

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2015
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/10/15</p> <p>Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Green Valley Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke</p>	K010000	<p>Allegation of Compliance Please accept the following plan of correction for the Life Safety Code Survey on February 10, 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.</p>	
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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.

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K010017 SS=E	<p>detectors in all resident sleeping rooms. The facility has a capacity of 242 and had a census of 102 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached shed used for facility storage.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/11/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the</p>	K010017	1.An electrically supervised	02/18/2015			

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	<p>facility failed to ensure 1 of 9 open use areas were separated from the corridor by walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above or met an Exception. LSC 19.3.6.1, Exception #1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 8 residents, as well as staff and visitors while in the 500 Unit.</p> <p>Findings include:</p>		<p>automatic smoke detection system was installed in the 500 hall RITA room by Safe Care on 2/18/2015.</p> <p>2.The facility was audited by the maintenance director on 2/12/2015 and no other areas were found that needed an electrically supervised automatic smoke detection system installed.</p> <p>3.The facility smoke detectors will be audited periodically by Safecare for placement and proper function for preventative maintenance.</p> <p>4.The maintenance director or designee will randomly audit 5 facility automatic smoke detectors to ensure correct placement and function at least weekly for no less than (3) months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

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	<p>Based on observation on 02/10/15 at 12:15 p.m. during a tour of the facility with the Maintenance Director, the 500 Unit RITA Room was open to the corridor. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The 500 RITA Room was not protected by an electrically supervised automatic smoke detection system, or the entire space was not arranged and located to allow direct supervision by the facility staff from the nurses' station or similar staffed space. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3-1.19(b)</p>						