	-	ND HUMAN SERVICES				FOR	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
						R	R-C
		155846	B. WING			11/	23/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN H	OUSE COTTAGES OF CA	ARMEL			16 GREEN HOUSE WAY CARMEL, IN 46032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 000}	INITIAL COMMENTS	3	{F 0	000}			
	This visit was for a P	Post Survey Revisit (PSR) to					
		d State Licensure Survey					
		er 4, 2021. This visit included					
	a PSR to the Investig	ation of Complaints 2752, IN00362607 and					
		ed on October 4, 2021.					
	Complaint IN0036374	44 - Corrected					
	Complaint IN0036275						
	Complaint IN0036260						
	Complaint IN0036237	77 - Corrected.					
	Survey dates: Noven	nber 22 and 23, 2021					
	Facility number: 0137	753					
	Provider number: 155						
	AIM number: 201362	150					
	Census Bed Type:						
	SNF/NF: 54						
	Total: 54						
	Census Payor Type:						
	Medicare: 5						
	Medicaid: 32 Other: 17						
	Total: 54						
	Green House Cottage	es of Carmel was found to					
	-	n 42 CFR Part 483, Subpart					
		3.1 in regard to the PSR to					
		d State Licensure Survey vestigation of Complaints					
		2752, IN00362607 and					
	IN00362377.	,					
	Quality review was or	ompleted on November 30,					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 155846 B. WING 11/23/2021	EDICARE & MEDICAID SERVICE	DEPARTMEN
155846 B. WING 11/23/2021	CIES (X1) PROVIDER/SUPPLIEF	STATEMENT OF DE
11120/2021	155846	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		NAME OF PROVID
616 GREEN HOUSE WAY		
GREEN HOUSE COTTAGES OF CARMEL CARMEL, IN 46032	IAGES OF CARMEL	GREEN HOUSE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ACH DEFICIENCY MUST BE PRECEDED BY I	PREFIX
{F 000} Continued From page 1 (F 000) 2021. (F 000)	ed From page 1	

FORM CMS-2567(02-99) Previous Versions Obsolete

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