DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00363744, IN00362752, IN00362607, IN00362377 and IN00361909. Complaint IN00363744-Substantiated. Federal/State deficiencies related to the allegations are cited at F759, F812 and F880. Complaint IN00362752-Substantiated. Federal/State deficiencies related to the allegations are cited at F812 and F880. Complaint IN00362607-Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F812 and F880. Complaint IN00362377-Substantiated. Federal/State deficiencies related to the allegations are cited at F573, F657 and F812. Complaint IN00361909-Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 27, 28, 29, 30, October 1 and 4, 2021. Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type:	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 requests paper compliance.	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare: 1 Medicaid: 38 Other: 14 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 13, 2021.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure staff placed residents call lights in reach for 3 of 3 residents reviewed for accommodation of needs. (Residents M, J and L) Findings include: 1. During an observation, on 09/27/21 at 10:54 a.m., Resident M was found resting in bed. The head of the bed was raised up to approximately 90 degrees and the call light was observed hooked to the head of the bed on the headboard where it was not accessible because it was behind the raised head of the bed. During an interview, on 09/27/21 at 10:56 a.m., CNA 8 indicated the call light should have been in reach.	F 0558	**F558 SS=D Reasonable accommodations needs/preferences** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** It is the practice of this facility to provide all elders with reasonable accommodation of elder needs and preferences. The call lights for residents M, J, and L were immediately repositioned to ensure it was within reach of each elder. **·How other residents having the potential to be affected by**	10/30/2021

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	The record for Resident M was reviewed on 09/30/21 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, age related physical debility and muscle weakness. A care plan, initiated on 09/24/20, indicated Resident M had a communication problem. Resident M was able to shake her head for yes and no questions and she rarely spoke. When she did speak her words were not clear. An intervention, initiated on 09/24/20, indicated the call light was to be in reach. A care plan, initiated on 06/09/17, indicated Resident M had a potential for falls due to poor safety awareness. An intervention, initiated on 06/09/17, was to ensure the call light was in reach. Under the same care plan, another intervention, initiated on 06/09/17, indicated the resident needed a safe environment with a working and reachable call light. 2. During an observation, on 09/28/21 at 02:58 p.m., Resident J was observed resting in a low bed. The call light cord was observed from the wall box running down the wall and then not observable. During an interview, on 09/28/21 at 3:00 p.m., LPN 13 indicated the call light was to be in reach. The record for Resident J was reviewed on 09/27/21 at 3:43 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, unspecified glaucoma and osteoarthritis. A care plan, initiated on 03/03/20, indicated Resident J had a potential risk for falls due to confusion. An intervention, initiated on 03/03/20, indicated to check placement of the call light and		**the same deficient practice will be identified and what corrective action(s) will be taken.** A 100% audit was conducted by the Executive Director to ensure each elders call light was within reach with no additional findings. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The DNS and or designee will provide education to staff related to the positioning and answering of call lights. Any staff that fail to comply with the information delivered in the in-service will be further educated and/or progressively disciplined as indicated. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Executive Director and/or designee will conduct rounds 5 days weekly, times 6 months or ongoing until 100% compliance achieved. This deficient finding will be monitored by the Executive	

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	ensure it was within reach. Another intervention, initiated on 06/04/21, indicated be sure the call light was within reach. 3. During an observation, on 09/28/21 at 3:10 p.m., Resident L was observed sitting in a chair, in the corner, of her room, the call light was observed to be on the other side of the room with the bed between the resident and call light. During an interview, on 09/28/21 at 03:11 p.m., CNA 14 indicated the call light should have been in the resident's reach and who ever had put her in her chair did not give her the call light. The record for Resident L was reviewed on 09/27/21 at 12:02 p.m. Diagnoses included, but were not limited to, dementia, heart failure and weakness. A care plan, initiated on 11/22/19, indicated Resident L was a potential fall risk related to impaired safety awareness and to check for the placement of the call light and ensure it was within reach. A care plan, initiated on 11/22/19, indicated Resident L had a hemiarthroplasty of the right hip from a fall and the call light was to be within reach. A current facility policy, titled "Use and Answering of Elder Call Light," dated 2001 and provided by the Admissions/Trainer (MAT) on 09/29/21 at 1:47 p.m., indicated "...When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident...." 3.1-3(v)(1)		Director and/or designee through the observation and review of audit tools. The findings of the audits will be reviewed, in the monthly QAPI times 6 months or ongoing until 100% threshold is achieved. **·By what date the systemic changes will be completed.** October 30, 2021	

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F 0573 SS=D Bldg. 00	483.10(g)(2)(i)(ii)(3) Right to Access/Purchase Copies of Records §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each			

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	resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.			
	Based on interview and record review, the facility failed to provide an "Authorization for Release of Medical Information" to the Resident Representative upon the initial request for a copy of a care plan for 1 of 1 resident reviewed for release of medical records. (Resident J) Finding includes: A document provided by the Social Services Worker (SSW) on 9/28/21 at 12:20 p.m., indicated "...6/29/21 Care Conference. Daughter requested a copy of care plan...SS (Social Services) informed medical records of daughter's request...7/13/21 Daughter made a request for a copy of care plan. SS informed IDT (Interdisciplinary Team) members and team wanted to review before sending to daughter...8/18/21 Daughter made another request for a copy of care plan...SS apologized for the confusion and delay...SS sent daughter a consent to release...Daughter sent the consent back but it was not filled out or signed, it was blank...SS consulted with ED (Executive Director)...SS consulted with ED...ED directed SS to send care plan to daughter...." An email correspondence from the Resident Representative, dated July 13, 2021, provided by the SSW on 09/28/21 at 12:20 p.m., indicated a request for a copy of a care plan from the care plan meeting on June 29, 2021 was made.	F 0573	**F573 SS=D Right to access/ purchase copies of records** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** It is the practice of this facility to provide authorization for release of medical information to the resident representative upon the initial request. The resident representative for elder J was provided with a release of medical information and a copy of the elder's care plan. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A 100% audit was conducted by the social service director and/or designee to ensure that a release of medical information was completed by the elder representative with no findings.	10/30/2021

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	An email correspondence from the Resident Representative, dated August 16, 2021, provided by the SSW on 09/28/21 at 12:20 p.m., indicated a request for a copy of a care plan from the care plan meeting on June 29, 2021 was made. An email correspondence from SSW to Resident Representative, dated August 16, 2021, indicated "...I'm sorry for any delay...I've attached a consent to release that needs to be filled out before it can be sent to you...." This email was the first email to mention the need for an authorization to have the care plan released to the Resident Representative. An email correspondence to the Resident Representative, dated 08/19/21, indicated "...Please find attached a copy of the care plan...." During an interview, on 10/04/21 at 8:40 a.m., the Social Services Worker initially indicated no authorization was needed for a copy of a care plan, she then indicated the facility had a medical records person, previously, which handled the Authorizations for Record Release and she thought the authorization had already been taken care of by the medical records person. A current facility policy, titled "Authorization for Release of Medical Information Form," dated 2016 and provided by the Executive Director on 09/28/21 at 10:29 a.m., indicated "...Team Members Responsible: Health Information Coordinator, Social Services, Nursing Director, Financial Director, Executive Director...To ensure ... Medical ... Information is protected and released only at the request of...Elder specified individuals, i.e. POA, Legal representative...the request will be made in writing utilizing a designated form...Complete the Authorization for...Copies will be provided within 48 hrs (hours)...."		· **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The social service director and/or designee will provide education to staff related to the release of medical information. ·**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The social service director and/or designee will provide each resident representative with a copy of the authorization of medical information during each care plan conference, times 6 months or ongoing until 100% compliance achieved. This deficient finding will be monitored by the Executive Director and/or designee through the observation and review of audit tools. The findings of the audits will be reviewed, in the monthly QAPI times 6 months or ongoing until 100% threshold is achieved. ·**By what date the systemic changes will be completed.**	

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	This Federal Tag relates to Complaint IN00362377. 3.1-4(b)(2)		October 30, 2021	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			

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	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview and record review, the facility failed to implement interventions documented in a fall care plan for a resident who was at risk for falls (Resident H) and failed to develop a diabetic care plan for a resident who had a diagnosis of Diabetes Mellitus (Resident K) for 2 of 14 residents reviewed for care plans. Findings include: 1. On 09/30/2021 at 10:59 a.m., the resident's room was observed to be cluttered, without a scoop mattress on the bed and his bathroom door was open. There was a sign taped to his bathroom door indicating "close the bathroom door when not in use." On 09/30/2021 at 3:03 p.m., the resident's bathroom door was observed open. On 10/01/2021 at 1:50 p.m., the resident's bathroom door was observed open and there was not a scoop mattress on his bed. On 10/04/2021 at 9:13 a.m., the resident's room was observed cluttered with a wristwatch, gloves, bag of drinking straws and a pencil sharpener on the floor. His bathroom door was open and there was not a scoop mattress on his bed.	F 0656	**F656 SS=D Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the practice of this facility to provide and arrange services to be provided by qualified persons in accordance with each elder's written plan of care. Elder H's fall interventions were implemented to reflect the elders fall care plan. Elder K's care plan has been updated to reflect the elder's diagnosis of diabetes mellitus. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** A 100% audit of all elders with a diagnosis of diabetes mellitus has been conducted to ensure each elder has an updated care plan. In addition, all fall care plans were reviewed to ensure interventions were implemented and in place for	10/30/2021

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	The record for Resident H was reviewed on 09/30/2021 at 11:08 a.m. Diagnoses included, but were not limited to, Parkinson's Disease, unsteadiness of feet and repeated falls. A Health Status note, dated 07/09/2021 at 9:27 a.m., indicated the resident was found lying on the fall mat at 5:00 a.m. The resident was in bed prior to the fall. A Health Status note, dated 08/11/2021 at 2:52 a.m., indicated the resident was found lying on a matt next to his bed. The resident was unable to say how the fall occurred. A fall care plan, dated 03/30/2021, indicated the resident was a risk for a fall due to gait, balance disturbances and poor safety awareness. Interventions included, but were not limited to, close the bathroom door when not in use to distract resident's obsessiveness of going to the bathroom frequently which was initiated on 04/14/2021, the use of a scoop mattress which was initiated on 04/22/2021 and the resident's room should be free of clutter which was initiated on 03/30/2021. During an observation and interview, on 10/04/2021 at 12:48 p.m., the MDS (Minimum Data Set) Coordinator indicated the resident did not have a scoop mattress on his bed and his bathroom door was open. She also indicated nursing should be following and implementing all care plan interventions. 2. The record for Resident K was reviewed on 09/28/21 at 2:48 p.m. Diagnoses included, but were not limited to, hypertension, depressive disorder and dementia. The Minimum Data Set Assessment, dated		each elder. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Nursing and/or designee will update staff on the policy related to the updating of comprehensive care plans. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** During routine rounds and chart audits, the director of nursing and/or designee will review 5 elders weekly, times 6 months to ensure each elder with a diagnosis of diabetes mellitus has a care plan. In addition, the director of nursing will review 5 elders fall care plans weekly, times 6 months to ensure each intervention is in place.This deficient finding will be monitored by the Director of nursing and/or designee through the observation and review of audit tools. The findings of the audits will be reviewed and trended, in the monthly QAPI times 6 months or ongoing until 100% threshold is	

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	07/26/21, indicated under Section I (where diagnoses are noted) indicated "...NO...." for diabetes and in section N (where medications given during the seven day review are noted) indicated the resident received seven insulin injections. A physician's order, dated 07/03/21, indicated to give Levemir (an insulin) by injection, 25 units daily for diabetes. During an interview, on 10/04/21 at 8:44 a.m., the MDS Coordinator indicated she was responsible to develop care plans for diabetes and Resident K did not have a diagnosis of diabetes. She then reviewed the resident record and indicated Resident K should have had a care plan for diabetes. A current facility policy, titled "Care Plan Completion," dated October 2019 and provided by the Executive Director on 10/04/21 at 11:16 a.m., indicated "...the IDT (interdisciplinary team) must evaluate information gained to develop a care plan that addresses...resident's...problems and needs...." This Federal Tag relates to Complaint IN00362607. 3.1-35(a) 3.1-35(b)(1)		achieved. **By what date the systemic changes will be completed.** October 30, 2021	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that			

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	includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to ensure the target dates on the comprehensive care plans were updated for 1 of 14 residents reviewed for care plan revision. (Resident J) Finding includes: The record for Resident J was reviewed on 09/27/21 at 3:43 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, glaucoma and chronic obstructive pulmonary disease. The care plans for Resident J contain 30 focus areas addressing the resident's preferences and care needs and each focus area has a goal target date of 08/28/21. The target dates had not been	F 0657	**F657 SS=D Care Plan timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The target dates for Elder J's care plan have been updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A 100% audit was conducted by the director of nursing and/or designee to ensure that the target	10/30/2021

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	10/04/2021

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	reassessed and updated on the care plan. During an interview, on 10/04/21 at 8:40 a.m., the Social Services Worker (SSW) indicated the care plans should have been updated if the target date was 08/31/21 and the dates (of the target goal) had past. A current facility policy, titled "Care Plan Completion," dated October 2019 and provided by the Executive Director on 10/04/21 at 11:16 a.m., indicated "...Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions...so that changes can be reflected in the comprehensive care plan...." This Federal tag relates to Complaint IN00362377. 3.1-35(d)(2)(B)		dates were updated on all elder's comprehensive care plans with no findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The director of nursing and/or designee will provide education to staff related to the policy for updating target dates on the comprehensive care plan. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The director of nursing and/or designee will review 5 comprehensive care plans weekly, times 6 months to ensure the target dates are updated for each elder. The results of the audit will be tracked and reviewed by the QAPI committee for ongoing compliance.This deficient finding will be monitored by the Director of nursing and/or designee through the review of audit tools. The findings of the audits will be reviewed and trended, in the monthly QAPI, times 6 months, or ongoing until 100% threshold is	

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			achieved. **By what date the systemic changes will be completed.** October 30, 2021	
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, interview and record review, the facility failed to provide nutritional supplements as ordered by the physician and Registered Dietician and failed to follow-up on recommendations from the Registered Dietician to prevent further weight loss for 1 of 5 residents reviewed for nutrition. (Resident D) This resulted in Resident D having a decrease in weight of 12.9% in 180 days. Finding includes:	F 0692	**F692 SS=G** **Nutrition/Hydration Status Maintenance** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Staff have been educated to provide nutritional supplements as ordered by the Physician and	10/30/2021

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	During a dining observation, on 09/27/2021 at 12:24 p.m., Resident D did not receive yogurt for lunch. During a dining observation, on 09/29/2021 at 9:02 a.m., the resident was not given a straw or a Provale cup (a specialized cup used to deliver small amounts of liquid with every drinking motion used with swallowing disorders). During a dining observation, on 9/29/2021 at 12:45 a.m., the resident was not given a Provale cup or yogurt. On 9/30/2021 at 9:49 a.m., the resident was in her room, sitting in her chair, she had a Styrofoam cup of water sitting on her bedside table. On 9/30/2021 at 3:20 p.m., a Styrofoam cup of water was in the resident's room. The resident indicated she was not given yogurt or ensure for lunch. During a dining observation, on 10/01/2021 at 8:55 a.m., the resident was not given a Provale cup. During an interview, on 10/01/2021 at 2:00 p.m., the resident indicated she was not given yogurt for lunch. During a kitchen tour with CNA 6 at 2:11 p.m., she indicated there was not any yogurt in either refrigerator. During a dining observation, on 10/04/2021 at 8:46 a.m., the resident was given water in a Styrofoam cup. During an interview, on 10/04/2021 at 09:20 a.m., the resident indicated she did not get her ensure		Dietitian. Elder D was not harmed by this deficient practice. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A 100% audit of all recommendations ordered by the physician or dietitian have been reviewed to ensure all supplements are provided as ordered. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The dietary manager and/or designee will provide education to staff related to providing elders with nutritional supplements as ordered by the physician or dietitian. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	with breakfast and in her room she had a large Styrofoam cup of water on her night stand. During a dining observation, on 10/04/2021 at 12:36 p.m. through 1:55 p.m., the resident was given a large Styrofoam cup of water and was not given Ensure or a straw. At 12:45 p.m., LPN 10 brought the resident a large plastic cup filled with lemonade. It was not a Provale cup and did not have a straw. During an interview, at that time, LPN 10 indicated "She just don't want it in that cup." She also did not receive yogurt. During an interview, at that time, CNA 7 indicated communication was poor and she was unaware of which residents were supposed to have yogurt with lunch. The nurse would be the one to know but did not communicate the information with her. At 1:13 p.m., LPN 10 indicated she did not know the resident was suppose to get a yogurt, she did not know where to find out if a resident was supposed to have anything special with meals. The record for Resident D was reviewed on 09/29/2021 at 10:10 a.m. Diagnoses, included but were not limited to, Parkinson's disease, stroke and malnutrition. A care plan, dated 10/20/2020, indicated the resident had an ADL (activities of daily living) performance deficit related to Parkinson's disease. Interventions included, but were not limited to, Provale cup for all liquids which was initiated on 11/20/2020. A care plan, dated 07/28/2021, indicated the resident was a nutritional risk related to Parkinson's disease, triggering for a significant weight loss x 30 day. Interventions included, but were not limited to, provide and serve supplements as ordered.		**assurance program will be put into place; and** The dietary manager and/or designee will review 5 elders weekly, times 6 months to ensure each elder is receiving nutritional supplements as ordered by the physician or dietitian. The results of the audit will be tracked and reviewed by the QAPI committee for ongoing compliance. This deficient finding will be monitored by the Dietary Manager and/or designee through the review of audit tools. The findings of the audits will be reviewed and trended, in the monthly QAPI, times 6 months, or ongoing until 100% threshold is achieved. **·By what date the systemic changes will be completed.** October 30, 2021	

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A physician's order, dated 01/18/2021, indicated the resident was to receive a mechanical soft texture diet (food which was ground up for easier swallowing), yogurt at lunch and all fluids in a Provale cup.

A physician's order, dated 08/30/2021, indicated the resident was to receive 120 ml (milliliters) of Med Pass (a nutritional supplement) four times a day.

A physician's order, dated 09/16/2021, indicated the resident was to receive one can of Ensure Plus two times a day with breakfast and lunch.

A dietary report sheet indicated the additional directions for the resident's diet were to provide one can of ensure with breakfast and lunch, give 120 ml of Med Pass, yogurt at lunch and all fluids provided in a Provale cup.

A RD (Registered Dietician) note, dated 08/28/2021, indicated the resident had a 8.4% significant weight loss over 30 days and recommended to offer yogurt at lunch and start Med Pass 120 ml four times a day. Also recommend to offer ice cream at dinner and yogurt at lunch related to the enjoyment of softer foods. Will discuss with the Nurse Practitioner (NP) to start an appetite stimulant.

A RD note, dated 09/15/2021, indicated the resident had a 7.4% significant weight loss over 30 days, a 7.8% significant loss over 90 days and a 12.9% significant loss over 180 days. The resident was receiving yogurt at lunch and ice cream at dinner to provide extra calories. The resident had increased difficulty feeding self and a decreased appetite. The RD recommended to offer

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	Ensure plus 1 can at meals and to discuss with the NP to start an appetite stimulant related to weight loss and intake of less than 50%. There was no documentation in the resident's record to indicated the NP was notified to discuss starting an appetite stimulant after the RD recommendation on 8/28/21 or 9/15/21. During an interview, on 10/04/21 at 3:29 p.m., the Admissions/Trainer (MAT) indicated it was the dieticians responsibility to follow through with her recommendations. Dietary interventions recommended from the RD would be documented on the resident's dietary sheet and kept in a binder in the kitchen. The CNAs and Nurses should know to refer to the sheet for added dietary recommendations for increased calories/nutritional value. The resident should have received yogurt with each lunch. During an interview, on 10/14/2021 at 3:30 p.m., the ED indicated each residents diet including nutritional supplements, special additions and restrictions were kept in a binder in the kitchen of each cottage. During an interview, on 10/4/21 at 4:30 p.m., the current dietician indicated she just started and had not been in to officially assess the resident yet and she was unable to talk with the previous RD who made the recommendations. She could not attribute as to why there was a delay in getting the order for the appetite stimulant. A nutrition/weight loss policy was not provided when requested, on 10/04/2025 at 4:15 p.m., the ED indicated at that time it was the expectation of nursing to follow physician orders.			

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	3.1-46(1)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			
	Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent based on medication errors observed during 2 of 25 opportunities for errors during random medication administration observations, resulting in a medication error rate of 8 percent (Residents P and N). Findings include: 1. During a random medication administration observation, on 09/28/2021 at 9:01 a.m., Qualified Medication Aide (QMA) 3 administered one loratadine (a medication for allergies) 10 mg (milligram) tablet to Resident P. Resident P's record was reviewed on 09/28/2021 at 12:31 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypothyroidism (low thyroid), hyperlipidemia (high cholesterol) and peripheral vascular disease. Current physician's orders were not observed to contain an order for loratadine 10 mg. During an interview, on 09/30/2021 at 10:11 a.m., LPN 9 was unable to locate a physician's order for the Loratadine 10 mg. LPN 9 indicated she remembered the resident had previously had an order for this medication, however she thought	F 0759	**F759 SS=D Free of medication error rates 5% or more** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Staff educated on the policy related to the administration of oral medications. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Medication administration observations will be conducted to ensure staff are following our policy related to the administration of medications. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.**	10/30/2021

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	the medication had been discontinued. On 09/30/2021 at 10:23 a.m., LPN 9 indicated she had talked with Resident P's nurse practitioner (NP) and the NP indicated this medication had been discontinued. LPN 9 indicated she was unable to locate an order for the loratadine 10 mg or the date of the discontinuation of this medication. During an interview, on 09/30/2021 at 11:58 a.m., the MDS (Minimum Data Set) Coordinator indicated she would research Resident P's physician orders regarding the Loratadine 10 mg. At 12:19 p.m., the MDS coordinator indicated she had found the following order, dated 07/13/2021 at 3:13 p.m., Loratadine Tablet 10 mg, give one tablet by mouth one time a day for allergy. The MDS coordinator indicated the physician order for Loratadine 10 mg was discontinued the following day on 07/14/2021. Resident P's Medication Administration Record (MAR), for the month of September 2021, was reviewed on 09/28/2021 at 2:12 p.m. Loratadine 10 mg was not listed as a medication to be administered to Resident P. 2. During an observation of medication administration, on 09/29/21 at 10:15 a.m., QMA 18 was observed to prepare one Vitamin B-12 500 milligrams (mg), one famotidine (a medication used for reflux) 20 mg, one divalproex (a medication used for seizures and bipolar disorder) 125 mg, one ferrous sulfate (an iron tablet) 325 mg, one allupurinol (a medication for gout) 100 mg and 17 grams of Miralax (a medication for constipation) for Resident N. When QMA 18 had finished preparing the medication and prior to administering the medications, it was brought to her attention the		The director of nursing and/or designee will provide education to staff related to the policy for medication administration. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The director of nursing and/or designee will observe 5 nurses weekly, times 6 months to ensure medications are administered according to our policy. The results of the audit will be tracked and reviewed by the QAPI committee for ongoing compliance. This deficient finding will be monitored by the Director of nursing and/or designee through the review of audit tools. The findings of the audits will be reviewed and trended, in the monthly QAPI, times 6 months, or ongoing until 100% threshold is achieved. **·By what date the systemic changes will be completed.**	

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	medication card and the order on her computer indicated Resident N was to receive two divalproex 125 mg. The QMA reviewed the order and indicated she was to give two divalproex 125 mg (for a total dose of 250 mg) to Resident N. A current facility policy, titled "Administration of Oral Medications," dated 2016 and provided by the Executive Director on 09/30/2021 at 3:27 p.m., indicated "...2. Check accuracy and completeness of each medication ordered (MAR). a. Verify the elder's name, drug name, drug dosage, route of administration and time of administration between medication container and medication administration record. b. If there is a discrepancy a household licensed nurse will check the physician's order and/or with a pharmacist...." This Federal Tag relates to Complaint IN00363744. 3.1-48(c)(1)		October 30, 2021	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure medications were stored in their pharmacy containers, failed to label medications when opened, failed to return/discard medications for residents no longer residing in the facility and failed to ensure medications were labeled with resident names for 1 of 3 medication carts reviewed for medication storage (Cottage 4 Medication Cart) Finding includes: During an observation of the medication cart in Cottage 4, on 09/29/21 at 11:23 a.m., with QMA 19 the following pills were found loose in the drawers of the cart: two small pink round tablets, one brown square tablet, one large round white tablet, one white oval tablet, one small white round tablet and one orange, partially dissolved tablet. In the top drawer, a Trelegy inhaler (an inhaler for chronic pulmonary obstructive disorder) was found without an open date and no resident label, one bottle of ipratropium (a medication used for allergic and nonallergic runny nose) nasal spray was found without an open date, a bottle of Combigan (a medication for glaucoma) eye drops	F 0761	**F761 SS=D Label/Store drugs and biologicals** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A medication storage audit was conducted with the cottage 4 medication cart to ensure medications were stored in their pharmacy containers, labeled correctly, old medications returned to pharmacy, and medications properly labeled with elder names. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All medication carts will be audited to ensure medications are properly stored and labeled according to facility policy.	10/30/2021

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GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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	was found wet in a container, the label was unreadable. In the second drawer, one bottle of over the counter Calcium was found without a label to indicate who the medication belonged to, a one quart bottle of ProMod (a supplement) was found without a label to indicate who it belonged to and one container of Reguloid (a medication for constipation) was found with an illegible label. In the third drawer, one tube of clotrimazole (an antifungal cream) was found for a resident which was no longer in the facility. During an interview, on 09/29/21 during the observation, QMA 19 indicated all staff were responsible to keep the cart clean and medications for residents which are no longer in the facility should be discarded. A current facility policy, titled "Storage of Medications," dated 2016 and provided by the Admissions/Trainer (MAT) on 09/29/21 at 1:47 p.m., indicated "...Medications will be maintained in the containers they were received from the pharmacist...." A current facility policy, titled "Labeling of Medication Containers," dated 2016 and provided by the Admissions/Trainer (MAT) on 09/29/21 at 1:47 p.m., indicated "...All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations...Medication labels must be legible at all times...Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy...Labels for...drug containers shall include all necessary information, such as...The resident's name...Labels		**·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The director of nursing and/or designee will provide education to staff related to the policy for storage and labeling of medications. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The director of nursing and/or designee will audit 3 medication carts weekly, times 6 months to ensure medications are administered according to our policy. The results of the audit will be tracked and reviewed by the QAPI committee for ongoing compliance. This deficient finding will be monitored by the Director of nursing and/or designee through the review of audit tools. The findings of the audits will be	

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for over the counter drugs shall include all necessary information, such as...The resident's name...." 3.1-25(j) 3.1-25(k)(1) 3.1-25(l)(1) 3.1-25(o) 3.1-25(r)		reviewed and trended, in the monthly QAPI, times 6 months, or ongoing until 100% threshold is achieved. **·By what date the systemic changes will be completed.** October 30, 2021	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview and record review, the facility failed to serve food in accordance with professional standards for food	F 0812	**F812 SS=F Food Procurement, Store/Prepare/Serve-Sanitary**	10/30/2021

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	10/04/2021

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

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	service safety when the staff failed to wear hair restraints to prevent hair from contaminating food, failed to ensure dry goods were sealed after opening, failed to remove expired items from the cabinets, refrigerators and pantry, failed to put open and use by dates on dry, refrigerated and frozen foods, failed to ensure a recipe was followed while preparing a pureed diet and failed to ensure kitchens were maintained for cleanliness and safety in 5 of 5 cottages reviewed. (Cottages 5, 2, 1, 4 and 3) Findings include: 1. During an observation of the kitchen in Cottage 5, on 10/04/2021 at 9:23 a.m., with CNA 1 present, the following was observed: a. In the Lower corner cabinet next to the stove: A large bottle of liquid butter alternative was found with an expiration date of 06/20/2021 and without a label to indicate when it was opened. A large bottle of sweet BBQ sauce, with an open date of 06/07/2021, was observed to have instructions to refrigerate after opening. Enriched white hominy corn grits had an open date of 03/12/2021 and an expiration date of 05/04/2021. A large bottle of vegetable oil was found half empty without a label to indicate when the bottle was opened. A plastic container of biscuit gravy & white sauce mix was observed to have been half empty and wrapped in cling wrap without a label to indicate when it was opened.		**·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** It is the practice of this provider to ensure that food is prepared, distributed, and served under sanitary conditions. No elders were identified to be affected by the alleged deficient practice. All items located in the pantry, refrigerator and freezer missing a label or date were immediately discarded. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All kitchens were inspected to ensure staff are wearing hairnets, dry goods are sealed after opening, expired items discarded, items contain open/use by dates, and recipes are followed for therapeutic diets. **·What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The dietary manager and/or designee will provide education to staff related to the dietary policy	

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	10/04/2021

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

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	b. In the black refrigerator/freezer in the kitchen area: A thermometer to monitor the temperature of the refrigerator and freezer was not observed. Foods in the freezer were packed in tightly with no air circulation around the packages of food. All packages had a buildup of ice crystal formation on the food inside of the bags. Temperature logs for the refrigerator were not observed and CNA 1 was unaware of the refrigerator temperature logs. A digital temperature was measured to be 47 degrees in the refrigerator and 18 degrees in the freezer. An open bottle of horseradish was observed to have an expiration date of 06/05/2021. Two partially used one pound blocks of unsalted butter were found unwrapped and open to air, without a label to indicate when they were opened. A dinner plate of mixed vegetables, a serving of potato salad and a piece of bread covered with ground meat in a red sauce was found covered in cling wrap and found without a label of when the item had been placed in the refrigerator or to whom the plate of food belonged. One open 12 ounce bottle of Gatorade fruit punch was found without a label to indicate when it was opened. One open bottle of Body Amor alkaline water was found without a label to indicate when it was opened. One 4 quart container, containing 2 quarts of an unknown brown substance, was found without a		and procedures, sanitary practices, and food storage. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. **·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The dietary manager and/or designee will audit 5 kitchens weekly, times 6 months to ensure food is served/stored with professional standards for food safety. The results of the audit will be tracked and reviewed by the QAPI committee for ongoing compliance. This deficient finding will be monitored by the Dietary manager and/or designee through the review of audit tools. The findings of the audits will be reviewed and trended, in the monthly QAPI, times 6 months, or ongoing until 100% threshold is achieved.	

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

label to identify the substance or indicate when the substance was placed in the refrigerator.

One gallon of milk, labeled as "fortified milk," had an expiration date of 09/27/2021.

One large container of coleslaw had an expiration date of 10/01/2021.

c. In the white refrigerator/freezer in the pantry area:

A thermometer to monitor the temperature of the refrigerator and freezer was not observed. Foods in the freezer were observed to have a buildup of ice crystal formation on the food inside the bags. Temperature logs for the freezer were not observed and CNA 1 was unaware of the freezer temperature logs. A digital temperature was measured to be 38 degrees in the refrigerator and 11 degrees in the freezer.

One unopened one-half gallon of milk was found with an expiration date of 09/09/2021.

On the bottom right shelf of the refrigerator, 8 loose eggs were found. 4 of the eggs were cracked with the yolk of the eggs spilling out. A large amount of yellow substance was observed dried on the shelf. A four pound container of unopened potatoes aug-gratin was on the shelf. The potato container was unable to be moved when touched.

The entire bottom of the refrigerator was observed to be soiled with an unidentifiable yellow substance.

d. The dry goods shelves:

One undated package of flour tortilla shells was

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed in a plastic bag. The bag was torn and open to air and the tortillas crumbled when picked up. The tortillas had an expiration date of 04/05/2021. One large, opened bottle of maple syrup was found without a label to indicate when the syrup was opened and found to have a label to refrigerate after opening. One opened 13 ounce bag of potato chips was found without a label to indicate when they were opened and an expiration date of 05/23/2021. Two unopened bottles of horseradish were found to have an expiration date of 06/05/2021. e. The free standing freezer in the dry pantry area: When the door to the freezer was opened, water was observed to be dripping from the bagged vegetables on the shelf and loaves of bread were soft to the touch. A thermometer to monitor the temperature of the freezer was not observed. Temperatures logs for the freezer were not observed and CNA 1 was unaware of the temperature logs. A digital temperature was measured to be 36 degrees. The following items were in the freezer: One unopened bag of dinner rolls One unopened bag of pre-cooked beef strips One wrapped fully cooked half ham One unopened 3 pound package of cooked ham steaks One unopened 2 pounds package of salami Ten unopened 7 ounce chicken pot pies Two unopened 3 pound packages of seasoned beef fajita strips Two unopened 4 pound bags of broccoli florets Two unopened 4 pounds bags of cauliflower			

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	155846	A. BUILDING 00 B. WING	10/04/2021

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

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florets
Two unopened 4 pound packages of fully cooked meatballs
One unopened 5 pound bag of cheddar potatoes
Fifteen unopened 8 ounce Ensure Plus drinks

2. On 09/27/21 at 12:31 p.m., Cook 21 was observed in the kitchen food preparation area of Cottage 2 with a turban type scarf wrapped around her head. The scarf covered the sides of her head, leaving the crown of her head uncovered. The cook was not observed to be wearing a hairnet.

3. During a medication pass in Cottage 2, on 09/28/2021 at 9:11 a.m., QMA (Qualified Medication Aide) 18 was observed to leave a resident's room and enter the kitchen food preparation area, without wearing a hair restraint to wash her hands. 4. During an observation in Cottage 1, on 9/27/2021 at 12:13 p.m., CNA 3 was observed to perform hand hygiene at the sink outside the kitchen. She put a very minimal amount of soap on her hands, turned on the faucet and began to wash her hands while under the running water. She washed her hands for less than ten seconds. She then entered the kitchen food prep area without her hair net on properly. Cook 4 walked into the kitchen, placed a foiled wrap dish into the oven and placed the rest of the lunch on the kitchen counter. He did not have a beard hair net covering in place. During an interview, at that time, Cook 4 indicated he should have had a beard hair net covering on and CNA 3 indicated she should have washed her hands for at least 20 seconds and not under the water. She also indicated she should have made sure all of her hair was in the hair net.

5. During an observation of the kitchen in Cottage

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

1, with CNA 6, on 10/01/2021 at 2:11 p.m., the following were observed:

a. A thermometer could not be located in freezer 1.

b. An unopened package of tortillas with an expiration date of 07/03/2021 and a half gallon of whole milk with an expiration date of 09/25/2021 was in refrigerator 1.

c. An unidentifiable plastic bag of meat which was discolored with freezer burn was in freezer 2.

d. Six unopened packages of tortillas with expiration dates of 09/17/2021 for 2 bags, 06/22/2021 for 3 bags, and 04/05/2021 for 1 bag was observed. One very soft, discolored and bruised melon was in the dry storage area.

During an interview, at the time of the kitchen tour, CNA 6 indicated she could not find a thermometer for freezer 1 and there should have been one, all expired foods should have been thrown away immediately and all foods should be labeled and dated.6. During an observation in Cottage 4, on 09/27/21 at 1:00 p.m., Cook 4 was observed to puree chicken breasts without using a recipe. At that time, Cook 4 indicated he did not have a recipe for puree to follow.

During an interview, on 09/27/21 at 1:59 p.m., the Director of Nursing indicated a recipe should have been followed when preparing pureed foods.

7. During an observation of the Cottage 4 Kitchen, on 09/30/21 beginning at 10:13 a.m., with Cook 4 in attendance the following items were noted:

a. In one freezer there was an undated and open bag of frozen fries in the freezer, an open and

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	undated bag of cheese ravioli, a small open and undated ice cream container and two open, unlabeled frozen plastic bottles of soda were found. At that time, Cook 4 indicated he believed the soda belonged to an employee. b. In the diary refrigerator, two one-gallon milk containers labeled whole milk were found. At that time, Cook 4 indicated the containers contained fortified milk which he had mixed and stored in the whole milk containers. They were not labeled to indicate anything other than whole milk was contained inside. c. In a drawer of the dairy refrigerator a package of sharp cheddar cheese slices was found open to air. d. In a refrigerator an eight-quart container with approximately 12 ounces remaining was found uncovered. e. In another freezer an open bag of crinkle cut fries was found open and without an open date, a bag of sausage links was found open and without an open date and a red substance was noted in the bottom of the freezer. At that time, Cook 4 indicated it was from when the freezer went out and frozen strawberries melted and had not been cleaned up. f. In the dry storage/pantry one package of tortillas was found with an expiration date of 06/22/21 and 12 more packages of tortillas were found with an expiration date of 09/17/21. g. Under a wire shelf in the dry storage/pantry an open single server half full pack of Snackin' Squares was found on the floor.			

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	155846	A. BUILDING 00 B. WING	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	h. The microwave was found with food debris on the top, bottom, and sides. At that time, Cook 4 indicated the microwave needed to be cleaned. During an observation of the Cottage 4 Kitchen (a kitchen in the memory care unit), on 09/30/21 beginning at 10:13 a.m., with Cook 4 in attendance the following items were observed: in a drawer by one refrigerator knives were stored in a drawer which did not lock. A large knife was found in a drawer on the kitchen island, located opposite the sink in the island, the drawer did not have a lock. On the right side of the stove the cabinet door was hanging and loose. There was a broken handle on a low cabinet to the left of the refrigerator, four below the counter cabinet doors were loose and needed to be screwed back into place and the kitchen sink was missing a faux drawer cover and the sink basin was visible the cabinet. During an interview, on 09/30/21 at 10:14 a.m., Cook 4 indicated he did not know where the quat disinfectant cleaner was kept or if the facility had any quat disinfectant. The bucket for the disinfectant was in another cottage and he had been using soapy water to clean the counter tops. During an observation of Cottage 4, on 09/30/21 at 2:21 p.m., a large round trash can was found uncovered with over-flowing trash, in the common area hall, outside of the kitchen. During an interview, on 09/30/21 at 2:22 p.m., Cook 4 indicated he had used the trash can for the kitchen and he was responsible to dump the trash. 8. During an observation of the Cottage 3 kitchen, with Cook 4 in attendance, on 10/01/21 beginning at 09:30 a.m., the following items were noted:			

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

a. The microwave was found to have food debris on the top, sides and bottom.

b. The freezer of the dairy refrigerator did not have a thermometer. In this freezer, two bags of frozen breadsticks were found open and undated and one bag of broken funnel cakes was found without an open date.

c. In the beverage cooler, three jars of horse radish were found with an expiration date of 06/05/21, a large brick of cream cheese received on 01/17/21 was found without an open date and an expiration date of 05/18/21.
A metal scoop with a plastic handle was found lying in the freezer, at that time, Cook 4 indicated it should not have been in the freezer.

During an observation of the Cottage 3 kitchen, with Cook 4 in attendance, on 10/01/21 beginning at 09:30 a.m., the following items were noted: the handle on a cabinet to the left of the sink was hanging sideways, the faux drawer on the kitchen island was missing leaving the sink basin visible through the cabinet and the cabinet below the sink in the kitchen island containing cleaning products did not lock.

During an observation of Cottage 3, on 09/27/21 at 11:30 a.m., a large, uncovered trash can was found in the common area hall, outside of the kitchen.

During an interview, during the walk through of the Cottage 3 Kitchen, Cook 4 indicated he had quat disinfectant tablets but no testing strips to check the chemical levels.

During an interview, on 10/04/21 at 12:08 p.m., Maintenance Staff 20 indicated he was notified

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	10/04/2021

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

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	verbally of repairs needed and he completed them right away. He was in the cottages daily looking at things and fixing them. The kitchens could always use work, he could go in fix the cabinets and then he would get a call a week later because they were broke again. He indicated his job was maintenance and repair. He was unable to say when he was last in Cottages 3 and 4 and did an assessment. He indicated Cottages 3 and 4 were not bad compared to restaurants. The Dietary Manger was unavailable for interview during the survey, according to the Executive Director (ED), when interviewed on 10/01/2021 at 3:11 p.m. A current facility policy, titled "Environmental Services Director," dated on June 2017 and provided by the ED on 10/4/21 at 11:00 a.m., indicated "...Performs routine maintenance on building interior and exterior...." A current facility policy and procedure was requested and received from the Executive Director on 10/04/2021 at 11:16 a.m. The policy, dated 2016, indicated "POLICY: Provided refrigerate and freezer storage facilities will keep food safe. They will be clean, dry and free of contaminates...PROCEDURE 1. Refrigerated Food Storage A. All refrigerated units will be kept clean and in good working order at all times B...foods will be maintained at or below 41 F [degrees Fahrenheit] unless otherwise specified. Temperature of the refrigerator units will be taken periodically to assure temperatures are at or below 41 F. C. Every refrigerator unit will have a thermometer... E. Once food is removed from the original packaging it will be stored in plastic containers with tight fitting lids or sealed tightly. All sealed food and containers will be labeled and			

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	10/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

dated..."

A current facility policy, titled "Dietary Policies and Procedures, Sanitary Practices," dated 2013 and provided by the ED on 10/14/2021 at 5:55 p.m., indicated "...Shahbazim [CNA/Cook] will wear hair restraint [hairnet...beard net] while in kitchen...The hair restraint should be worn to cover all exposed hair...."

A current facility policy, titled "Hand Hygiene/Hand Washing," dated 2016 and provided by the ED on 10/04/20221 at 11:16 a.m., indicated "...All team members who have direct contact with elders or food will wash their hands for at least 20 seconds...."

A current facility policy, titled "Refrigerator & Freezer Storage," dated 2016 and provided by the ED on 10/04/2021 at 5:00 p.m., indicated "...All sealed foods and containers will be labeled and dated...Every freezer will have an internal thermometer...Any food items found to be past safe use dates or expiration dates will be discarded immediately...."

An undated facility policy, titled "Nursing Home Resident Right," provided by the Executive Director on 10/04/21 at 4:13 p.m., indicated "...rights you have as a nursing home resident...A safe, clean, comfortable, home-like environment...."

This Federal Tag relates to Complaints IN00362607, IN00363744, IN00362377 and IN00362752.

3.1-21(a)(3)
3.1-21(i)(1)
3.1-21(i)(2)

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	10/04/2021

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

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	3.1-21(i)(3) 3.1-21(i)(5) 3.1-21(j)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should			

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of the	F 0880	F 880 SS=E Infection Prevention and Control A Directed Plan of Correction (DPOC) is imposed in accordance	10/30/2021

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	Covid-19 virus, when the facility failed to ensure staff preformed hand hygiene after touching face masks, failed to ensure staff wore face masks and eye protection properly, failed to perform hand hygiene when changing gloves during resident care and failed to ensure masks were in use while working over food during food preparation for 5 of 5 randomly observed staff members. (CNA 12, CNA 8, Cook 4, Physical Therapist 16 and an unidentified CNA) Findings include: 1. On 09/29/21 at 8:51 a.m., during an observation of morning care for Resident 22, CNA 12 was observed to perform hand hygiene and don gloves. She picked out the resident's clothing, then put shoes on the resident and explained she was going to get the resident up. CNA 12 put Resident 22's hands on her walker, put a gait belt around the resident's waist and assisted her to the restroom. The CNA assisted the resident to the commode and removed the gait belt and the resident's shoes. The CNA then proceeded to wash the resident beginning with her upper thighs, mons pubis (the rounded area in front of the pubic bones at the lower part of the belly), then dried the area with a towel. The CNA put a clean brief on the resident, pulled it up to her thighs and then put the resident's pants on, pulling them up to her thighs. The CNA then put shoes on the resident. The CNA removed the resident's shirt and proceeded to wash under the resident's arms, apply deodorant and put a new shirt on the resident. CNA 12 then put the gait belt around the resident's waist. She then removed her gloves, discarded them, and put on new gloves. The CNA was not observed to perform hand hygiene after the glove removal or prior to putting on new gloves. CNA 12 combed the		with 42 CFR § 488.424 effective October 30, 2021. Green House Cottages of Carmel must include the following in their POC for the deficient practice cited at F880: **A.Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1). The Director of Nursing (DON) or Designee will educate the facility staff on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. 2.) Ensure staff are educated, with return demonstration, for hand hygiene and understanding when to perform hand hygiene. For this education and return demonstration, the following resources will be used: · Facility policy: don and doff PPE · Facility policy: Hand Hygiene · CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected	

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	resident's hair, used a clean cloth to wash her face and then removed and discarded her gloves. CNA 12 applied new gloves and assisted the resident to a standing position, dried the resident's perineum (the area between the anus and genitals) with toilet paper. The CNA then removed her left glove, discarded the glove, put on a new glove, pulled the resident's pants up, assisted the resident out of the bathroom, discarded the used linens, removed her gloves, discarded them, and assisted the resident out of the room. The CNA was not observed to change gloves after handling shoes, prior to washing the resident's upper thighs and mons pubis, prior to handling a clean brief, after handling shoes again, prior to washing the resident's upper body and she was not observed to perform hand hygiene when glove changes were performed. During an interview, on 09/29/21 at 9:09 a.m., CNA 12 indicated hand hygiene was to be performed after removing gloves and after providing care. She did not perform hand hygiene with gloves changes. 2. During a random observation, on 09/27/21 at 10:58 a.m., CNA 8 was observed to adjust her mask with her hands. She did not perform hand hygiene after touching the mask. 3. During a random observation, on 09/27/21 at 11:03 a.m., Cook 4 was observed working in the kitchen, standing over asparagus with his mask under his nose. During an interview, on 09/27/21 at 11:04 a.m., Cook 4 indicated he could not breath with the mask on. During a random observation, on 09/27/21 at 11:26		Covid – 19 · CDC Guidance: Sequence For Putting On Personal Protective Equipment (PPE) · CDC Resource: hand washing and sanitizer · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) **B. Systemic** 1). A root cause analysis (RCA) was conducted by the Director of Nursing, to determine the root cause resulting in the facilities Infection Control citation. a). Through staff interviews, it was determined that staff developed a misunderstanding from education provided that the wearing of masks could be relaxed when not in direct patient care areas The facility leadership team failed to ensure proper storage of PPE and full implementation of continuous mandatory PPE requirements – all staff must wear a surgical mask at all times and practice proper hand hygiene b). The solutions and systemic changes developed by the Director of Nursing: The Director of Nursing (DON),or	

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	a.m., Cook 4 was observed, again, in the kitchen preparing food with his mask below his nose. He put his mask up over his nose with his gloved hand. He was not observed to remove the glove used to adjust his mask and continued with his task. 4. During a random observation, on 09/27/21 at 11:23 a.m., Physical Therapist 16 was observed working in close proximately (less than 6 feet) with Resident 51. He was using a face shield and his mask was observed to be positioned below his chin. During an interview, on 09/27/21 at 11:24 a.m., Physical Therapist 16 indicated Resident 51 could not hear him and she needed to see his mouth. He put his mask up and was not observed to perform hand hygiene after touching the mask.5. During an observation in Cottage 5, on 09/29/2021 at 1:46 p.m., an unidentified CNA was observed to be walking in the common area of the facility towards the laundry room. The CNA's eye protection was observed on top of her head and she was carrying a large bundle of laundry in her arms, in front of her body, against her uniform. A current facility policy, titled "Mash Use Policy and Procedure," undated and provided by the Marketing/Admissions/Trainer (MAT) on 09/29/21 at 1:47 p.m., indicated "...Wash your hands or use hand sanitizer after each time you adjust your mask...." A current facility policy, titled "Standard Precautions for Infection Prevention and Control," dated 2016 and provided by the Executive Director on 10/04/21 at 11:16 a.m., indicated "...Wash hands after touching blood, body fluids, secretions, excretions and contaminated items		Designee will educate the facility staff on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Ensure all staff involved are educated on the need to maintain face covering over the mouth and nose at all times when in use. For this education and return demonstration, the following resources will be used: · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) · Facility policy: How to use PPE · Facility policy: Hand washing · CDC Guidance: Sequence For Putting On Personal Protective Equipment (PPE) · CDC Resource: Hand washing and sanitizer The DON, or Designee will re-educate the facility staff on the policy: Use of PPE While in the Facility	

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	regardless of whether gloves are worn...Wash hands immediately after gloves are removed...Use soap and water or an alcohol based product for routine hand hygiene...Change gloves between tasks and procedures on the same elder and after contact with material that may contain a high concentration of microorganisms...." This Federal tag relates to Complaints IN00362752, IN00363744 and IN00362607. 3.1-18(b) 3.1-18(l)		The DON, or Designee will review with the facility staff: CDC Resource for Facemask Do's and Don'ts The DON, or Designee will post the CDC Resource for Facemask Do's and Don'ts throughout the facility as a visual reminder to the staff on the proper way to wear your facemask at all times. The DON, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily to ensure staff are wearing face masks appropriately while in the facility and enforce corrective measures and education if deficiencies are observed. 2). The DON, and ED reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **C. Training:** 1).Per the LTC infection control assessment review and revision by the DON. The following training needs were identified and implemented by the DON to the	

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			facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. - Standard Precautions - Appropriate mouth, nose and eye protection (e.g. facemask) is worn. The DON, IP or Designee will educate the facility staff on the policy: Use of PPE While in the Facility 1). Per the RCA completed by the DON and ED, the following training needs were identified and implemented by the DON with training resources and polices provided and submitted as part of the DPOC documentation. The Director of Nursing (DON),) or Designee will educate the facility staff on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. For this education and return demonstration, the following resources will be used: · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) · Facility policy: How to use	

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			PPE · Facility policy: Hand washing · CDC Guidance: Hand washing · CDC Guidance: Sequence For Putting On Personal Protective Equipment (PPE) · CDC Resource: Face masks do’s and don’ts The DON, IP or Designee will re-educate the facility staff on the policy: Use of PPE While in the Facility The DON, IP or Designee will review with the facility staff: CDC Resource for Facemask Do’s and Don’ts **D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** 1). The DON, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily for 6 weeks and until compliance is maintained: to ensure staff are wearing face masks appropriately while in the facility, face masks are stored in	

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			an appropriate manner, and enforce corrective measures and education if deficiencies are observed 2). The DON, or designated facility leadership will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and ensure the CDC Resource for Facemask Do's and Don'ts continues to be posted throughout the facility. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	