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	07/07/2021

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00356714. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00356714 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: July 6 and 7, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 57 Total:57 Census Payor Type: Medicare: 7 Medicaid: 37 Other: 13 Total: 57 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 14, 2021.	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.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident was adequately supervised during toileting and failed to accurately assess for injuries upon discovering the resident had fallen for 1 of 3 residents reviewed for accidents. (Resident B) Resident B required an emergency room visit and staple placement to a laceration sustained during the fall. During an observation of Cottage 4, on July 06, 2021 at 10:17 a.m., LPN 2 was observed in the nursing office on the phone. Resident B was in a wheelchair parked in the doorway facing into the office. LPN 2 hung up the phone and indicated she was going to do a treatment on the resident. The nurse walked over to the overhead cabinets, moved items around, then closed them. She turned to Resident B, lowered herself to eye level, and asked the resident to look at her. She then asked the resident to hold her hands and squeeze. She then moved down to the resident's left leg, removed her sock and shoe, and looked at her left ankle and foot. The nurse put the sock and shoe back on resident and asked if she wanted a drink. A drink of water was provided, and the nurse indicated she was finished with the resident. The nurse made no indication the resident had recently fallen. Resident B was alert, clean, dry and did not show signs of distress. The nurse removed the resident from the doorway and began a walk through of the cottage. During an observation of Resident B, on July 06, 2021 at 3:23 p.m., with the Director of Nursing in attendance, five staples were noted on the back of Resident B's head. The wound was linear from the	F 0689	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 ensure each resident receives adequate supervision and assistance devices to prevent accidents. Resident B returned from hospital with staples placement to the laceration, since then the staples has been removed and the area has healed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nursing staff will be in-serviced on Fall Prevention & Management protocol and toileting. 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:	07/30/2021

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	10 o'clock to 5 o'clock position and no bleeding was present. The length of the wound was difficult to assess due to areas of dried blood on the scalp. The resident was alert and did not appear to be distressed. The record for Resident B was reviewed on July 06, 2021 at 3:35 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia and syncope and collapse (fainting). A nursing note, dated July 06, 2021 at 12:15 p.m., indicated the resident was found on her back inside the visitor bathroom. She did not remember what happen. The DON (Director of Nursing), NP (Nurse Practitioner) and her daughter were notified. The NP gave the okay to send the resident to the hospital for stitches on the back of her head because she had an opened area which was bleeding. A care plan, initiated on November 14, 2017, indicated the resident was at a risk for self-care related to Alzheimer's disease and required supervision and assist of one staff for toileting. A care plan, initiated on November 14, 2017, indicated the resident had the potential for a fall related to impaired safety awareness and blood pressure fluctuations. The emergency room (ER) report indicated Resident B was admitted to the ER on 07/06/21 at 12:05 p.m. She presented to the Emergency Department after suffering from an unwitnessed fall approximately 2 hours past, bleeding was controlled prior to admission. She came in with a "significant" 2 cm (centimeter) laceration to her left occipital scalp (back of head). The patient had no recollection and was unable to provide an		All falls will be called to DON/designee to ensure the fall prevention policy is followed for 6 months and audit sheet will be completed on each fall. 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 for no less than 6 months.	

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	accurate history. The resident was on warfarin (a blood thinner) therapy. The resident was discharged from the ER on 07/06/21 at 2:14 p.m. During an interview, on July 06, 2021 at 12:57 a.m., LPN 2 indicated Resident B had fallen prior to the initial observation of the cottage, at 10:17 a.m., that morning but she was unable to give the time of the fall. LPN 2 indicated she did not do a neurological check (an assessment which included pulse, respiration, and blood pressure measurements, assessment of pupil size and reactivity, and equality of hand grip strength). She had checked the resident's vital signs, skin and legs. The resident did sustain a small opening on the back of her head, but she did not measure it and there was no bleeding. The nurse put the time of the fall at 10:48 a.m., and she contacted emergency transportation, via 911, at 11:13 a.m. The family member and physician were contacted but she could not recall the time of contact. After checking the record, the nurse indicated she called 911 at 11:35 a.m., maybe 11:40 a.m. She did not place the call sooner because she did not know the resident needed staples/sutures to the head wound. She did notify the Director of Nursing. LPN 2 then revisited the incident, indicating the resident was found laying in feces, she had the resident cleaned up and contacted the Director of Nursing who responded after the walk through of the cottage. She then left Cottage 4 and went to Cottage 5. The Director of Nursing called her and asked if she was aware a resident had fallen. She informed him she was going to do an assessment. The Director of Nursing told her to return to Cottage 4 and complete the assessment. She did return to the cottage and complete an assessment and this was when she found a small opening at the back of the resident's head. There was no bleeding at the time and she			

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	did not measure the wound. She informed the Director of Nursing the resident needed to go to the hospital and she called emergency medical services. During an interview, on July 06, 2021 at 1:11 p.m., CNA 3 indicated Resident B fell sometime between 9:30 a.m. and 9:45 a.m., that morning. She was washing dishes and cleaning up from breakfast when LPN 2 asked her to help with a resident who was in the rest room. The nurse then went to the office. CNA 3 indicated she went to the common area restroom. The door was slightly open, there was diarrhea everywhere, in the commode, on the seat and on the floor. The resident was laying on the floor and was bleeding, but she could not tell where the blood was coming from. Resident B was alert and told CNA 3 she needed help, asked the CNA not to leave her she needed help. CNA 3 went to get the nurse and informed her the resident was on the floor. CNA 3 indicated the nurse told her to clean the resident up first. Another staff member went to get help. CNA 3 noted the resident had an open area on her hand but did not observe any bleeding from the resident's head. She did clean the resident up and even brushed her hair and did not see any bleeding. The nurse was not observed to have checked the resident's vital signs or do any assessment but went to the office and got on the phone and computer. She indicated the State Surveyor entered the cottage while she (CNA 3) was carrying the soiled linens used to clean up the resident after the fall. The surveyor walked around the cottage and went to the nursing office. The nurse completed a walk through with the surveyor and then exited the cottage after the observation was completed and the surveyor had exited the cottage. The Director of Nursing did come and look at the resident. She indicated			

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	another staff member did observe bleeding from the resident's head, but it was a couple hours later, about 2 hours later, and she did observe emergency services arrive around 11:30 a.m. During an interview, on July 06, 2021 at 1:31 p.m., Staff Member 4 indicated she witnessed Resident B on the bathroom floor, laying in feces and blood. It was around 9:30 a.m. The nurse did not come and assess the resident. She recalled there were residents eating breakfast and Resident B left the area and went to the bathroom, she believed the nurse was aware the resident was in the bathroom and LPN 2 asked another staff member to go help the resident. The CNA went to assist and found the resident on the floor. The CNA informed the nurse. The nurse did not go assess the resident, but instead went to the nursing office. Staff Member 4 went to get help of another CNA. She then went to assist with dining in place of the second CNA. The nurse was still in the office. She indicated she did observed bleeding about two hours later. The emergency services arrived close to 11:30-11:45 a.m. Emergency services was not contacted until after the resident had been cleaned up. During an interview, on July 06, 2021 at 2:32 p.m., the Director of Nursing indicated he did look at Resident B. She had sustained a skin tear on her hand and an injury on the back of her head approximately 2.5 centimeters long and 0.2 centimeters deep, but he did not measure the wound. There was a little blood. The resident was sent out to the hospital related to a head injury. During an interview, on July 06, 2021 at 3:07 p.m., CNA 5 indicated a resident fell in the restroom. She did not witness the fall, but did observe the resident on the floor in blood and feces. The			

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	nurse told CNA 3 to clean up the resident. CNA 5 assisted her. The nurse did not assess the resident. The nurse went into the office. The fall was about 9:30 a.m. During an interview, on July 07, 2021 at 2:25 p.m., the MDS Coordinator indicated neuro-checks were to be completed for an unwitnessed fall, if unwitnessed and the resident indicated they did not hit their head then they did not need to be completed. A Post Fall 72-Hour Monitoring Report for Resident B indicated there was no documented time for the base line (initial assessment) vital signs. The following times were documented with vital signs and neuro checks: 10:45, 11:00, 11:15 and 11:30. There was a notation in the upper right corner which indicated "...Back at 2:21 p.m." There was no documentation for the 3:00 p.m. neurological check and the next documented assessment was on 07/07/21 at 6:00 a.m. A facility document, titled "Post Fall 72-Hour Monitoring Report," provided the Executive Director on July 07, 2021, indicated "...This assessment should be completed at the following intervals for follow up for falls...A fall that is unwitnessed, or in which the head is struck, requires neurological checks...Initial assessment (B-baseline) followed by q (every) 15 min (minutes) x 4...q30 min x 2...every hour x 2...once per shift for 72 hours...Time of fall...10:45...." An undated facility policy, titled "Fall Prevention and Management Protocol," provided by the MDS Coordinator on July 07, 2021 at 2:25 p.m., indicated "...Document a progress note on the fall, include the following information ...How you became aware of the fall...Condition/position the			

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	elder was found in...Ask the elder what they were doing at the time of the fall...ROM(range of motion) at time of fall...Pain level and location...Injury sustained...Vital signs ...Neuro checks if applicable...Interventions that were in place at time of fall...documentation that you notified MD(physician) and family...include measurement in note...Initiate neuro checks: ANY unwitnessed fall...." This Federal tag relates to Complaint IN00356714. 3.1-45(a)(2)			