DON indicated QMA 1 should not be giving medication to a resident while on the toilet, it was an infection control and a dignity issue. QMA 1 should perform hand hygiene after scratching her stocking hat and performing a medication pass. 5. During a tour of laundry room in Cottage 3 and Cottage 4, with Consultant Nurse, on 12/1/22 from 1:30 p. m., to 1:45 p.m., the following were observed: a. The first laundry room in Cottage 3 had no separation of the clean and dirty laundry area. A white bath towel was found on the floor with a 2-inch brown stain. The towel was not in a bag. The floor of the laundry room was more than 50 percent dirty with dried stains, dirt, and dust. The washer and dryer had dirt, dust, and dried stains on the outside, and the glass on the inside of the machine had dirt and grime on them. b. The second laundry room in Cottage 3 had no separation of the clean and dirty laundry area. The floor of the laundry room was more than 50 percent dirty with dried stains, dirt, and dust. The washer and dryer had dirt, dust, and dried stains on the outside, and the glass on the inside of the machine had dirt and grime on them. c. The first laundry room in Cottage 4 had no separation of the clean and dirty laundry area. The floor of the laundry room was more than 50 percent dirty with dried stains, dirt, and dust. On the soap dispenser and on top of the machine, a quarter size spot of dried blood was found with fingerprint impression lines. The washer and dryers had dirt, dust, and dried stains on the outside, and the glass on the inside of the machine had dirt and grime on them. (continued on next page)

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	155846	A. Building B. Wing	12/08/2022

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. The second laundry room in Cottage 4 had no separation of the clean and dirty laundry area. The floor of the laundry room was more than 50 percent dirty with dried stains, dirt, and dust. The washer and dryer had dirt, dust, and dried stains on the outside, and the glass on the inside of the machine had dirt and grime on them. A two-foot area of water was observed under the washing machine on the floor. 37727 6. During an observation of Resident 53's pressure dressing change, on 11/30/22 at 10:37 a.m., LPN 23 removed the old dressing from the resident's pressure sore, she then removed her gloves and washed her hands. She put on new gloves and cleansed the wound with normal saline (salt water) and opened the medihoney (a medication used to treat open pressure sores) tube and spread it on the new dressing, directly from the tube not using a clean application stick. She then placed the dressing onto the wound and dated it. She did not change her gloves in between cleaning the dirty wound and putting on the treatment and a clean dressing. During an interview, at that time, LPN 23 indicated she should have removed her gloves and washed her hands when going from cleaning the resident's dirty wound to putting on medication and applying the clean dressing. The record for Resident 53 was reviewed on 11/30/22 at 2:00 p.m. Diagnoses included, but were not limited to, pressure ulcer of sacral region, morbid obesity, and diabetes mellitus. A current physician's order, dated 11/15/22, indicated to cleanse the residents pressure wound with normal saline, apply medihoney, and cover with a dry dressing every day for pressure wound healing. A current care plan, initiated 11/07/22, indicated the resident had a pressure ulcer to her coccyx. Interventions included, but were not limited to, administer treatments as ordered. 7. On 11/28/2022 at 11:39 a.m., an unidentified CNA (certified nursing assistant) was observed to emerge from a room on the south side of Cottage 5 holding a large amount of loosed, uncovered soiled linen on her left shoulder, balancing the load of soiled linen next to her face. The CNA briefly entered another resident room and then proceeded to carry the uncovered linens the length of the cottage and deliver them to the laundry room. During an interview, on 12/1/22 at 3:00 p.m., the Consultant Nurse indicated the laundry room needed to have a dedicated clean and dirty area for linens, the equipment needed to be repaired or replaced, the floor needed to be mopped, staff needed education on infection control with linens, a process needed to be developed and implemented for laundry to include transporting dirty clothes or lines especially when the linens are soiled with body fluids. Staff should be wearing gloves and gowns, and soiled linens and towels should be bagged appropriately as the staff carry the linens through the facility. A current policy, titled Hand Washing When Providing Direct Care to an Elder, undated and provided by the Director of Nursing on 11/30/22 at 2:00 p.m., indicated .9. Wash hands if moving from a contaminated-body site to a clean-body site during elder care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A current policy, titled Standard Precautions for Infection Control Prevention and Control, undated and provided by the Director of Nursing on 11/30/22 at 2:00 p.m., indicated .i. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items regardless if gloves are worn .ii. Wash hands immediately after gloves are removed .between infected wound sites and when necessary to avoid transfer of microorganisms A current policy, titled Wound Care, undated and provided by the Director of Nursing on 11/30/22 at 2:00 p.m. , indicated .Steps in the procedure .Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Put on gloves .remove ointments and creams from their containers 3.1-18(b)(4)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 47346 Based on interview and record review, the facility failed to establish an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use for 12 of 12 months reviewed for antibiotic stewardship. Finding includes: A review of the facility QAPI plan, dated 11/1/22, indicated the facility had no antibiotic stewardship program in place. The root cause was due to the lack of tools to document and track infections, lack of education for staff, and a frequent turn over in management and floor staff. The goal of the QAPI plan was to establish an antibiotic program. There was no documentation the QAPI plan this had been started. During a document review, on 12/1/22 at 11:00 a.m., the Nurse Consultant provided a binder titled Antibiotic Stewardship. The binder did not contain information of any tracking for 2022. The Nurse Consultant indicated the facility would use the McGeer Criteria Forms which were to be completed by the nursing staff and would be reviewed by IDT (Interdisciplinary Team) and the provider, with recommendations being made. During an interview, on 12/1/22 at 11:00 a.m., the Nurse Consultant indicated the facility had not been involved in an antibiotic stewardship program for a long time. She recently discovered the concern when reviewing the facility records. It was important to have an antibiotic stewardship program to ensure the treatment of infections and to reduce adverse events such as antibiotic resistance. Residents, family, staff, and clinicians need an antibiotic stewardship program to learn about antibiotic resistance and opportunities for improving antibiotic use. A current facility policy, titled Antibiotic Stewardship-Orders for Antibiotic, dated 5/20/20, indicated the antibiotics will be prescribed and administered to residents under the guidance of the community's antibiotic stewardship program and in conjunction with the community's general policy for medication utilization and prescribing. 3.1-18(b)(3)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 47346 Based on interview and record review, the facility failed to implement COVID - 19 vaccination policy and procedures by providing education on COVID-19 to staff, offering the COVID -19 vaccination, and report COVID-19 vaccination status to the NHSN for staff. This had the potential to affect 64 of 64 residents who resided in the facility. Findings include: The COVID-19 Staff Vaccination Status for Providers matrix indicated: a. Total number of staff was 62. b. Total number of staff partially vaccinated was 5 c. Total number of staff completely vaccinated was 54. d. No pending exemptions. e. One granted exemption. f. No temporary delay of new hire. g. Two staff were not vaccinated without exemption or delay. A review of the facility QAPI plan, dated 11/1/22, indicated the facility had no infection control system in place or covid vaccine program. The root cause was due to the lack of tools to document and track infections, lack of education for staff, and a frequent turn over in management and floor staff. The goal of the QAPI plan was to establish an infection control program and covid vaccine program. There was no documentation the QAPI plan had been started. During an interview, on 12/1/22, at 2:32 p.m., the Consultant Nurse indicated the facility had not educated, documented refusals if there were any, or offered staff the COVID 19 vaccine. The facility recently held a vaccination clinic for all the resident to receive their influenza and COVID-19 vaccine. The facility did not maintain documentation prior to her involvement to assist the facility to build the infection prevention program. There were two staff members the facility did not have documentation on vaccination status or an exemption. During an interview, on 12/1/22, at 3:59 p.m., the Consultant Nurse indicated the facility sent a message to staff requesting vaccination status for COVID-19 but had not received information from some staff. The facility had not recently sent in information to the National Healthcare Safety Network (NHSN (healthcare-associated infection (HAI) tracking system) on vaccination status. A facility policy on COVID-19 was requested but was not provided. The Consultant Nurse indicated the facility did not have a policy at this time and she was working on developing the infection prevention program with the Director of Nursing. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.1-18(b)(6)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47346 Based on observation and interview, the facility failed to maintain a functional and safe environment related to multiple gaps in the flooring for 2 of 6 cottages reviewed for environment. (Cottage 3 and Cottage 4) Findings include: 1. During an initial tour of Cottage 3, on 11/28/22 at 11:15 a.m., there was an accumulation of dried food and dirt in multiple areas of the flooring where the vinyl planks had separated from each other. Many areas measured a 1/2 inch up to 5 inches. During an observation, on 11/28/22 at 11:52 a.m., Cottage 3 had 2-inch gaps in the flooring throughout the cottage main living areas and an area in the dining room had a separation of flooring which measured 6 inches. 2. During an observation, on 11/28/22 at 11:34 a.m., the dining room in Cottage 4 had multiple gaps in the flooring which had 1/4-to-1/2-inch separation. Within the cracks were dust, dirt, and food particles. During an observation, on 11/28/22 at 11:44 a.m., in Cottage 4, near Room B, a corner of the laminate flooring plank had peeled up. During an interview, on 11/28/22 at 12:05 p.m., Certified Nursing Assistant (CNA) 3, in Cottage 4, indicated she had noticed multiple areas of separation in the flooring. Cottage 4 seemed to have a lot more separation and it was difficult to get the dirt out of the groves. Some of the residents who use a walker could get their walker stuck. During an interview, on 11/28/22 at 3:04 p.m., CNA 4 indicated the flooring had separated in multiple areas of Cottage 4 including the main common areas and in the residents' rooms. During an interview, on 11/28/22 at 3:16 p.m., the Maintenance Director indicated the flooring had been an issue where it had separated from each other leaving gaps to collect dirt and food particles. It was a safety concern with the residents. During an interview, on 11/29/22 at 9:20 a.m., the Executive Director verified there was multiple areas in Cottage 3 and Cottage 4 where the flooring had separated in some areas which needed to have the flooring pushed back together and other areas needed repair. 3.1-19(f)(5)