STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING _____ B. WING _____	R-C 07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00348988, IN00349905, IN00350758, IN00351036, and IN00353622 completed on May 20, 2021. This visit included a PSR to the COVID-19 Focused Infection Control Survey completed on May 20, 2021. This visit was in conjunction with the PSR for the Investigation of Complaints IN00354637 and IN00354558 completed on June 24, 2021. This visit was also in conjunction with the PSR for the Investigation of Complaint IN00356714 completed on July 7, 2021. Complaint IN00348988 - Corrected. Complaint IN00349905 - Corrected. Complaint IN00350758 - Corrected. Complaint IN00351036 - Corrected. Complaint IN00353622 - Corrected. Complaint IN00354637 - Corrected. Complaint IN00354558 - Corrected. Complaint IN00356714 - Corrected. Survey dates: July 28 and 29, 2021 Facility number: 013753 Provider number: 155846 AIM number: 21137532 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 5	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING _____ B. WING _____	R-C 07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 Medicaid: 37 Other: 13 Total: 55 Green House Cottages of Carmel was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00348988, IN00349905, IN00350758, IN00351036, and IN00353622, and the PSR to the COVID-19 Focused Infection Control Survey. Quality review completed on August 6, 2021.	{F 000}		