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	09/01/2021

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 the Investigation of Complaints IN00361272, IN00361303, and IN00361503. Complaint IN00361272 - Substantiated. Federal deficiencies related to the allegations are cited at F880. Complaint IN00361303 - Unsubstantiated. Complaint IN00361503 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 31 and September 1, 2021. Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 2 Medicaid: 43 Other: 13 Total: 58 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 3, 2021.	F 0000	reparation 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.	
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			

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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	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 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			

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	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 observations, interviews and record reviews, the facility failed to properly ensure visitors were screened prior to entry to prevent the spread of COVID-19 during a global pandemic for 3 of 6 cottages (Cottages 5, 3, and 4). Findings include: On 8/31/21 at 7:55 a.m., during an observation of the entrance to Cottage 5, the door was locked to the entrance. CNA 30 opened the door as she was exiting and indicated to self-screen. There	F 0880	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. There was not resident affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	09/21/2021

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	was a thermometer mounted to the wall, hand sanitizer and screening logs. During an interview at 7:57 a.m., LPN 20, who worked for agency staffing indicated she was unsure of the facility screening process. On 8/31/21 at 8:10 A.M., QMA 40 opened the door to Cottage 3 in response to the doorbell. There was a thermometer mounted to the wall. No other items were on the table in the foyer entry way. QMA 30 indicated during interview at this time, screening occurred in the nurse's room. This room was located approximately 10 steps forward and to the left. The main living room area was in that area. On 8/31/21 at 8:12 a.m., during an observation of the entrance to Cottage 4, the door was locked to the entrance. QMA 7 opened the door the door to Cottage 4 in response to the doorbell. There was a thermometer mounted to the wall, hand sanitizer, and screening logs, she indicated to self-screen. QMA 7 indicated during interview at this time, she believed visitors screened themselves. During an interview, on 8/31/21 at 3:07 p.m., the Administrator indicated staff screen at start of shift at the cottage they are assigned and visitors screen at the cottage they are visiting. Screening sheets were reviewed daily by Department Managers and they all work day shift hours. From the Indiana Department of Health, "COVID-19 LTC Facility Infection Control Guidance," updated 6/1/21 and indicated "...CORE PRINCIPLES OF INFECTION PREVENTION...Screening must occur for all who enter the facility; (e. g. visitors, vendors, and staff) for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and		action(s) will be taken. All Elders have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All staff will be re-educated on the COVID 19 screening process for all staff, vendors, visitors including the ISDH. Signs will be posted for all staff, vendors, and visitors to be screened in the administration cottage during business hours, after business hour they will be screened in Cottage 1. All visitors will be issued a visitors pass for the day. How the corrective action(s) will be monitored to ensure the deficient practice will not recure, ie., what quality assurance program will be put into place. Staff will alert DON/ designee if a visitor entrance a cottage without the visitors pass daily for 6 months. This will be reviewed 5 days week in morning meeting. The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review, update, and make changes as needed for sustaining substantial compliance	

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	observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor 's vaccination status)...." This Federal tag relates to complaint IN00361272. 3.1-18(a)		for no less than 6 months. The date the systemic changes will be completed: Sept 21, 2021	