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	06/24/2021

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 IN00355213, IN00354637 and IN00354558. Complaint IN00355213 - Unsubstantiated due to lack of evidence. Complaint IN00354637 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F684, F689 and F726. Complaint IN00354558 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F684. Unrelated deficiencies are cited at F550 and F641. Survey dates: June 23 and 24, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 8 Medicaid: 34 Other: 14 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 30, 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.	

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.

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	06/24/2021

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 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	06/24/2021

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
	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to provide privacy for a resident's catheter drainage bag for 1 of 1 randomly observed resident with an indwelling urinary (Foley) catheter. (Resident F) Finding includes: During an observation, on 6/23/21 at 11:55 a.m., Resident F was in a wheelchair being escorted from her room to the common area by Certified Nurse Aide (CNA) 1. Her urinary catheter drainage bag was under her wheelchair and was not covered. Yellow urine was visible inside the bag. Eight residents, two CNAs, one Licensed Practical Nurse (LPN) and a family member were present in the common area. Resident F's medical record was reviewed on 6/23/21 at 10:31 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder (neurological disorder affecting kidney function), anxiety disorder, dementia, urinary tract infections, retention of urine, congestive heart failure and hypertension. Resident F's Care Plan, dated 11/24/19, reflected the following: "I have an indwelling Foley catheter related to urinary retention due to neurogenic bladder...I have bladder spasms...I am resistant to leave my catheter alone and at times I pulled it out on my own related to diagnosis anxiety, vascular dementia...." Resident F's physician's order, dated 5/23/18, included Foley catheter care every shift, flush Foley catheter with 50 cubic centimeters of normal	F 0550	F 550 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A cover was placed on the catheter bag. **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 Elders with a catheter have 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;** Educate the staff on making sure all catheter bags have a cover on them. **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.** DON/designee will audit through observation to ensure all catheter bags have covers 4 times a week, then biweekly for 2 months, then monthly for 3 months. The results of the audit will be reviewed at the monthly quality assurance	07/09/2021

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	06/24/2021

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
	saline when needed every 24 hours for occlusion. Her physician's order, dated 2/6/21, included changing the Foley catheter every night shift starting on the 6th and ending on the 6th every month for a diagnosis of neurogenic bladder. During an interview, on 6/23/21 at 12:00 p.m., CNA 1 indicated the collection bag needed to be covered and she would find out where she could get a privacy bag. During an interview, on 6/23/21 at 12:20 p.m., LPN 2 indicated the drainage bag needed to be covered for the resident's dignity. She gave CNA 1 a pillowcase to cover the drainage bag. She indicated the facility did not have privacy bags designed to cover catheter drainage bags. A current facility policy, titled "Indwelling Urinary Catheter, Care on Elder," dated 11/07/08 and provided by the Executive Director on 6/24/21 at 1:11 p.m., did not address the provision of privacy for Foley catheter drainage bags. 3.1-3(t)		meeting. Changes may be established to the auditing process, based upon the results of audits. ="" p=""> **="" b="">**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview and record review, the facility failed to ensure an accurate assessment was completed for 1 of 10 residents reviewed for Minimum Data Set (MDS) assessments. (Resident F) Finding includes: During an observation, on 6/23/21 at 11:55 a.m.,	F 0641	="" span=""> **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 that each elder have an accurate Minimum Data Set	07/09/2021

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	06/24/2021

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
	Resident F was sitting in her wheelchair. A urinary catheter drainage bag with yellow urine was visible under the wheelchair. Resident F's medical record was reviewed on 6/23/21 at 10:31 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder (problem with the nervous system affecting bladder function), anxiety disorder, dementia, urinary tract infections, retention of urine, congestive heart failure and hypertension. Resident F's MDS bladder assessment indicated the resident had no indwelling urinary Foley catheter. The bladder assessment was signed by the MDS Coordinator on 4/29/21. Resident F's physician's order, dated 5/23/18, included Foley catheter care every shift and flushing the Foley catheter with 50 cubic centimeters of normal saline when needed every 24 hours for occlusion. A physician's order, dated 2/6/21, included changing the Foley catheter every night shift starting on the 6th and ending on the 6th every month for a diagnosis of neurogenic bladder. Resident F's Care Plan, dated 11/24/19, reflected the following: "I have an indwelling Foley catheter related to urinary retention due to neurogenic bladder ...I have bladder spasms ...I am resistant to leave my catheter alone and at times I pulled it out on my own r/t [related to] diagnosis anxiety, vascular dementia...." During an interview, on 6/24/21 at 1:25 p.m., the MDS Coordinator reviewed the current MDS assessment dated 4/29/21 and indicated the bowel and bladder assessment was incorrect.		competed. Resident F's MDS was corrected during survey. **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 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;** MDS will audit all Elders with catheters to ensure they are coded correctly on MDS. **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.** MDS Coord/designee will review all orders during the look back period to ensure accuracy on all MDS being completed. This will be done weekly for 6 months before submission of MDS. The results will be reviewed in the monthly Quality Assurance Meeting. Any concerns will be addressed upon discovery. ="" bdate=""> **span=""><**	

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	06/24/2021

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
	3.1-31(c)(6)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide necessary services to 1 of 6 residents reviewed who required assistance with oral hygiene. (Resident B) Finding includes: During an observation, on 6/23/21 at 10:30 a.m., with Licensed Practical Nurse (LPN) 5 and Certified Nurse Aides (CNAs) 6 and 7, Resident B was unable to follow directions to open her mouth or smile widely. With limited visibility, she was observed to be missing a tooth on the bottom left and top right. There were white and yellow substances across the top gum line. Areas along the top gum line were bright red, possibly indicating irritated gums. During an interview, on 5/19/21 at 10:50 a.m., Resident B's daughter indicated her mother was usually meticulous with her teeth. When Covid-19 restrictions were lifted in April 2021, and they were able to visit, they discovered she had a front tooth broken off at the gum line. They used her funds to pay her personal dentist to remove one tooth and were told by her dentist she would need oral surgery to remove at least five other rotten and broken teeth. They asked staff about the last dental visit in October 2020 at the facility and were told the resident refused to let them clean her teeth. Equally disturbing was a comment made by	F 0677	F 677 **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 all residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be take** 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 nursing staff will be reeducated on the mouth care policy.	07/09/2021

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	06/24/2021

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 caretaker, the resident had not let them brush her teeth since she had resided there (over two years). Resident B's medical record was reviewed on 6/23/21 at 10:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia (difficulty swallowing), anxiety disorder and cognitive communication deficit. Resident B's annual minimum data set (MDS) assessment, dated 5/24/21, indicated she had severely impaired cognitive status. She required extensive assistance by one person for personal hygiene. Resident B's care plan, initiated on 6/07/19, reflected she had the potential for poor oral/dental health problems. She required staff assistance with oral care. She ground her teeth and bit her toothbrush. Interventions included, but were not limited to, coordinate arrangements for dental care, observe/document/report as needed any signs or symptoms of oral/dental problems needing attention (pain; abscess; debris in mouth; lips cracked or bleeding; teeth missing, loose, broken, eroded, or decayed) and provide mouth care as per ADL (assistance with daily living) personal hygiene. The facility's CNA assignment sheet, undated, reflected she required assistance with oral care in the morning and evening. Resident B's "Look Back Report" of the CNAs charting of care, dated 6/24/21, reflected CNAs did not provide personal hygiene during the following shifts of May and June 2021. Day, evening, and night of 5/07/21, 5/12/21,		**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.** DON/designee will do oral care checks on 5 elders a day 5 days a week for 2 months then 3 days for 2 months then 2 days a week for 2 months. The result will be reviewed in the monthly Quality Assurance Meeting. Any concerns will be addressed upon discovery. /b>	

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	06/24/2021

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
	5/13/21, 5/24/21, 5/27/21, and 5/28/21. Evening and night of 05/01/21, 05/02/21, 5/06/21, 5/08/21, 5/09/21, 5/16/21, 5//17/21, 5/18/21, 5/20/21, 5/23/21, 5/25/21, 6/03/21, 6/09/21, and 6/24/21. Resident B's medication and treatment administration records for May and June 2021 reflected no documentation related to oral care. Resident B's social service note, dated 10/20/20, reflected "[Dentist] attempted to provide dental services to elder today. Elder was combative and examination was difficult." Resident B's Dental Exam, dated 10/20/20, indicated due to lack of cooperation, hitting and trying to bite, the examination was difficult. The exam details noted her periodontal health was poor. There was generalized heavy plaque, calculus (tarter) and generalized periodontal disease. Cleaning was recommended if the resident would tolerate it. Resident B's progress note, dated 4/29/21, indicated her daughter arranged for the resident to see a dentist on 05/04/21. During an interview, on 6/23/21 at 10:30 a.m., CNA 7 indicated she brushed the resident's teeth and rinsed her mouth in the morning. The resident usually swallowed the rinse instead of spitting it out, and when she spit it out, it went everywhere. The resident was unable to follow directions. The CNAs did not chart oral care. During an interview, on 6/23/21 at 10:30 a.m., LPN 5 indicated Resident B generally screamed when staff did oral care. She could tell CNA 7 performed oral care in the morning because she could hear			

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	06/24/2021

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
	the resident screaming. She indicated the CNAs did not chart oral care but informed her when they did it. The nurses documented it was completed in the medication administration record. During an interview, on 6/24/21 at 11:10 a.m., the Medical Records Director indicated Resident B's medical record included no other record of a dental visit other than the visit on 10/20/20 by the facility's dentist. The facility did not receive the records from the resident's visit with her personal dentist on 5/04/21. The CNAs did not specifically chart oral care. They charted the provision of personal hygiene, which included oral care. She reviewed Resident B's record and found no other record of oral care charted in nurses' notes, medication administration records, shower sheets, or skin assessment sheets during May or June 2021. A current facility policy, titled "Mouth Care," dated October 2010 and provided by the Executive Director on 6/24/21 at 1:15 p.m., indicated "The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth...The following information should be recorded in the resident's medical record: 1. The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record ...If the resident refused the treatment, the reason(s) why and the intervention taken...Notify the supervisor if the resident refuses mouth care...." The Federal tag relates to Complaints IN00354558			

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	06/24/2021

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
	and IN00354637. 3.1-38(a)(3)(C)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure availability and administration of a resident's antipsychotic medication was completed in accordance with professional standards of practice for 1 of 4 residents reviewed for pharmacy services. (Resident E) Finding includes: During a telephone interview, on 6/23/21 at 2:30 p.m., Resident E's daughter indicated a few weeks ago the resident did not receive multiple doses of buspirone HCL (for anxiety) 5 milligrams (mg) on 6/03/21 through 6/06/21. She emailed the Director of Nurses (DON) on 6/07/21. He indicated he would order the missing medication from the facility's pharmacy. Resident E's medical record was reviewed on 6/23/21 at 11:22. Diagnoses included, but were not limited to, generalized anxiety disorder and dementia. Resident E's physician's order, dated 2/23/21,	F 0684	F 684 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident E's missing medication was found on medication cart and given as order. The doctor was notified of missed medication. There was no negative outcome noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be take** All Elders have the potential to be affected. **What measures will be put into place and what systemic changes will be made to**	07/09/2021

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	06/24/2021

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
	included buspirone HCL 5 mg, give 1 tablet by mouth 3 times a day. Resident E's Care Plan, reviewed on 6/24/21 at 10:37 p.m., indicated "I use an anti-anxiety medication related to anxiety disorder...I may refuse ADL care at times such as yelling out when staff assist me with lying down to rest or taking a shower. I have a diagnosis of dementia and anxiety...." Resident E's Medication Administration Record (MAR), for the month of June 2021, reflected Resident E did not receive her buspirone HCL 5 mg on the following days: 6/03/21, 6/05/21 and 6/06/21. Resident E's progress notes, dated 6/03/21 at 10:00 p.m., reflected the drug was not available. On 6/05/21 at 10:08 p.m., the medication was requested from the family. On 6/6/21 at 10:17 p.m., the facility was waiting for the pharmacy delivery. During an interview, on 6/24/21 at 11:40 a.m., the DON indicated he was not aware Resident E was missing buspirone HCL 5 mg tablets on 6/03/21 through 6/06/21 until 6/07/21. The DON indicated the Emergency Drug Kit (EDK) did not contain buspirone HCL 5 mg for the nurses to use as a backup supply. Resident E's card of 30 tablets of buspirone HCL 5 mg was later found for Resident E in the medication cart on 6/07/21 by the DON. The DON indicated agency staff worked the weekend and did not know how to refill the medication, so they did not call the pharmacy or doctor on or before 6/3/21 for a refill. The DON indicated if the pharmacy was not called before 6/03/21 for a refill, than the documentation on 6/04/21 was probably inaccurate on the MAR. The DON indicated the correct procedure for missing		**ensure that the Deficient practice does not recur;** Nursing staff will be re-educated on the availability and administration of anti-psychotic/ anti-anxiety medication. **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.** DON/designee will audit 5 days a week 2 elders' medication a day for 2 months, then 2 elders 3 days a week for 2months, then 2 elders 2 days a week for 2 months. /a> /b>	

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	06/24/2021

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
	medication was for the nurse to notify the pharmacy and physician of the missing medication. A current facility policy, titled "Administration of Oral Medications," dated 11/4/01 and provided by the Executive Director on 6/24/21 at 9:45 a.m., did not address the availability and administration of antipsychotic medication. This Federal tag relates to Complaint IN00354558 and IN00345637. 3.1-37(a)			
F 0689 SS=D 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 §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 2 of 3 residents observed receiving assistance with activities of daily living (ADLs) received adequate assistive devices to prevent injuries or accidents when 3 of 5 Certified Nurse Aides (CNAs 6, 7 and 8) transferred the residents without a gait belt. (Residents B and L) 1. During an observation, on 06/23/21 at 10:30 a.m., with Licensed Practical Nurse (LPN) 5, CNAs 6 and 7 escorted Resident B from the common area into her bedroom in her wheelchair. CNAs 6 and 7	F 0689	/b> **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 that the resident receives adequate supervision and assistance devices to prevent accidents. There was no negative outcome from the deficient	07/09/2021

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	06/24/2021

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
	transferred the resident from the wheelchair to her bed by putting their arms under the resident's arms, across her axilla (armpit) and under her shoulder joint and by holding onto the elastic waist of her pants. The resident's shoulders rose during the transfer and the waist of her pants rose to the middle of her back. After the LPN examined the resident's feet and teeth, the CNAs transferred the resident from the bed back to the wheelchair. The CNAs placed their arms under the resident's arms again, and their hands on the resident's elastic waistband. A gait belt was observed hanging on the back of the resident's bedroom door. Resident B's medical record was reviewed on 6/23/21 at 10:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, unsteadiness on feet, history of falling, difficulty in walking and anxiety disorder. Resident B's quarterly minimum data set (MDS) assessment, dated 5/24/21, reflected she had severely impaired cognitive skills for daily decision making. She required extensive assistance by two people for transfers between surfaces. Resident B's Care Plan, initiated on 5/22/19, reflected she had an activities of daily (ADL) living self-care deficit related to dementia. Approaches included, but were not limited to, required an extensive assistance by two staff to move between surfaces. The care plan also indicated she had limited physical mobility related to dementia and a history of a right patella (knee cap) fracture. The CNA Assignment Sheet, undated, reflected Resident B required two people to assist with		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 take** 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;** Nursing staff will be re-educated on the gait belt transfers. **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.** DON/designee will observe 3 transfer a day using gait belts 5 days a week for 2 months then 2 transfers a day using gait belts for 4 months. Any concerns will be addressed upon discovery. **/b>** **/b>**	

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	06/24/2021

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
	transfers. During an interview, on 6/23/21 at 10:30 a.m., CNA 7 indicated they did not use a gait belt during the transfer because the resident usually stood up. 2. During an observation, on 06/24/21 at 9:00 a.m., Resident L was observed sitting in the toilet of her suite, supervised by CNA 8. CNA 8 indicated she was employed through an agency and this was her first time meeting the resident. The CNA transferred the resident from the toilet to the wheelchair in the following manner. She asked the resident to place her hand on the handrail in front of and to the left of the resident. The resident was unable to follow her instructions, so the CNA helped her place her hands on the handrail. The CNA then put her hand under the resident's arm, across her axilla and under her shoulder joint to help her standup from the toilet and pivot around to the side bar. The resident's shoulder was observed to rise. The CNA pulled up the resident's pull-up briefs and pants while the resident stood independently. The CNA put her hand on the resident's elastic waistband of the pants to lower her into wheelchair. When asked how she knew what level of assistance the resident required for transfers, the CNA indicated she had an assignment sheet. When she reviewed the assignment sheet, she indicated it must not have been accurate because it said she required one person to assist her with a walker, but the resident did not have a walker. The CNA was told during shift report the resident stood on her own, so she did not use a gait belt. A gait belt was hanging on the back of the resident's door. Resident L's medical record was reviewed on 6/24/21 at 9:30 a.m. Diagnoses included, but were not limited to, fracture of the shaft or right tibia			

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	06/24/2021

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
	(leg bone below the knee), need for assistance with personal care, difficulty walking, age-related osteoporosis and Alzheimer's disease. Resident L's admission MDS assessment, dated 6/3/21, indicated she had a severely impaired cognitive status. She required extensive assistance by two people for transfers and toilet use. Resident L's Care Plan, initiated on 6/11/21, reflected she had ADL self-care performance deficit related to dementia, trauma and weakness. She was totally dependent on two staff for toilet use. She was able to transfer with the assistance of two staff. The CNA Assignment Sheet, undated, reflected Resident L required one person to assist with transfers. During an interview, on 6/24/21 at 9:55 a.m., the Staff Development Coordinator (SDC) indicated Resident L was steadier than when she was admitted to the facility. The SDC updated the CNA assignment sheets every week. Her expectations were for nursing staff to use a gait belt when assisting a resident with transfers. A current facility policy, titled "Using a Transfer Belt in Transferring an Elder between Two Surfaces," undated and provided by the Staff Development Coordinator on 6/24/21 at 10:40 a.m., reflected "...5. Place transfer belt around elder's waist. 6. Assist elder to edge of the surface on which they are sitting. 7. Grasping the sides of the transfer belt, say to the elder, "On the count of three I would like you to stand up...9. On the count of three guide the elder to the standing position. If the transfer belt is loose, tighten. 10.			

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	06/24/2021

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
	Assist the elder to pivot so they are standing in front of the surface they want to transfer to. 11. Assist elder to lower self to the surface keeping your grasp on the sides of the transfer belt...." This Federal TAG related to Complaint IN00354637. 3.1-45(a)(2)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are			

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	06/24/2021

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
	able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview and record review, the facility failed to ensure 3 of 5 Certified Nurse Aides (CNAs 6, 7 and 8) demonstrated competency in skills and techniques necessary to care for 2 of 3 residents observed being transferred between surfaces. (Residents B and L). 1. During an observation, on 06/23/21 at 10:30 a.m., with Licensed Practical Nurse (LPN) 5, CNAs 6 and 7 escorted Resident B from the common area into her bedroom in her wheelchair. CNAs 6 and 7 transferred the resident from the wheelchair to her bed by putting their arms under the resident's arms, across her axilla (armpit) and under her shoulder joint and by holding onto the elastic waist of her pants. The resident's shoulders rose during the transfer and the waist of her pants rose to the middle of her back. After the LPN examined the resident's feet and teeth, the CNAs transferred the resident from the bed back to the wheelchair. The CNAs placed their arms under the resident's arms again, and their hands on the resident's elastic waistband. A gait belt was observed hanging on the back of the resident's bedroom door. Resident B's medical record was reviewed on 6/23/21 at 10:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, osteoarthritis, unsteadiness on feet, history of falling, difficulty in walking and anxiety disorder. Resident B's quarterly minimum data set (MDS) assessment, dated 5/24/21, reflected she had severely impaired cognitive skills for daily	F 0726	/bf> **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 that the resident receives adequate supervision and assistance devices to prevent accidents. There was no negative outcome from the 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 take** 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;**Nursing staff will be re-educated on the gait belt transfers. **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.** DON/designee will observe 3 transfer a day using gait belts 5 days a week for 2 months then 2	07/09/2021

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	06/24/2021

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
	decision making. She required extensive assistance by two people for transfers between surfaces. Resident B's Care Plan, initiated on 5/22/19, reflected she had an activities of daily (ADL) living self-care deficit related to dementia. Approaches included, but were not limited to, required an extensive assistance by two staff to move between surfaces. The care plan also indicated she had limited physical mobility related to dementia and a history of a right patella (knee cap) fracture. The CNA Assignment Sheet, undated, reflected Resident B required two people to assist with transfers. During an interview, on 6/23/21 at 10:30 a.m., CNA 7 indicated they did not use a gait belt during the transfer because the resident usually stood up. 2. During an observation, on 06/24/21 at 9:00 a.m., Resident L was observed sitting in the toilet of her suite, supervised by CNA 8. CNA 8 indicated she was employed through an agency and this was her first time meeting the resident. The CNA transferred the resident from the toilet to the wheelchair in the following manner. She asked the resident to place her hand on the handrail in front of and to the left of the resident. The resident was unable to follow her instructions, so the CNA helped her place her hands on the handrail. The CNA then put her hand under the resident's arm, across her axilla and under her shoulder joint to help her standup from the toilet and pivot around to the side bar. The resident's shoulder was observed to rise. The CNA pulled up the resident's pull-up briefs and pants while the resident stood independently. The CNA put her		transfers a day using gait belts for 4 months. Any concerns will be addressed upon discovery. **span="">** /bdate> **span="">**	

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	06/24/2021

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
	hand on the resident's elastic waistband of the pants to lower her into wheelchair. When asked how she knew what level of assistance the resident required for transfers, the CNA indicated she had an assignment sheet. When she reviewed the assignment sheet, she indicated it must not have been accurate because it said she required one person to assist her with a walker, but the resident did not have a walker. The CNA was told during shift report the resident stood on her own, so she did not use a gait belt. A gait belt was hanging on the back of the resident's door. Resident L's medical record was reviewed on 6/24/21 at 9:30 a.m. Diagnoses included, but were not limited to, fracture of the shaft or right tibia (leg bone below the knee), need for assistance with personal care, difficulty walking, age-related osteoporosis and Alzheimer's disease. Resident L's admission MDS assessment, dated 6/3/21, indicated she had a severely impaired cognitive status. She required extensive assistance by two people for transfers and toilet use. Resident L's Care Plan, initiated on 6/11/21, reflected she had ADL self-care performance deficit related to dementia, trauma and weakness. She was totally dependent on two staff for toilet use. She was able to transfer with the assistance of two staff. The CNA Assignment Sheet, undated, reflected Resident L required one person to assist with transfers. During an interview, on 6/24/21 at 9:55 a.m., the Staff Development Coordinator (SDC) indicated Resident L was steadier than when she 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	06/24/2021

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

admitted to the facility. The SDC updated the CNA assignment sheets every week. Her expectations were for nursing staff to use a gait belt when assisting a resident with transfers.

A current facility policy, titled "Using a Transfer Belt in Transferring an Elder between Two Surfaces," undated and provided by the Staff Development Coordinator on 6/24/21 at 10:40 a.m., reflected "...5. Place transfer belt around elder's waist. 6. Assist elder to edge of the surface on which they are sitting. 7. Grasping the sides of the transfer belt, say to the elder, "On the count of three I would like you to stand up...9. On the count of three guide the elder to the standing position. If the transfer belt is loose, tighten. 10. Assist the elder to pivot so they are standing in front of the surface they want to transfer to. 11. Assist elder to lower self to the surface keeping your grasp on the sides of the transfer belt...."

The Indiana State Department of Health Nurse Aide Curriculum, revised on 11/19/15, reflected "...Procedure #26: Transfer to Wheelchair. Step 4. Stand in front of resident and apply gait belt around resident's abdomen. Rationale: Gait belts reduce strain on your back and provides for security for the resident. 5. Grasp the gait belt securely on both sides of the resident. Provides security for the resident and enables them to turn...7. On the count of three, help resident into standing position by straightening your knees...10. Lower resident into wheelchair by bending your knees and leaning forward...."

This Federal TAG related to Complaint IN00354637.

3.1-14(i)