

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  02/03/2016
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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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K 0000  Bldg. 01	<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: 02/03/16</p> <p>Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370</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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 103</p>	K 0000	<p>Allegation of Compliance Please accept the following plan of correction for the Life Safety annual survey on February 3, 2016. 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>	

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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K 0020 SS=B Bldg. 01	<p>at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached wooden storage shed which was not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection for 1 of 2 basement exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect all staff who work in the basement and kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/03/16 at 11:40 a.m. with the maintenance supervisor, the kitchen stairway door failed to self-close and latch into the door frame, leaving a one inch gap along the latching side of the door. Furthermore,</p>	K 0020	<p>1. On 2/22/2016, Safecare installed positive latching hardware to the basement/kitchen stairway door (see attachment A).</p> <p>2. The facility was audited by the maintenance director on 2/4/2016 to ensure enclosure of stairway vertical openings.</p> <p>3. The facility stairway doors will be audited at least weekly to ensure self-closure and positive latch into the door frame as a preventative maintenance procedure.</p> <p>4. The maintenance director or designee will perform an audit of the stairway doors to ensure self-closure and positive latch into the door frame at least weekly and record audits into preventative maintenance TELS system. The results of these audits will be presented to the monthly QAPI</p>	02/22/2016

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K 0025 SS=E Bldg. 01	<p>the kitchen stairway door lacked latching hardware. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/03/16 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 17 attic smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 10 residents who reside on the Northwest 400 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 02/03/16 at</p>	K 0025	<p>Committee for further review and recommendation. Plan to be updated as indicated.</p> <p>1.On 2/4/2016, the maintenance director applied fire stopping material around the penetration identified in the attic smoke barrier (see attachment B).</p> <p>2.The facility smoke barriers were audited by the maintenance director on 2/4/2016 to ensure there was no penetration identified.</p> <p>3.The facility smoke barriers will be audited the day of or day after a vendor performs service in the attic to ensure necessary penetration is properly addressed, fire stopping</p>	02/22/2016

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K 0029 SS=E Bldg. 01	<p>12:30 p.m., the Northwest 400 Hall attic smoke barrier wall had a three inch open electrical conduit on both sides of the smoke barrier wall and a one inch gap around a two inch sprinkler pipe penetration with no fire stopping material around the penetration. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/03/16 at 1:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 14 hazardous areas, such as a storage room for combustibles over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient</p>	K 0029	<p>material will be applied around the penetration by the maintenance director or designee.</p> <p>4.The maintenance director will audit the facility smoke barriers at least on a quarterly basis and record audit in the preventative maintenance TELS system. The results of these audits will be presented to the QAPI committee for further review and recommendation. Plan to be updated as indicated.</p> <p>1.On 2/3/2016, the maintenance director applied a door closure to the kitchen storage room that was identified (see attachment C).</p> <p>2.Corridor doors to hazardous areas were audited by the maintenance director on 2/4/2016 to ensure proper door closures were installed as needed.</p>	02/22/2016

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	<p>practice could affect staff who use the kitchen storage room in the kitchen walk in Freezer Hall.</p> <p>Findings include:</p> <p>Based on observation on 02/03/16 at 11:20 a.m. with the maintenance supervisor, the kitchen storage room, which each measured seventy five square feet and stored thirty seven cardboard boxes of paper supplies and dry food, lacked a self-closing device on the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/03/16 at 1:00 p.m.</p> <p>3.1-19(b)</p>		<p>3.The corridor doors will be audited by the maintenance director periodically to ensure self-closing devices are in place and automatically close and latch into the door frame.</p> <p>4.Corridor doors to hazardous areas will be audited by the maintenance director or designee monthly for the next three months and continue quarterly to ensure self-closing devices are in place as needed and properly close and latch into the door frame. The results of these audits will be presented to the QAPI committee for further review and recommendation. Plan to be updated as indicated.</p>				