

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 12/05/2013
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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: 12/05/13</p> <p>Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370</p> <p>Surveyor: Mark Bugni, 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident</p>	K010000	<p>Allegation of Compliance Please accept the following plan of correction for the annual survey on December 5th, 2013.</p> <p>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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	<p>sleeping rooms. The facility has a capacity of 242 and had a census of 91 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled except one detached wooden storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/10/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<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 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 68 residents who use the main dining room located adjacent to the service hall where the laundry room and emergency generator transfer switch room are located.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 12/05/13 during a tour of the facility from 9:10 a.m. to 1:55 p.m., the following ceiling smoke barriers were not fire stopped;</p> <p>a. The basement ceiling in the boiler room had four, six inch by six inch and three, twelve inch by ten inch square areas</p>	K010025	The ceiling smoke barriers indicated were repaired and fire stopped .The maintenance director audited the facility to ensure smoke barriers were properly fire stopped on 12/11/13 and made repairs as needed.The maintenance staff was inserviced by the Executive Director on 12/9/13, on ensuring that all smoke barriers are fire stopped after contract work is completed and as necessary.The maintenance director or designee will randomly audit facility rooms ensure smoke barriers are fire stopped at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months.The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to	12/18/2013			

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	<p>of drywall missing in the south ceiling portion of the room.</p> <p>b. The laundry room ceiling area behind the dryers had two, three inch circular areas of drywall missing and a one inch gap around an electrical conduit penetration.</p> <p>c. The emergency generator transfer switch room ceiling had three electrical conduit penetrations with three inch gaps around the penetrations.</p> <p>d. The central supply room ceiling had a half inch gap around an electrical conduit penetration.</p> <p>e. The 500 Hall sprinkler riser room ceiling had a half inch gap around a copper water pipe penetration.</p> <p>f. The 600 Hall environmental storage room had eleven ceiling electrical conduit penetrations with one quarter inch gaps around each penetration.</p> <p>The missing ceiling drywall and penetrations not firestopped were verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the exit conference on 12/05/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>		discontinuing audits. Plan to be updated as indicated.	

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K010029 SS=E	<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 door to 6 of 18 hazardous areas such as combustibile storage rooms over 50 square feet in size were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice affects 36 residents who reside on the 500 Hall and use the unoccupied 100 Hall and 200 Hall corridors leading to the main dining room.</p> <p>Findings include:</p> <p>Based on observations on 12/05/13 during a tour of the 200 Hall and 500 Hall from 12:20 p.m. to 1:30 p.m. with the maintenance supervisor, the doors to unoccupied resident rooms 213, 221, 222, 101, 109, and 112 which each measured two hundred forty square feet in size and</p>	K010029	<p>Door closures were installed to rooms 213, 221, 222, 101, 109, and 112. Other rooms were audited by the maintenance director on 12/10/13, for the need of door closures and were properly placed as needed. The maintenance staff was inserviced by the executive director on 12/9/13, on ensuring proper door closures are installed on rooms that are being used for storage. The maintenance director or designee will randomly audit to ensure door closures are installed in rooms that are being used for storage at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95%</p>	12/18/2013			

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	<p>stored combustible cardboard boxes of paper supplies, plastic bed mattresses, wooden chairs, wooden tables, and cardboard boxes of new beds each lacked self closing devices. Based on an interview with the maintenance supervisor on 12/05/13 at 11:30 a.m., the 100 Hall and 200 Hall are currently unoccupied and being renovated and some resident rooms are being used as storage rooms. The lack of self closing devices on the 100 Hall and 200 Hall resident rooms 213, 221, 222, 101, 109, and 112 used as combustible storage rooms was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the exit conference on 12/05/13 at 12:50 p.m.</p> <p>3.1-19(b)</p>		<p>compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit accesses with a ramp was provided with handrail. LSC 7.1 requires means of egress comply with Chapter 7. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice affects 36 residents who reside on the 500 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/05/13 at 12:45 p.m., the 500 Hall south exit discharged onto a fifty foot sloping sidewalk leading to the parking lot with at least three feet of fall along the entire length of sidewalk leading to the parking lot. Furthermore, there was a four foot</p>	K010038	A four foot handrail was added to the identified area at the bottom of the sloping sidewalk. Other exterior handrails were audited by the maintenance director on 12/9/13 and not in violation. The handrails will be audited periodically for placement and proper function as a preventative maintenance procedure. The maintenance director or designee will audit the grounds to ensure handrails are in place and in good working order at least weekly for no less than (3) months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.	12/18/2013			

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	<p>section at the bottom of the sloping sidewalk lacking handrail. This was verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing at the exit conference on 12/05/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>			

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K010056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 6 of 200 rooms were completely sprinkled. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observation on 12/05/13 during a tour of the 300 Hall, 500 Hall and 600 Hall with the maintenance supervisor from 10:00 a.m. to 1:35 p.m., the following rooms had sprinklers blocked by ceiling mounted light fixtures extending ten inches down from the ceiling, which obstructed the sprinkler from providing full coverage in each room: the 600 Hall oxygen storage room, the 600 Hall environmental storage room, the 600 Hall mechanical room, the 500</p>	K010056	<p>Ceiling lights identified were moved to ensure there was no obstruction of the sprinkler from providing full coverage in each room. The facility was audited by the maintenance director on 12/10/13, to ensure that sprinklers were not obstructed by ceiling mounted light fixtures. The maintenance staff were educated by the Executive Director on 12/9/13, to ensure routine facility monitoring is completed to ensure sprinklers are not obstructed. The maintenance director or designee will randomly audit rooms to ensure sprinkler heads are not obstructed from providing full coverage in rooms at least five (5) rooms per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Performance</p>	12/18/2013			

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	Hall janitor room, the 500 Hall clean linen room, and the 400 Hall dietary utility room. The obstructed sprinklers were verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing at the exit conference on 12/05/13 at 1:55 p.m. 3.1-19(b)		Improvement Committee. The Performance Improvement Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.				

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 44 wet location resident care areas were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice does not affect any residents since these rooms are staff offices.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/05/13 during a tour of the facility from 9:00 a.m. to 1:55 p.m., the 600 Hall staff kitchen, the 300 Hall housekeeping room, and the</p>	K010147	<p>Ground-fault circuit interrupters (GFCI) were placed in the areas identified. The facility was audited by the maintenance director on 12/10/13 and no other areas were found that needed GFCIs placed. Maintenance staff were inserviced by the Executive Director on 12/9/13 to ensure routine facility monitoring of receptacles and fixed equipment within the area of a potentially wet location to have ground-fault circuit interrupter (GFCI) protection. The safety committee will audit to ensure GFCIs are located within an area of a possible wet location at least monthly for no less than (3) months. The results of these audits will be presented to the monthly Performance Improvement Committee. The Performance Improvement 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>	12/18/2013

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	<p>500 Hall pantry storage room each had a handwash sink with electric outlets within two feet of the sink which were not provided with ground fault circuit interrupters. Furthermore, the main electrical panel serving each area was observed and the rooms were not provided with a ground fault circuit interrupters in each electric breaker panel. This was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the exit conference on 12/05/13 at 1:55 p.m.</p> <p>3.1-19(b)</p>			