STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00357620, IN00358390, IN00358395, IN00358750, IN00359070, IN00359688, and IN00360029. Complaint IN00357620 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00358390 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00358395 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00358750 - Unsubstantiated due to lack of evidence. Complaint IN00359070 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00359688. Unsubstantiated due to lack of evidence. Complaint IN00360029 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684. Survey dates: August 4, 5, 6, and 9, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 55 Total: 55	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility or Management Group of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully request paper compliance. ="" p=""> ="" p=""> ="" p="">	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Payor Type: Medicare: 4 Medicaid: 37 Other: 14 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2021.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to provide nursing services and treatment for a non-pressure wound for 1 of 3 residents reviewed (Resident E) and failed to provide routine assessments per physician's order and care plan for 2 of 3 residents reviewed for wound prevention (Residents E and F). Findings include: 1. On 8/4/21 at 4:38 p.m., Resident E was observed sitting at a dining table among peers, watching those around her with a flat affect. She was wearing protective arm sleeves on both arms from the palm to above the elbow and had a	F 0684	=" p=">
=" p=">
=" b=">
b=">
=" p=">
=" b=">**What corrective action (s) will be accomplished for those residents found to have bee affected by the deficient practice.**
The treatment for resident E was completed.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	09/05/2021

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	hearing aide in her left ear tethered to the front of her shirt with a metal clip. The resident responded to a staff member when asked a specific question but did not initiate conversation. On 8/9/21 at 9:46 a.m., Resident E was observed sitting at a dining table among peers finishing up breakfast. The resident was repeatedly stacking 2 cups and pushing the cups and a plate away from her. The plate of food and 1 cup of liquid had been consumed, and 1 cup had a small amount of unidentified white liquid remaining. Resident E was dressed in clean clothing, was wearing protective arm sleeves on both arms from the palm to above the elbow, no odors. On 8/9/21 at 10:18 a.m., Resident E was observed sitting beside the fireplace wearing protective arm sleeves on both arms. On 8/9/21 at 10:21 a.m., Resident E's skin was observed with Qualified Medication Aide (QMA) 16. A large dark beefy red colored wound was observed on the resident's right breast, open to air, with no dressing. QMA 16 indicated she would let the nurse know the resident did not have a dressing on her breast. Resident E's record was reviewed on 8/6/21 at 11:26 a.m. Diagnoses on Resident E's profile included, but were not limited to, small cell b-cell lymphoma (cancer) unspecified site, vascular dementia without behavioral disturbance, and neuromuscular dysfunction of the bladder. The annual MDS (Minimum Data Set) assessment, completed on 7/14/21, assessed Resident E as having the ability to make herself		**taken.** All Elders have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**Nursing staff will be re-educated on doing treatments and assessments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recure, ie., what quality assurance program will be put into place.** DON/designee will check 5 days a week 2 elders' treatments a day to ensure they are completed as ordered for 2 months, then 2 elders 3 days a week for **b="">** ="" p="">** The date the systemic changes will be completed: Sept 5, 2021** **span="">** ="" p="">**	

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	understood, and sometimes understood others. The Brief Interview for Mental Status (BIMS) score of 3 indicated severe cognitive impairment. Resident E required extensive assistance of 2 or more persons physical assistance for bed mobility, transfers, dressing, and toilet use. Extensive assistance of 1 person physical assistance for personal hygiene. She had an indwelling catheter and was frequently incontinent of bowel. Resident was at risk for developing pressure ulcers. Lesion on the breast. Application of non-surgical dressing and medications/ ointments other than to the feet. A Care Plan for Resident E, dated 10/17/17, indicated she had the potential risk for developing a pressure ulcer due to impaired bed mobility and a foley catheter. Her goal was to have intact skin, free of redness, blisters, or discoloration by/through review date. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, and complete skin risk assessment weekly. The care plans lacked documentation of a right breast cancer lesion. A Nursing Progress Note, dated 6/19/21 at 8:07 a.m., indicated Resident E had a hard mass on the breast that was bleeding. An ultrasound had been scheduled for the right breast lesion. A Nursing Progress Note, dated 6/19/21 at 9:32 p.m., indicated Resident E had a right breast lesion with scant serosanguinous (blood tinged) drainage, the area was hard to touch and remained red. Physician's orders for Resident E included, a. On 5/19/20 weekly skin assessment. Complete visual head to toe skin assessment every Saturday			

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	day shift for skin monitoring, complete under assessments, document findings in progress note and include complete set of vital signs. b. On 7/14/21 every shift check placement of dressing to right breast. If not intact cleanse area with normal saline (NS) and apply Optifoam (a padded dressing with silicone borders). c. On 7/15/21 check and change dressing to right breast every 8 hours as needed for soilage. d. On 7/24/21 cleanse right breast with NS and apply Optifoam daily on night shift. The Treatment Administration Records (TARs) for Resident E, dated July and August 2021, had documentation indicated the weekly skin assessment had been completed weekly on Saturday. The medical record lacked documentation to indicate the Weekly Skin Assessments had been completed on 7/3, 7/17, 7/31, or 8/7/21. The TAR for Resident E, dated July 2021, indicated the record lacked documentation to indicate the right breast had been cleansed with NS and the Optifoam dressing changed from 7/14/21 to 7/23/21. A Nursing Progress Note, dated 7/14/21 at 6:33 a.m., indicated Resident E had a right breast mass measuring 6.0 centimeters (cm) x (by) 6.0 cm with the surface area measuring 5.0 cm x 5.0 cm with minimal bright red bleeding. A Nursing Progress Note, dated 7/14/21 at 7:23 a.m., indicated orders had been obtained for Resident E to cleanse right breast with NS and apply Optifoam daily. A Nursing Progress Note, dated 7/14/21 at 4:10 p.m., indicated verbal orders had been obtained			

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	from the Nurse Practitioner (NP) to keep area to right breast cleaned and covered with Optifoam daily. Nursing Progress Notes for Resident E, dated 7/15/21 to 8/3/21, lacked documentation the right breast lesion had been observed, assessed, or the dressing changed. During an interview on 8/6/21 at 10:29 a.m., Resident E's daughter indicated her mother had an open sore on her breast that was supposed to have the dressing checked and changed daily. Last month the resident had gone 9 days without having the dressing changes. On 7/24/21 the daughter had observed the dressing dated 7/15/21 and had reported it to the weekend supervisor who indicated he would take care of it. During an interview on 8/9/21 at 10:24 a.m., QMA 16 indicated she was responsible for basic skin care and skin tears. The nurse was responsible for wounds and skin conditions such as Resident E's, and the QMA was unable to access information on the resident's wound in the electronic medical record (EMR). QMA 16 indicated if she received information about a new resident skin area from an aide, she would have immediately notified the nurse and Director of Nursing (DON). She would then have documented the wound information on the shift report as she was not allowed to document resident wounds in the resident medical record. During an interview on 8/9/21 at 10:31 a.m., Registered Nurse (RN) 17 indicated she was an agency nurse, and it was her first time working in these cottages, so she was not familiar with the residents. Resident E's treatment order to her breast indicated check dressing for placement			

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	every shift by the nurse and replace as needed. Night shift orders were for the nurse to cleanse the breast with NS and apply Optifoam every night. RN 17 indicated if she had received information of a new resident wound, she would have assessed the wound, filled out a skin assessment form including measurements, notified the DON, called the physician for new orders, notified the responsible party, and would have let the resident know what new orders had been obtained. The new wound information was to be passed on in report, documented in the progress notes and physician's orders, and an alert charting order would have been put in to tell nurses to document on the area, and change of condition documentation completed. During an interview on 8/9/21 at 10:58 a.m., the DON indicated the licensed nurse was responsible for providing wound care per resident treatment orders and documenting on the TAR. If an aide found a new wound, the aide was to notify the nurse. The nurse was responsible to assess the wound, notify the physician for a new order, then notify the DON. Documentation of a new wound should have been completed on an incident report, and wound assessment. Routine wound assessments were completed weekly by the licensed nurse, and the aide visualized skin on shower days. It was the responsibility of the DON to monitor for completion of weekly skin assessments. The licensed nurse was ultimately responsible for assuring the weekly skin assessments and wound treatments were completed as ordered. During an interview on 8/9/21 at 12:09 p.m., the Administrator (ADM) indicated, Resident E's daughter had been upset in July when the dressing to the resident's breast had not been changed			

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	daily, but there had not been an order at that time to change the dressing daily. On 7/14/21 an order was written to cleanse the right breast area and change the dressing every evening. On 7/15/21 the order was changed to every shift check dressing for placement, if not intact cleanse and replace. The order was not signed off every shift on the TAR as the nurse put the order in the electronic system incorrectly. On 7/24/21 the daughter was upset about the order not being done daily, so the DON called the physician and had the order changed to have the dressing changed every night. The ADM did not believe the dressing had not been changed for 9 days in July. 2. On 8/4/21 at 4:21 p.m., Resident F was observed lying in bed propped on her right side facing the window, bed in low position, fall mat at bedside, and a call light on her chest clipped to a blanket. Bedding and clothing were observed clean with no odors. On 8/9/21 at 9:48 a.m., Resident F was observed lying in bed, propped with a pillow onto her left side facing the bathroom, awake, alert, and talkative. The resident was observed wearing protective arm sleeves on bilat arms from hands to above elbows. On 8/9/21 at 10:04 a.m., observation of Resident F's bottom with QMA 16. The resident's brief was wet with urine, no open areas or redness to the bottom observed. A package of briefs, wet wipes, and protective cream observed at bedside. Resident F's record was reviewed on 8/6/21 at 2:00 p.m. Diagnoses on Resident F's profile included, but were not limited to, Alzheimer's Disease, dementia, and psychotic disorder with			

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	delusions. The quarterly MDS assessment, completed on 7/22/21, assessed Resident F as having the ability to make herself understood and rarely understood by others. BIMS score of 99 indicated the resident was unable to complete the assessment. Resident F required extensive assistance of 2 or more persons physical assist for bed mobility, transfers, dressing, and toileting. She did not walk in the room or corridor. Extensive assistance of 1 person physical assist for locomotion on and off the unit, eating, and personal hygiene. She was always incontinent of bladder and bowel. A Care Plan for Resident F, dated 8/9/18, indicated she had the potential risk for developing a pressure ulcer due to incontinence and impaired bed mobility. Her goal was to have intact skin, free of redness, blisters, or discoloration by/through review date. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, and complete skin risk assessment weekly. Physician's orders for Resident F included, a. On 8/6/18 weekly skin assessment. Complete visual head to toe skin assessment every Monday day shift for skin monitoring, complete under assessments, document findings in progress note and include complete set of vital signs. b. On 3/6/21 Riley's Butt Paste apply to buttock/rectal area 6 times daily. The Treatment Administration Records (TARs) for Resident F, dated July and August 2021, had documentation indicating the weekly skin assessment had been completed weekly on			

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	Saturday. The medical record lacked documentation to indicate the Weekly Skin Assessments had been completed since 7/23/21. During an interview on 8/5/21 at 2:51 p.m. the resident's family member indicated during a recent visit she realized staff were using butt paste on the resident, and when she asked to see the residents bottom staff refused to let her see. Due to not seeing the residents bottom she was sure the resident had a sore bottom. On 8/9/21 at 12:15 p.m., the ADM provided a Wound Care policy, dated October 2010, and indicated the policy was the one currently being used by the facility. The policy indicated, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing ...1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess any special needs for the resident...." This Federal tag relates to Complaints IN00359070 and IN00360029. 3.1-37(a)			