PRINTED: 12/07/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC.	_			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155070	B. WING		10/19/2023	
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 10/19 Facility Number: 0 Provider Number: 1002 At this Emergency Valley Care Center Emergency Prepare Medicare and Mediand Suppliers, 42 C	0/23 00028 155070 275370 Preparedness survey, Green was found in compliance with dness Requirements for caid Participating Providers	E 0000			
	Quality Review con	npleted on 10/31/23				
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/19 Facility Number: 0	00028	K 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Greg Dattilo Executive Director 12/05/2023

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPL	
		155070	B. WI	NG		10/19/	2023
	ROVIDER OR SUPPLIER			3118 GI	DDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one story facility determined to be of was fully sprinklere system with hard we corridors and spaces battery powered sm sleeping rooms. The and had a census of	articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty with a partial basement was Type V (000) construction and d. The facility has a fire alarm ired smoke detectors in the sopen to the corridors, plus oke alarms in all resident e facility has a capacity of 141 121 at the time of this survey. In the detector of the corridors of the corridors of the capacity of the facility has a capacity of the facility has a capacity of the facility has a capacity of the corridors of this survey.					
K 0100 SS=E Bldg. 01	Section 18.1 and a that are not address. K-tags, but are de along with the app NFPA standard cit on Form CMS-2561. Based on observa failed to ensure corrooms would close aper 4.6.12.3. LSC 4 safety features obvious required by the Cod	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included 67. attion and interview, the facility ridor doors to 2 of over 75 and latch into the door frame 1.6.12.3 requires existing life ous to the public if not le, shall be either maintained or cient practice could affect over	K 0	100	K100 – General Requirements What corrective actions will I accomplished for those residents found to have been affected by the deficient practice? Maintenance Director fixed doc	oe I	11/18/2023

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155070	B. WING		10/19/2023
	PROVIDER OR SUPPLIEF		3118 0	ADDRESS, CITY, STATE, ZIP COD SREEN VALLEY RD ALBANY, IN 47150	1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWING BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	Findings include: Based on observation Director during a to to 4:15 p.m. on 10/ Medical Records rollocated near the conformation device, self-closing device, self-close and latch tested to close multiat the time of the observation of the ob	ons with the Maintenance our of the facility from 1:30 p.m. 19/23, the corridor door to the form and the old mail room each ofference room near the main to both equipped with a but each door would not into the door frame when iple times. Based on interview observations, the Maintenance aforementioned corridor door lif-close and latch into the door to close multiple times. The review, observation, and the failed to ensure two of over sets were maintained per 12.3 requires existing life safety the public if not required by either maintained or removed. The review is the review of the public if not required by either maintained or removed. The could affect over 20 to visitors. The Way of the Maintenance Director with	TAG	so they self-close and latch in following locations Medical Records Office Old Mail Room Maintenance Director remove paint so the Fire Resistance Rating were visible at the folk locations 9A by room 521 13A by the Sensor Root How other residents have the potential to be affected by the same deficient practice will identified and what corrective actions will be taken? 20 Resident, Staff, and Visito could be affected. No residents were affected. Maintenance Director and Maintenance assistant have be educated that doors need to be self-closing and that fire rating doors need to be legible and painted over. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance assistant have be educated that doors need to be self-closing and that fire rating doors need to be legible and painted over.	an the december on the december of the december on the december of the decembe
	L on 10/19/23, two do	oor label locations are painted.	1	How will the corrective action	ons I

The aforementioned documentation stated the

be monitored to ensure the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	ľ í	UILDING	onstruction 01	(X3) DATE : COMPL 10/19/	ETED
	PROVIDER OR SUPPLIER			3118 GI	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	"13A by Sensor Ro Based on observation Director during a to to 4:15 p.m. on 10/1 labels on the aforen were painted and no These findings were	identified as "9A by 521" and om" were "Painted Over". ons with the Maintenance our of the facility from 1:30 p.m. 19/23, the fire resistance rating mentioned two door locations of legible. The reviewed with the Executive aintenance Director during the			deficient practice will not recur, i.e., what quality assurance programs will be pinto place? Maintenance Director/Designed complete auditing of all doors ensure that all doors self-closed and latch and that fire ratings a visible and legible on corridor doors. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.	e to to e are till be ty ns. iews	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuously maintain accordance with	- General ays, corridors, exit cations, and accesses are h Chapter 7, and the means nuously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0	211	K211 – Mean of Egress What corrective actions will l accomplished for those residents found to have beer		11/18/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155070 B. WING 10/19/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE fire or other emergency. This deficient practice affected by the deficient could affect over 20 residents, staff and visitors if practice? needing to exit the facility. Maintenance Director immediately moved Wooden Stairs from Findings include: corridor in 600 Hall Based on observations with the Maintenance How other residents have the Director during a tour of the facility from 1:30 p.m. potential to be affected by the to 4:15 p.m. on 10/19/23, a wooden stair device for same deficient practice will be the Therapy Gym was stored in the corridor identified and what corrective outside Room 602 in the 600 Hall. The device actions will be taken? projected three feet into the eight foot wide Over 20 residents, staff, and corridor. An upholstered chair was also stored in visitors could be affected by the corridor outside Room 603 in the 600 Hall and Means of Egress being free from also projected three feet into the eight foot wide obstructions corridor. Based on interview at the time of the Maintenance Director audited all observations, the Maintenance Director stated the corridors for anything that would 600 Hall does not currently house any residents obstruct any means of Egress. and has been vacant for an unspecified period of time but agreed the aforementioned means of What measures will be put into egress was not continually maintained free of all place or what systemic obstructions or impediments to full instant use in changes will be made to the case of fire or other emergency. ensure that the deficient practice does not recur? These findings were reviewed with the Executive Maintenance Director and Director and the Maintenance Director during the Maintenance assistant have been exit conference. educated on Means of Egress 3.1-19(b) How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? Maintenance Director/Designee to complete auditing of all Corridors are free from obstructions. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	ľ	JILDING	onstruction 01	(X3) DATE COMPL 10/19/	ETED
NAME OF F	PROVIDER OR SUPPLIEF	- L			ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
GREEN '	VALLEY CARE CEI	NTER		NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					The results of these reviews we discussed at the monthly facil QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months are for a total of 6 months and duration of rewill be increased as needed if areas of noncompliance are identified during the auditing process.	ity :hs. views	
K 0222 SS=E Bldg. 01	be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special loc clinical security neused, only one loc permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special loc safety needs of the the Clinical or Secure being met. In electrical locks that	king arrangements for the eds of the patient are eking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPL	ETED
		155070	B. WING			10/19/	/2023
			CTI	DEET A	DDDECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ODEENIN	VALLEY OADE OE	NITED			REEN VALLEY RD		
GREEN	VALLEY CARE CE	NIER	I NE	EVV AL	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	G	DEFICIENCY)		DATE
	building is protect	ed by a supervised					
	automatic sprinkle	er system and the locked					
	space is protected	by a complete smoke					
	detection system	(or is constantly monitored					
	at an attended loc	ation within the locked					
	space); and both t	the sprinkler and detection					
	systems are arran	ged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE	SS LOCKING					
	ARRANGEMENT	S					
	Approved, listed d	lelayed-egress locking					
	systems installed	in accordance with					
	7.2.1.6.1 shall be	permitted on door					
	assemblies servin	g low and ordinary hazard					
	contents in buildin	igs protected throughout by					
	an approved, supe	ervised automatic fire					
	detection system	or an approved, supervised					
	automatic sprinkle	er system.					
	18.2.2.2.4, 19.2.2	.2.4					
	ACCESS-CONTR	OLLED EGRESS					
	LOCKING ARRAN						
	Access-Controlled	d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2						
		BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
	1	sed automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		ation and interview, the facility	K 0222		K222 – Egress Doors		11/18/2023
		means of egress through 2 of			What corrective actions will	be	
		cks were readily accessible for			accomplished for those		
	all residents, staff a	nd visitors. LSC 7.2.1.6.1,			residents found to have been	า	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	r í	UILDING	onstruction 01	(X3) DATE COMPL 10/19/	ETED
		100070	Б. ,,		ADDRESS STATE TIP COD	10/13/	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
GREEN \	VALLEY CARE CEI	NTER			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		cks allows approved, listed,			affected by the deficient		
		s shall be permitted to be			practice?		
		erving low and ordinary			Maintenance Director immedi	-	
	hazard contents in b				fixed door so that Codes listed		
		oproved, supervised automatic			matched up with the code tha		
	_	m installed in accordance with			marked in the following location	ns	
		pproved, supervised automatic			Exit on 300 hall next to		
		stalled in accordance with			room 316		
		nere permitted in Chapters 12			Exit in the Sunroom		
	through 42, provide				Maintenance Director fixed		
		k upon actuation of an			corridor door set to the kitcher		
		ed automatic sprinkler system			from the service hall so that it		
		nce with Section 9.7, or upon			more than one releasing oper	ation.	
	-	heat detector or not more			l		
		ectors of an approved,			How other residents have th		
	_	ic fire detection system			potential to be affected by th		
		nce with Section 9.6.			same deficient practice will		
		ck upon loss of power			identified and what corrective	е	
	_	or locking mechanism.			actions will be taken?		
		process shall release the lock			Over 20 residents, staff, and		
		apon application of a force to			visitors could be affected by D		
		equired in 7.2.1.5.4 that shall			codes not matching the codes	i	
	^	xceed 15 lbf nor required to be			that were marked.	-4:-1	
		ed for more than 3 seconds.			Over 2 Kitchen have the poter	าแลเ	
		e release process shall activate the vicinity of the door. Once			of being affected Maintenance Director and		
	_	een released by the application				oon	
		sing device, relocking shall be			Maintenance assistant have be educated on Egress Doors.	CCII	
	by manual means o	-			educated on Egress Doors.		
		approved by the authority			What measures will be put in	nto	
	_	a delay not exceeding 30			place or what systemic	110	
	seconds shall be per	-			changes will be made to		
	_	acent to the release device,			ensure that the deficient		
		dily visible, durable sign in			practice does not recur?		
		1 inch high and at least 1/8			Maintenance Director and		
		on a contrasting background			Maintenance assistant have b	ieen	
	that reads:	on a contrasting ouckground			educated on Egress Doors.	COII	
	"PUSH UNTIL AL	ARM SOUNDS			Cadoaled on Egress Doors.		
		PENED IN 15 SECONDS".			How will the corrective actio	ne	
		ice could affect over 20			be monitored to ensure the		
		·			,		•

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 01 COMPLETE B. WING 10/19/20			ETED			
		ROVIDER OR SUPPLIER		•	3118 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD	•	
	GREEN \	ALLEY CARE CEN	NTER		NEW A	LBANY, IN 47150		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	TAG	residents, staff and facility. Findings include: Based on observation Director during a to to 4:15 p.m. on 10/10 outside of the facility door to the the facil	cons with the Maintenance our of the facility from 1:30 p.m. 19/23, the exit door to the try in the Sun Room and the exit of the facility in the 300 Hall each marked as a facility exit fach exit door also had a coor to release the door to release each door to open was nor but it was the incorrect door to open. Each door was ayed egress door with the egress signage. Each door so for 15 seconds. Based on the observations, the cor stated each exit door was a well and agreed the doors the necessary delayed. The reviewed with the Executive faintenance Director during the state hall with not more than the try is a constant of the provise on a door if the releasing device on a door if the releasing device having of operation and readily ighting conditions. The		TAG	CROSS-REFERENCED TO THE APPROPRIA	put ee to s vill be tty hs.	DATE

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		X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155070	B. Wl	ING		10/19/	/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	releasing mechanism	n for any latch shall be located					
	not less than 34 incl	nes, and not more than 48					
	inches above the fin	ished floor. Doors shall be					
	operable with not m	ore than one releasing					
	operation. Section	A.7.2.1.5.10 states examples of					
	_	e arranged to release latches					
		rs, and panic bars. This					
	deficient practice co	ould affect over 2 kitchen staff.					
	Findings include:						
	Director during a to to 4:15 p.m. on 10/1 the kitchen from the with two locks on the time of the observative during the required more than open the door.	ons with the Maintenance our of the facility from 1:30 p.m. 19/23, the corridor door set to be service hall was equipped one door. Based on interview at rivations, the Maintenance afforementioned door set one releasing operation to be reviewed with the Executive content of the content of the facility					
	3.1-19(b)						
K 0223 SS=E Bldg. 01	enclosure, or horiz or hazardous area and kept in the clo open by a release 7.2.1.8.2 that auto doors throughout t entire facility upon * Required manua	osing Devices assageway, stairway contal exit, smoke barrier, enclosure are self-closing esed position, unless held device complying with matically closes all such the smoke compartment or					

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PRINTED: 12/07/2023

	T OF HEALTH AND HUI R MEDICARE & MEDIC					MB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE	E SURVEY PLETED 9/2023
	PROVIDER OR SUPPLIEF		3118 (CADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	required smoke de * Automatic sprink * Loss of power. 18.2.2.7, 18.2.2 Based on observation failed to ensure 1 or in the 600 Hall are closed position, unlidevice complying with deficient practice of staff and visitors in Findings include: Based on observation Director during a toto 4:15 p.m. on 10/ as door 4A in the converse was propped in the paint can placed up interview at the time Maintenance Direct currently house any vacant for an unspeading and the corridor position. These findings were	rough the opening or a etection system; and der system, if installed; and a c.2.8, 19.2.2.2.7, 19.2.2.2.8 con and interview, the facility of 1 sets of smoke barrier doors self-closing and kept in the ess held open by a release with LSC Section 7.2.1.8.2. This could affect over 20 residents, the 600 Hall. The many self-closing and kept in the ess held open by a release with LSC Section 7.2.1.8.2. This could affect over 20 residents, the 600 Hall. The many self-closing and kept in the ess held open by a release with LSC Section 7.2.1.8.2. This could affect over 20 residents, the 600 Hall fully open position with a against the door set in the 600 Hall fully open position with a against the door. Based on e of the observations, the tor stated the 600 Hall does not residents and has been cified period of time but was used to prop the north door set in the fully open The reviewed with the Executive enintenance Director during the	K 0223	K223 – Doors with Self-Clos Devices What corrective actions will accomplished for those residents found to have be affected by the deficient practice? Maintenance Director immediate removed Paint Can so it would prop open door with Self-Clobevice. How other residents have the potential to be affected by same deficient practice will identified and what correct actions will be taken? Over 20 residents could be affected by having objects propping open doors with self-closing devices. Maintenance Director audited doors with self-closing devices. Maintenance Director and Maintenance assistant have educated on Doors with self-closing devices What measures will be put place or what systemic changes will be made to ensure that the deficient	Il be en diately uld not posing the the I be ive	11/18/2023

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Facility ID: 000028

practice does not recur? Maintenance Director and Maintenance assistant have been

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155070	A. BUILDING B. WING	01	COMPLETED 10/19/2023
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD JLBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				educated on Doors with self-closing devices	
				How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be pinto place? Maintenance Director/Designed complete auditing of all doors a self-closing devices to make to ensure they are free of any obpropping open door. Auditing woccur 4 x's/weekly x's 4 weeks x's monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 month Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.	e to with ects vill d, 4 ill be ty ns. iews
K 0232 SS=E Bldg. 01	unobstructed) ser at least 4 feet and convenient remov on stretchers, exc 19.2.3.4, exceptio 19.2.3.4, 19.2.3.5	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the al of nonambulatory patients ept as modified by ns 1-5.			
		on and interview, the facility	K 0232	K232 – Aisle, Corridor, or Ram	11/18/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155070 B. WING 10/19/2023

	NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD			
GREEN	VALLEY CARE CENTER	N	=VV AI	LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TA	G		DATE	
	13 corridors or met an exception per 19.2.3.4(5).			What corrective actions will be		
	LSC 19.2.3.4(5) states where the corridor width is			accomplished for those		
	at least 8 feet, projections into the required width			residents found to have been		
	shall be permitted for fixed furniture, provided that			affected by the deficient		
	all of the following conditions are met:			practice?		
	(a) the fixed furniture is securely attached to the			Maintenance Director immediately		
	floor or to the wall.			removed upholstered chair from		
	(b) the fixed furniture does not reduce the clear			Corridor.		
	unobstructed corridor width to less than six feet,					
	except as permitted by 19.2.3.4(2).			How other residents have the		
	(c) the fixed furniture is located only on one side			potential to be affected by the		
	of the corridor.			same deficient practice will be		
	(d) the fixed furniture is grouped such that each			identified and what corrective		
	grouping does not exceed an area of 50 square			actions will be taken?		
	feet.			Over 20 residents, staff, and		
	(e) the fixed furniture groupings addressed in			visitors have the potential to be		
	19.2.3.4(5)(d) are separated from each other by a			affected.		
	distance of at least 10 feet.			Maintenance Director audited all		
	(f) the fixed furniture is located so as to not			corridors to ensure there was		
	obstruct access to building service and fire			nothing violating the 3 foot rule for		
	protection equipment.			an 8 foot Corridor.		
	(g) corridors throughout the smoke compartment are protected by an electrically supervised			Maintenance Director and		
	automatic smoke detection system in accordance			Maintenance assistant have been		
	with 19.3.4, or the fixed furniture spaces are			educated on items not projecting more than 3 feet in an 8 foot		
	arranged and located to allow direct supervision			corridor.		
	by the facility staff from a nurse's station or similar			comdor.		
	space.			What measures will be put into		
	(h) the smoke compartment is protected			place or what systemic		
	throughout by an approved, supervised automatic			changes will be made to		
	sprinkler system in accordance with 19.3.5.8.			ensure that the deficient		
	This deficient practice could affect over 20			practice does not recur?		
	residents, staff and visitors if needing to exit the			Maintenance Director and		
	facility.			Maintenance assistant have been		
				educated on items not projecting		
	Findings include:			more than 3 feet in an 8 foot		
				corridor.		
	Based on observations with the Maintenance					
	Director during a tour of the facility from 1:30 p.m.			How will the corrective actions		
	to 4:15 p.m. on 10/19/23, an upholstered chair was			be monitored to ensure the		
	1 ' '	1			1	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/19/2023	
	PROVIDER OR SUPPLIEF		3118	FADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF stored in the corridor Hall and projected to wide corridor. The floor or to the wall. of the observations, stated the 600 Hall residents and has be period of time but a furniture storage log floor or to the wall. These findings were		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) deficient practice will not recur, i.e., what quality assurance programs will be printo place? Maintenance Director/Designe complete auditing of all Corridot to ensure there nothing project more than 3 feet in an 8 foot Corridor. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 month Frequency and duration of reviewill be increased as needed if a areas of noncompliance are identified during the auditing process.	e to ors ting ill be ty	
K 0281 SS=E Bldg. 01	discharge, is arrai and shall be eithe or capable of auto manual intervention 18.2.8, 19.2.8 Based on observation failed to ensure egromeans of egress was any single lighting the area in darkness illumination shall be failure of any single in an illumination leads to the either the entire that the en	ans of Egress ans of egress, including exit nged in accordance with 7.8 r continuously in operation matic operation without	K 0281	K281 – Illumination of Means of Egress What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The outdoor lighting fixtures fo Exits from 600 Hall and Therage	pe r	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/19/2023	
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD JLBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
TAG	could affect over 20	O residents, staff and visitors in ng to exit the facility.	TAG	were completely replaced with new outdoor lighting fixtures	5.112	
	Director during a to to 4:15 p.m. on 10/600 Hall by Room separate light bulbs was burnt out. In a the Therapy Room lighting fixture con Based on interview observations, the Mother aforementioned equipped with the relighting fixtures.	ons with the Maintenance our of the facility from 1:30 p.m. 19/23, the exit discharge for the 619 was equipped with two but one of the two light bulbs ddition, the exit discharge for was equipped with only one taining a single light bulb. at the time of the laintenance Director agreed two exit discharges was not minimum number of operable ereviewed with the Executive aintenance Director during the		How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited outdoor lighting fixtures to ensithat they fixtures are working properly. Maintenance Director and Maintenance assistant have be educated on Illuminations of Means of Egress What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance assistant have be educated on Illuminations of Means of Egress How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be print or place? Maintenance Director/Designe complete auditing of all outdoor lighting fixtures to ensure they	e e e e e e e e e e e e e e e e e e e	

working properly. Auditing will

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONDITION OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155070 B. WING		ONSTRUCTION (X3) DATE SURVEY COMPLETED 10/19/2023		
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ILBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lightin Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on observatio failed to ensure 2 of emergency lighting accordance with LS states battery operationly reliable types of provided with suital them in properly chaused in such lights of their intended use a 70, National Electric could affect over 20 Findings include: Based on observation Director during a to	ng ng g of at least 1-1/2-hour ed automatically in	K 0291	occur 4 x's/weekly x's 4 weeks x's monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months Frequency and duration of rewill be increased as needed if areas of noncompliance are identified during the auditing process. K291 – Emergency Lighting What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Emergency Lighting fixtures for both 300 and 600 were replaced. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Over 20 residents, staff, and visitors have the potential to be affected. Maintenance Director audited	be ity hs. views any 11/18/2023 be n or sed. e ne be re
	_	xed to the wall above the exit		Emergency Exit Fixtures to	uii e

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door to the outside of the facility in the 300 Hall

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ensure they are working properly

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155070	B. W	NG _		10/19/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			REEN VALLEY RD		
GREEN \	VALLEY CARE CEI	NTER			LBANY, IN 47150		
OKELIN	VALLET GARL GET	VILIX		INCV A			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	n the 600 Hall by Room 619			Maintenance Director and		
		inate when its respective test			Maintenance assistant have b	een	
	_	multiple times. Based on			educated on proper working		
		e of the observations, the			Emergency Lighting		
		tor agreed the aforementioned			l		
		nergency lighting systems			What measures will be put in	ito	
	failed to illuminate when its respective test button				place or what systemic		
	was pushed multiple times.				changes will be made to		
	These findings were reviewed with the Evecutive				ensure that the deficient		
	These findings were reviewed with the Executive				practice does not recur?		
	Director and the Maintenance Director during the exit conference.				Maintenance Director and Maintenance assistant have b	000	
	exit conference.				educated on proper working	een	
	3.1-19(b)				Emergency Lighting		
	3.1-17(0)				Emergency Lighting		
					How will the corrective actio	ne	
					be monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be	put	
					into place?	F	
					Maintenance Director/Designe	e to	
					complete auditing of all		
					Emergency Lighting Fixtures t	.0	
					ensure all are working properl		
					Auditing will occur 4 x's/week	-	
					x's 4 weeks, 4 x's monthly x's	-	
					months.		
					The results of these reviews w	vill be	
					discussed at the monthly facili	ity	
					QAPI meeting monthly for 3		
					months and then quarterly		
					thereafter for a total of 6 mont		
					Frequency and duration of rev		
					will be increased as needed if	any	
					areas of noncompliance are		
					identified during the auditing		
					process.		
			I				l

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	onstruction 01	(X3) DATE COMPL	ETED	
		155070	B. WI	NG		10/19/	2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AM OF CORRECTION		(X5)	٦
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.L	DATE	
K 0300	NFPA 101	1						
SS=E	Protection - Other							
Bldg. 01	Protection - Other							
	List in the REMAR	KS section any LSC						
	Section 18.3 and 1	19.3 Protection						
	requirements that	are not addressed by the						
	provided K-tags, b	ut are deficient. This						
	information, along with the applicable Life Safety Code or NFPA standard citation,							
		d on Form CMS-2567.						
	Based on observation and interview, the facility failed to replace battery operated smoke alarms		K 0	300	K300 – Protection		11/18/2023	
					What corrective actions will I	be		
		ent sleeping rooms in the 600			accomplished for those			
		with NFPA 72. NFPA 72, 2010			residents found to have beer	1		
		2.1.1.1 states inspection,			affected by the deficient			
	_	ance programs shall satisfy			practice?			
	_	this Code and conform to the			Smoke Detectors in rooms 608,			
		turer's published instructions.			609, 614, 616, 617 will be			
	Section 14.4.8.1 star				replaced with new Smoke			
	_	e manufacturer's published			Detectors			
	_	and multiple-station smoke			Smoke Detector will be installed	ed in		
	_	aced when they fail to respond			room 618			
		out shall not remain in service						
		s from the date of manufacture.			How other residents have the			
	•				potential to be affected by th			
	600 Hall.	visitors in the vicinity of the			same deficient practice will be			
	ооо пан.				identified and what corrective actions will be taken?	е		
	Findings include:				Over 20 residents, staff, and			
	i manigs metade.				visitors have the potential to be	0		
	Based on observation	ons with the Maintenance			affected.	G		
		ur of the facility from 1:30 p.m.			Maintenance Director audited	all		
		9/23, manufacturer's			Smoke Detectors to ensure the			
	•	ted to the BRK Model 83R			were less than 10 years old ar	-		
		oke detector mounted on the			all rooms had Smoke Detector			
		leeping room 608. 609, 614, 616			Maintenance Director and			
	-	Hall each indicated the smoke			Maintenance assistant have be	een		
		actured in June 2000. Room			educated on Smoke Detectors			
		moke detector installed in the			ensure they are less than 10	=		
		om. Based on interview at the			years old and that all rooms ha	ad a		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED 10/19/2023			
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
GREEN \	VALLEY CARE CEN	ITER		NEW AI	LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ions, the Maintenance		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) Smoke Detector installed.	TE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	Director stated the 6 house any residents unspecified period 6 Director stated batter installed in other poreplaced in 2022 but smoke detectors were and agreed resident operated smoke detectors were each was more operated smoke detectors were each was more operated smoke detectors were each was more operated smoke detectors and the Markett conference. 3.1-19(b) NFPA 101 Hazardous Areas Hazardous Areas Hazardous Areas Hazardous areas barrier having 1-he (with 3/4 hour fire automatic fire exting accordance with 8 approved automatic option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	and has been vacant for an of time. The Maintenance cry operated smoke detectors ritions of the facility were to the 600 Hall battery operated re not replaced at that time sleeping room battery ectors installed in the 600 Hall ethan ten years old. The reviewed with the Executive cintenance Director during the error fire resistance rating rated doors) or an inguishing system in 1.7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting in accordance with 8.4.			What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance assistant have be educated on Smoke Detectors ensure they are less than 10 years old and that all rooms has Smoke Detector installed.	een s to	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155070 B. WING 10/19/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility K 0321 11/18/2023 K321 - Hazardous Area failed to ensure 3 of over 11 hazardous areas such Enclosure as combustible storage rooms/spaces (over 50 What corrective actions will be square feet) and soiled linen and trash collection accomplished for those rooms exceeding 64 gallons were separated from residents found to have been other spaces by smoke resistant partitions and affected by the deficient doors. Doors shall be self closing or automatic practice? closing in accordance with 7.2.1.8. This deficient Maintenance Director placed door practice could affect over 20 residents, staff and knob in door that had hole visitors. Maintenance Director installed Self-Closing Device in kitchen Findings include: Maintenance Director fixed Self-Closing Device door for room Based on observations with the Maintenance 611 Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, the following was noted: How other residents have the a. the corridor door to the Clean Utility Room in potential to be affected by the the 600 Hall had a hole in the door where a door same deficient practice will be

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were stored in the room.

handle had been installed which caused the door

to not latch into the door frame. Two large trash

b. the self closing device on one of the corridor

doors in the door set to the kitchen storage room

kitchen storage room exceeded fifty square feet in

size and was used to store combustible boxes for

from the service corridor was removed. The

bags each filled with clothes exceeding 64 gallons

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identified and what corrective

visitors have the potential to be

Maintenance Director audited all

doors that require Self-Closing

Devices to ensure they worked

properly and were present on

Over 20 residents, staff, and

actions will be taken?

affected.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/19/2023
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR kitchen supplies. c. the self closing of Room 611 failed to into the door frame times. Room 611 e and was used to sto supplies. Based on interview observations, the M the aforementioned not separated from resistant partitions at These findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Levice for the corridor door to self close and latch the door when tested to close multiple acceded fifty square feet in size are combustible boxes and at the time of the aintenance Director agreed three hazardous areas were other spaces with smoke			peen — Into DATE Deen — Into Deen — Into Deen
				1	[

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/19/2023 155070 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0324 **NFPA 101** SS=D Cooking Facilities Bldg. 01 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96. Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2. 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review, observation, and K 0324 K324 - Cooking Facilities 11/18/2023 interview; the facility failed to ensure 1 of 1 What corrective actions will be kitchen exhaust systems was inspected accomplished for those semiannually. NFPA 96, 2011 Edition, Standard residents found to have been for Ventilation Control and Fire Protection of affected by the deficient Commercial Cooking Operations, Section 11.4 practice? states the entire exhaust system shall be Maintenance Director scheduled inspected for grease buildup by a properly kitchen exhaust inspection for trained, qualified, and certified person(s) December 2023 acceptable to the authority having jurisdiction Maintenance Director fixed door to and in accordance with Table 11.4. Table 11.4, kitchen so that it would have more

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Schedule for Inspection for Grease Buildup,

requires systems serving moderate volume

cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon

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open door.

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than one releasing operation to

How other residents have the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155070	B. W	ING		10/19/2023	
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			REEN VALLEY RD		
GREEN \	VALLEY CARE CEN	NTER			LBANY, IN 47150		
			-		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		A LSC IDENTIFYING INFORMATION haust system is found to be		TAG		DATE	
	-	deposits from grease laden			potential to be affected by the		
		-			same deficient practice will I		
	vapors, the contaminated portions of the exhaust				identified and what corrective	e	
	system shall be cleaned by a properly trained,				actions will be taken?		
	qualified, and certified person(s) acceptable to the				All Kitchen staff have the pote	enuai	
	authority having jurisdiction. Hoods, grease				to be affected.	-11	
	removal devices, fans, ducts, and other				Maintenance Director audited	all	
	appurtenances shall be cleaned to remove combustible contaminants prior to surfaces				inspections for the kitchen to	-41	
				ensure they have been compl			
		ontaminated with grease or			as required and that all corrido	or	
	oily sludge. After the exhaust system is cleaned, it				doors have more than one		
	shall not be coated with powder or other				releasing operation.		
	substance. When an exhaust cleaning service is used, a certificate showing the name of the				Maintenance Director and		
	· ·	_			Maintenance assistant have b		
		the name of the person			educated on Kitchen Facilities		
	-	k, and the date of inspection or			What measures will be put in	110	
	-	aintained on the premises.			place or what systemic		
	staff.	ice could affect all kitchen			changes will be made to		
	starr.				ensure that the deficient		
	Eindings in abida.				practice does not recur?		
	Findings include:				Maintenance Director and		
	Rosed on review of	the kitchen range hood			Maintenance assistant have been		
		or's "Service Report"			educated on Kitchen Facilities	o.	
	•	d 06/12/23 with the Executive			How will the corrective actio	ne	
		aintenance Director during			be monitored to ensure the	113	
		10:20 a.m. to 1:30 p.m. on			deficient practice will not		
		tation of a kitchen exhaust			recur, i.e., what quality		
		ix months prior to 06/12/23			assurance programs will be	nut	
		or review. Based on interview			into place?	put	
		d review, the Maintenance			Maintenance Director/Designe	ee to	
		cumentation of a kitchen			complete auditing of all kitche		
	_	pection six months prior to			inspections and door sets that		
		vailable for review. Based on			require more than one releasi		
		ne Maintenance Director			operation. Auditing will occur	_	
		facility from 1:30 p.m. to 4:15			x's/weekly x's 4 weeks, 4 x's	'	
		ne kitchen range hood			monthly x's 5 months.		
	-	or had affixed a sticker to the			The results of these reviews v	vill he	
	-	which only documented the			discussed at the monthly facil		
	_	range hood inspection			QAPI meeting monthly for 3	ity	
1	most recent kitchell	range nood mopeenon	1		I AVELLING THOUGHT IN TOLOUR		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVE COMPLETED 10/19/2023	Y
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP BREEN VALLEY RD ALBANY, IN 47150	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COME APPROPRIATE	(X5) PLETION ATE
	_	/23. e reviewed with the Executive aintenance Director during the		months and then quathereafter for a total of Frequency and durat will be increased as rareas of noncompliar identified during the aprocess.	of 6 months. ion of reviews needed if any nce are	
	failed to provide 1 of kitchen from the ser one releasing opera states a latch or other shall be provided we an obvious method operated under all 1 releasing mechanism not less than 34 inclining inches above the fir operable with not more operation. Section devices that might be include knobs, leve	of 1 corridor door sets to the rvice hall with not more than tion. LSC Section 7.2.1.5.10 er fastening device on a door ith a releasing device having of operation and readily ighting conditions. The m for any latch shall be located thes, and not more than 48 hished floor. Doors shall be more than one releasing A.7.2.1.5.10 states examples of the arranged to release latches rs, and panic bars. This build affect over 2 kitchen staff.				
	Director during a to to 4:15 p.m. on 10/2 the kitchen from the with two locks on the time of the observative during the required more than open the door.	ons with the Maintenance our of the facility from 1:30 p.m. 19/23, the corridor door set to be service hall was equipped one door. Based on interview at rivations, the Maintenance aforementioned door set one releasing operation to be reviewed with the Executive content of the content of the reviewed with the Executive content of the reviewed content of the				

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	OF OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2023	
	PROVIDER OR SUPPLIER		3	3118 GF	DDRESS, CITY, STATE, ZIP COD REEN VALLEY RD BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0341 SS=F Bldg. 01	3.1-19(b) NFPA 101 Fire Alarm System Fire Alarm System A fire alarm system and components a accordance with N Code, and NFPA Code to provide er part of the building occupied, detection alarm control unit, detection is also in appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1, Based on observation failed to maintain 1 accordance with NF Code, 2010 Edition location of the dedict disconnecting mean identified at the con states, for fire alarm disconnecting mean ALARM CIRCUIT fire alarm systems t shall have a red man the circuit disconne accessible only to a 10.5.5.3 states the d connections shall be	n - Installation n - Installation m is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm ffective warning of fire in any g. In areas not continuously in is installed at each fire In new occupancy, installed at notification ower extenders, and in transmitting equipment. wiring or other is are monitored for 9.6, 9.6.1.8 ion and interview, the facility of 1 fire alarm systems in ifPA 72, National Fire Alarm is Section 10.5.5.2.1 states, the cated branch circuit is shall be permanently trol unit. Section 10.5.5.2.2 in systems the circuit is shall be identified as "FIRE in Section 10.5.5.2.3 states for the circuit disconnecting means ricking. Section 10.5.5.2.4 states cetting means shall be uthorized personnel. Section edicated branch circuit(s) and the protected against physical ient practice could affect all	K 034	-1	K341 – Fire Alarm System - Installation What corrective actions will I accomplished for those residents found to have been affected by the deficient practice? Alarm Circuit Breaker now has signage that identifies as "Alar Circuit Breaker" and has a lock placed on breaker box How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents, staff, and visitors have the potential to be affected.	red m ked	11/18/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPI A. BUILDIN B. WING			(X3) DATE SURVEY COMPLETED 10/19/2023	
NAME OF P	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP COD	-	
					N VALLEY RD		
GREEN	VALLEY CARE CE	NIER	, INE	W ALDAI	NY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI		EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	Findings include:	LISC IDENTIFYING INFORMATION	TAC	_	intenance Director has aud	dit a d	DATE
	rindings include.				oreaker boxes to ensure p		
	Based on observations with the Maintenance				ntification and are locked	орсі	
	Director during a tour of the facility from 1:30 p.m.				perly		
	_	19/23, the fire alarm circuit			intenance Director and		
		mounted electrical panel in the		Mai	intenance assistant have b	een	
		as "Panel E ATS 2 Gen			ıcated on fire alarm systen		
	Power" was not identified with red marking as				circuit disconnecting mea	ns	
		and access to the circuit			all be identified as "FIRE		
	breaker was not locked. Based on interview at the				ARM CIRCUIT." Section		
	time of the observations, the Maintenance Director agreed the dedicated branch circuit				5.5.2.3 states for fire alarm		
	· ·	is for the facility's fire alarm		-	tems the circuit disconnec ans shall have a red marki	-	
		perly identified and was not			ction 10.5.5.2.4 states the	iig.	
	locked.	you, judanianou unu mus nes			cuit disconnecting means s	hall	
					accessible only to authoriz		
	These findings were	e reviewed with the Executive			sonnel. Section 10.5.5.3 s		
	Director and the Ma	aintenance Director during the		the	dedicated branch circuit(s) and	
	exit conference.			con	nections shall be protecte	d	
				_	ainst physical damage.		
	3.1-19(b)				at measures will be put in	nto	
				-	ce or what systemic		
					anges will be made to sure that the deficient		
					ctice does not recur?		
				1 -	intenance Director and		
					intenance assistant have b	een	
				edu	ıcated on fire alarm systen	าร	
				the	circuit disconnecting mea	ns	
					all be identified as "FIRE		
					ARM CIRCUIT." Section		
					5.5.2.3 states for fire alarm		
				-	tems the circuit disconnec	-	
					ans shall have a red marki ction 10.5.5.2.4 states the	ng.	
					ction 10.5.5.2.4 states the cuit disconnecting means s	hall	
					accessible only to authoriz		
					sonnel. Section 10.5.5.3 s		
					dedicated branch circuit(s		
					nections shall be protecte	•	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CC JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OI CORRECTION	155070	B. W.		<u> </u>	10/19/2023	
	PROVIDER OR SUPPLIER		<u> </u>	3118 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150	L	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF			ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	against physical damage.	DATE	
					How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/Designed complete auditing fire alarm systems the circuit disconnect means shall be identified as "I ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnect means shall have a red marking Section 10.5.5.2.4 states the circuit disconnecting means as be accessible only to authoriz personnel. Section 10.5.5.3 states the dedicated branch circuit (sonnections shall be protected against physical damage. Auditing will occur 4 x's/week x's 4 weeks, 4 x's monthly x's months. The results of these reviews we discussed at the monthly facil QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months are requency and duration of reviewless of noncompliance are identified during the auditing process.	put ee to ing FIRE ing ng. nall ed ates and d ly 5 vill be ty hs. riews	
K 0351 SS=E	NFPA 101 Sprinkler System	- Installation					

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED		
		B. WING		10/19/2023			
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			3118 G NEW A	STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150 ID PROVIDER'S PLAN OF CORRECTION (X5)			
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
Bldg. 01	Spinkler System - 2012 EXISTING Nursing homes, a by construction ty throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II constituted for sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Instandard for the Installation of 13, 2010 edition, Seescutcheons, or other annular space arour or shall be listed for deficient practice of staff and visitors. Findings include: Based on observation Director during a toto 4:15 p.m. on 10/15	nd hospitals where required	K 0351	K351– Sprinkler System – Installation What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Escutcheons will be installed of the following Sprinkler Heads Kitchen 600 Hall Utility Room 600 Hall Shower Room Room 615 Room 620 400 Hall Sensory Room Sprinklers will be installed for the following in the Conference Room	n		

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escutcheon:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/19/2023 155070 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE a. in the kitchen. How other residents have the b. 600 Hall Clean Utility Room. potential to be affected by the c. 600 Hall Shower Room. same deficient practice will be d. in the restroom for Room 615. identified and what corrective e. in Room 620. actions will be taken? f. in the closet in the Sensory Room. 20 residents, staff, and visitors Based on interview at the time of the have the potential to be affected. observations, the Maintenance Director agreed Maintenance Director Audited all the aforementioned ceiling mounted sprinkler Sprinkler Heads to ensure locations were each missing its escutcheon. Escutcheons are installed and installed properly These findings were reviewed with the Executive Maintenance Director and Director and the Maintenance Director during the Maintenance assistant have been exit conference. educated on plates, escutcheons, or other devices used to cover the 3.1-19(b) annular space around a sprinkler shall be metallic, or shall be listed 2. Based on observation and interview, the facility for use around a sprinkler. failed to ensure a complete automatic sprinkler Maintenance Director and system was installed in accordance with NFPA 13, Maintenance assistant have been Standard for the Installation of Sprinkler Systems, educated on states sprinklers to provide complete coverage for all portions of shall be located, spaced, and the building. NFPA 13, 2010 Edition, Section positioned 8.5.1.1 states sprinklers shall be located, spaced, What measures will be put into and positioned in accordance with the place or what systemic requirements of Section 8.5. This deficient changes will be made to practice could affect over 10 residents, staff and ensure that the deficient visitors in the vicinity of the conference room near practice does not recur? the main entrance lobby. Maintenance Director and Maintenance assistant have been Findings include: educated on PIVs and holes in the ceiling. Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. How will the corrective actions

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to 4:15 p.m. on 10/19/23, a bulkhead extended

down more than 18 inches from the ceiling above

the eraser board area of the conference room near

the main entrance lobby. The bulkhead created

obstruction to the sprinkler spray pattern for the

ceiling mounted sprinklers installed in the room.

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into place?

be monitored to ensure the

assurance programs will be put

Maintenance Director/Designee to

deficient practice will not

recur, i.e., what quality

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155070 B. WING 10/19/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE The area above the eraser board was not complete auditing all Sprinkler equipped with sprinklers. Based on interview at heads to ensure all Sprinkler the time of the observations, the Maintenance heads are installed and installed Director agreed the area behind the bulkhead properly. Auditing will occur 4 above the eraser board area in the conference x's/weekly x's 4 weeks, 4 x's room was not provided with sprinkler coverage. monthly x's 5 months. The results of these reviews will be These findings were reviewed with the Executive discussed at the monthly facility Director and the Maintenance Director during the QAPI meeting monthly for 3 exit conference. months and then quarterly thereafter for a total of 6 months. 3.1-19(b) Frequency and duration of reviews 3.1-19(ff) will be increased as needed if any areas of noncompliance are identified during the auditing process. K 0352 **NFPA 101** SS=F Sprinkler System - Supervisory Signals Bldg. 01 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility K 0352 Waiver has been requested 01/31/2024 failed to maintain automatic sprinkler systems in K352 - Sprinkler System accordance with LSC 9.7. LSC 19.3.5.1 states Supervisory Signals buildings containing nursing homes shall be What corrective actions will be protected throughout by an approved, supervised accomplished for those automatic sprinkler system in accordance with residents found to have been Section 9.7. LSC 9.7.2.1 states where supervised affected by the deficient automatic sprinkler systems are required by practice?

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another section of this Code, supervisory

attachments shall be installed and monitored for

integrity in accordance with NFPA 72, National

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PIV will have Electronically

Monitor System installed

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
155070		B. W	ING		10/19/	2023	
l				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					REEN VALLEY RD		
GREEN '	VALLEY CARE CE	NTER			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	-	gnaling Code, and a distinctive			How other residents have the		
		shall be provided to indicate a			potential to be affected by the		
		ld impair the satisfactory			same deficient practice will	be	
		rinkler system. Supervisory			identified and what corrective	ve	
	_	and shall be displayed either			actions will be taken?		
		the protected building that is			All residents, staff, and visitor		
	-	l by qualified personnel or at			have the potential to be affec		
		tely located receiving facility.			Maintenance Director has cal		
	_	tice could affect all residents,			facility monitoring service to g		
	staff, and visitors in	n the facility.			PIV Monitoring System instal	led	
					Maintenance Director and		
	Findings include:				Maintenance assistant have l	peen	
					educated on PIVs		
	Based on observations with the Maintenance				What measures will be put i	nto	
	Director during a tour of the facility from 1:30 p.m.				place or what systemic		
	to 4:15 p.m. on 10/19/23, the Post Indicator Valve				changes will be made to		
	(PIV) located outside the facility on the southeast				ensure that the deficient		
	side of the property was not electrically				practice does not recur?		
	supervised. Based on interview at the time of the				Maintenance Director and		
observations, the Maintenance Director agreed				Maintenance assistant have l	peen		
	the PIV was not electrically supervised.				educated on PIVs		
	These findings were reviewed with the Executive				How will the corrective action	ons	
Director and the Maintenance Director exit conference.		aintenance Director during the			be monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
	3.1-19(b)				assurance programs will be	put	
					into place?		
					Maintenance Director/Designee to		
					complete auditing of PIV to ensure		
					Monitoring System is working		
					properly. Auditing will occur 4		
					x's/weekly x's 4 weeks, 4 x's		
			monthly x's 5 months.		عمالالت		
					The results of these reviews		
					discussed at the monthly faci	ııty	
					QAPI meeting monthly for 3		
					months and then quarterly	41	
					thereafter for a total of 6 mon		
				Frequency and duration of re	views		

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DEPARTMEN	T OF HEALTH AND HU	MAN SERVICES			FO!	RM APPROVED
CENTERS FO	R MEDICARE & MEDIC				_	IB NO. 0938-039
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	<u>01 </u>	COMPI	
		155070	B. WING		10/19	/2023
NAME OF	PROVIDER OR SUPPLIE	D	STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	K	3118	GREEN VALLEY RD		
GREEN	VALLEY CARE CE	NTER	NEW	ALBANY, IN 47150		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)		DEFICIENCY)		DATE
				will be increased as needed if	any	
				areas of noncompliance are		
				identified during the auditing		
				process.		
K 0353	NFPA 101					
SS=F		Maintananae and Tastina				
Bldg. 01	1 .	- Maintenance and Testing				
blug. U I	1 .	- Maintenance and Testing				
	•	er and standpipe systems				
		sted, and maintained in				
		NFPA 25, Standard for the				
	-	ng, and Maintaining of				
		Protection Systems.				
		m design, maintenance,				
		sting are maintained in a				
		nd readily available.				
	a) Date sprinkle	r system last checked				
	b) Who provided	d system test				
	c) Water system	n supply source				
	Provide in PEMA	 RKS information on				
		non-required or partial				
	automatic sprinkle					
	-					
	9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility		K 0353	K353– Sprinkler System –		11/18/2023
		1 fire department connections	K 0555	Maintenance and Testing		11/16/2023
		with NFPA 25, 2011 Edition,		What corrective actions will	ho	
		spection, Testing, and		accomplished for those	NG	
		ater-Based Fire Protection		l '	_	
		13.7.1 requires fire department		residents found to have been	•	
				affected by the deficient		
		nspected quarterly to verify		practice?	1	
	the following:	, , , , , , , , , , , , , , , , , , , ,	PIV Identification Sign mounted			
	(1) The fire departs	ment connections are visible	1	Sprinklers will be installed for	the	I

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and accessible.

rotate smoothly.

(2) Couplings or swivels are not damaged and

(3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition.

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have been fixed

If continuation sheet

holes in the Conference Room

Ceiling holes in the basement

How other residents have the

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STATEMENT OF DEFICIENCIES		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2023		
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE		
	(5) Identification si	gns are in place.		potential to be affected by the			
	(6) The check valve	e is not leaking.		same deficient practice will be			
	(7) The automatic of	lrain valve is in place and	identified and what correct				
	operating properly.			actions will be taken?			
		ment connection clapper(s) is in		10 residents, staff, and visitors			
	place and operating			have the potential to be affected.			
	_	ice could affect all residents,		Maintenance Director ensued			
	staff, and visitors.			there were no holes in the ceiling			
				Maintenance Director and			
	Findings include:			Maintenance assistant have bee			
				educated on PIVs and holes in t	he		
	Based on observations with the Maintenance			ceiling.			
	Director during a tour of the facility from 1:30 p.m.			What measures will be put into			
	to 4:15 p.m. on 10/19/23, the fire department			place or what systemic			
	connection (FDC), which was located next to the			changes will be made to			
	Post Indicator Valve (PIV) outside the facility on			ensure that the deficient			
	the southeast side of the property, was not			practice does not recur?			
	provided with an identification sign. Based on			Maintenance Director and			
	interview at the time of the observations, the			Maintenance assistant have bee			
	Maintenance Director agreed the FDC was not			educated on PIVs and holes in t	he		
	provided with the necessary identification signage. These findings were reviewed with the Executive Director and the Maintenance Director during the			ceiling.			
				How will the corrective actions			
				be monitored to ensure the			
				deficient practice will not			
	exit conference.			recur, i.e., what quality			
				assurance programs will be pu	ıt		
	3.1-19(b)			into place?			
				Maintenance Director/Designee			
	2. Based on observation and interview, the facility			complete auditing of PIV to ensure			
	failed to maintain the ceiling construction on 2 of			of proper signage and holes in			
	2 levels in the facility in accordance with NFPA			ceiling. Auditing will occur 4			
	13. NFPA 13, 2010 edition, Section 3.3.5.4 defines			x's/weekly x's 4 weeks, 4 x's			
	a smooth ceiling as a continuous ceiling free from			monthly x's 5 months.			
	significant irregularities, lumps, or indentations.			The results of these reviews will			
	The ceiling traps hot air and gases around the			discussed at the monthly facility			
	*	the sprinkler to operate at a		QAPI meeting monthly for 3			
		are. Section 8.5.4.1.1 states the		months and then quarterly			
distance between the sprinkler deflector and the			thereafter for a total of 6 months				

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ceiling above shall be selected based on the type

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Frequency and duration of reviews

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2023				
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER			3118 G	STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(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				
ING	of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors. Findings include:		1710	will be increased as needed i areas of noncompliance are identified during the auditing process.	f any			
	Based on observation Director during a to to 4:15 p.m. on 10/1 the suspended ceiling the eraser board in the main entrance lobby hole was noted in the corridor outside the door. Based on interpretations, the Machine the aforementioned ceiling construction barriers.	ons with the Maintenance our of the facility from 1:30 p.m. 19/23, two holes were noted in a behind the bulkhead above the conference room near the facility. In addition, a ten inch long the ceiling in the basement sprinkler riser room entrance enview at the time of the aintenance Director agreed openings did not maintain the in the two ceiling smoke the reviewed with the Executive aintenance Director during the						
	failed to ensure 1 of the facility were rep NFPA 25. NFPA 2 Testing, and Mainte Protection Systems, states sprinklers sha shall be free of corr and physical damag correct orientation (sidewall). Furthern	ation and interview, the facility Fover 100 sprinkler heads in blaced in accordance with 5, Standard for the Inspection, mance of Water-Based Fire 2011 Edition, Section 5.2.1.1.1 all not show signs of leakage; osion, foreign materials, paint, e; and shall be installed in the e.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler any of the following shall be						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 10/19/2023	
NAME OF F	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COD)
GREEN \	VALLEY CARE CEI	NTER		GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	
TAG	(2) Corrosion	CESC IDENTIFY TING INFORMATION	IAG		DATE
	(3) Physical Damag				
		the glass bulb heat responsive			
	element				
	(5) Loading (6) Painting unless	painted by the sprinkler			
	manufacturer.	painted by the sprinkler			
		sprinklers that are loaded with			
	_	to clean sprinklers with			
	_	y a vacuum provided that the			
	equipment does not touch the sprinkler. This deficient practice could affect over 2 staff				
	and visitors in the kitchen.				
	Findings include:				
	Based on observations with the Maintenance				
	Director during a tour of the facility from 1:30 p.m.				
	to 4:15 p.m. on 10/19/23, the sprinkler installed on				
	the ceiling in the Janitor's Closet in the kitchen				
	-	rosion. Based on interview at			
	the time of the observations, the Maintenance Director agreed the aforementioned automatic				
	sprinkler location was corroded.				
	These findings were reviewed with the Executive				
	Director and the Maintenance Director during the				
	exit conference.				
	3.1-19(b)				
	4. Based on observation and interview, the facility				
	failed to maintain all sprinkler systems in				
	accordance with NFPA 25. NFPA 25, Standard for				
	the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011				
	edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials				
	either resting on the pipe or hung from the pipe.				
This deficient practice could affect over two staff					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155070 B. WING 10/19/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE and visitors in the basement Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, one white data cable was affixed to horizontal sprinkler piping near the ceiling in the Maintenance Shop in the basement. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler pipe location was used to support non-system components. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) K 0355 **NFPA 101** SS=E Portable Fire Extinguishers Bldg. 01 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility K 0355 K355 - Portable Fire 11/18/2023 failed to ensure 4 of 45 portable fire extinguishers Extinguishers were inspected at least monthly and the What corrective actions will be inspections were documented including the date accomplished for those and initials of the person performing the residents found to have been inspection in accordance with NFPA 10. LSC affected by the deficient 9.7.4.1 states portable fire extinguishers shall be practice? selected, installed, inspected and maintained in Fire Extinguishers in the following accordance with NFPA 10. NFPA 10, the location were inspected and Standard for Portable Fire Extinguishers, 2010 marked inspected for the following

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Edition, Section 7.2.1.2 states fire extinguishers

shall be inspected either manually or by means of

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locations

Therapy Gym

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documentation.

during the exit conference.

2023.

d. in the kitchen by the MSDS room for September

observations, the Maintenance Director agreed

the aforementioned portable fire extinguisher

locations each had missing monthly inspection

Executive Director and the Maintenance Director

These findings were not reviewed with the

Based on interview at the time of the

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If continuation sheet

How will the corrective actions

assurance programs will be put

Maintenance Director/Designee to

Extinguishers to ensure they have

be monitored to ensure the

deficient practice will not

complete auditing of all Fire

been inspected and marked

recur, i.e., what quality

into place?

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		A. BUILDING <u>01</u> B. WING		COMPLETED 10/19/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
K 0363 SS=E Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combusting is not except to core complying wif provided with a contact of the conta	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain		inspected. Auditing will occur's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews discussed at the monthly factor QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 more Frequency and duration of rewill be increased as needed areas of noncompliance are identified during the auditing process.	will be ility onths. eviews		

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLET			ETED
		155070	B. W	ING		10/19/	/2023
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					REEN VALLEY RD		
GREEN '	VALLEY CARE CEI	NTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	i e	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY 1		DATE
	1 ' '	no impediment to the rs. Hold open devices that					
	-	door is pushed or pulled are					
		ed protective plates of					
		re permitted. Dutch doors					
	_	6 are permitted. Door					
	_	beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	-					
	sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window						
	assemblies.						
		Parts 403, 418, 460, 482,					
	483, and 485						
		S details of doors such as					
		ngs, automatics closing					
	devices, etc.		17.0	2.62	Kasa Gamidana Baana		11/10/2022
		on and interview, the facility f over 100 corridor doors had	K 0	363	K363 – Corridors - Doors	h.a.	11/18/2023
		losing and latching into the			What corrective actions will accomplished for those	be	
		ald resist the passage of			residents found to have beer	1	
		ent practice could affect over			affected by the deficient	-	
	40 residents, staff a	-			practice?		
					The following areas were fixed	i	
	Findings include:				Corridor to ADON Office		
					Containers were remove	ed	
		ons with the Maintenance			making it a non-storage area		
	_	our of the facility from 1:30 p.m.			Room 424 latches into o	loor	
	_	19/23, the following was noted:			frame		
		meter hole was noted in the			How other residents have the		
		300 Hall Assistant Director of			potential to be affected by th		
	Nursing Office.	to the service hall was not			same deficient practice will be		
		sitive latching device.			identified and what correctiv actions will be taken?	e	
		to Room 424 would not latch			40 residents, staff, and visitors	2	
		when tested to close multiple			have the potential to be affected		
	times				Maintenance Director ensured		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF d. a wedge was place Room 603 to prop to position. e. the corridor door room was not provithe door into the do f. the corridor door Hall Nurse's Station a door handle to latter frame. Based on interview observations, the M the aforementioned impediment to clos frame and would not These findings were	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ced under the corridor door to the door in the fully open to the 600 Hall Clean Utility ded with a door handle to latch for frame. the the offices behind the 600 in Office was not provided with ich the door into the door	P	DEFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Corridors are free of holes that they latch properly to door frant and that proper latches are installed. Maintenance Director and Maintenance assistant have be educated that Corridors corrid doors had no impediment to closing and latching into the deframe and would resist the passage of smoke. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance Director and Maintenance assistant have be educated that Corridors corrid doors had no impediment to closing and latching into the deframe and would resist the passage of smoke. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/Designed complete auditing of all Corrid Doors to ensure doors had no impediment to closing and latching into the door frame ar would resist the passage of	t mes een or oor ato een or oor put ee to or	(X5) COMPLETION DATE
					smoke. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews were also as the second	vill be	

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NTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED					
	155070	B. WING	10/19/2023					

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD NEW ALBANY, IN 47150 GREEN VALLEY CARE CENTER

(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
THE RESCENTION ON ESC IDENTIFY THE ORIGINATION THE	DEFICIENCY)	DATE
	discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	
SS=D Bldg. 01 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure wall mounted electrical outlet boxes in 1 of 1 Environmental Supply Closets in the 300 Hall was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect over 2 staff and visitors in the 300 Hall Environmental Supply Closet. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m.	K511– Utilities – Gas and Electric What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 300 Hall Supply Closet wall mounted outlet box was replaced with new cover How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? 2 residents, staff, and visitors have the potential to be affected. Maintenance Director ensured all outlet covers were covered and free of cracks	11/18/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155070	B. W	NG		10/19/	2023
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					REEN VALLEY RD		
GREEN \	VALLEY CARE CE	NTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
		missing its cover plate. Based			Maintenance assistant have b	een	
		time of the observations, the			educated that receptacle		
		for agreed the aforementioned			faceplates shall be installed so	n as	
		completely covered with a			to completely cover the openir		
	cover plate.	vemprovery severed with a			and seat against the mounting	-	
	cover place.				surface.	'	
	These findings were	e reviewed with the Executive			What measures will be put in	_{ito}	
	_	aintenance Director during the			place or what systemic		
	exit conference.	and Director during the			changes will be made to		
	Jan Comoronec.				ensure that the deficient		
	3.1-19(b)				practice does not recur?		
	3.1 17(0)				Maintenance Director and		
					Maintenance assistant have b	oon	
					educated that receptacle	CCII	
					faceplates shall be installed so		
					to completely cover the openir		
					and seat against the mounting	-	
					surface.	'	
					Surface.		
					How will the corrective action	ne	
					be monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be	nut	
					into place?		
					Maintenance Director/Designe	e to	
					complete auditing of all Electri		
					Outlets to ensure receptacle		
					faceplates shall be installed so	, _{as}	
					to completely cover the openir		
					and seat against the mounting	~	
					surface.	'	
					Auditing will occur 4 x's/week	lv	
					x's 4 weeks, 4 x's monthly x's	•	
					months.	~	
					The results of these reviews w	/ill be	
					discussed at the monthly facili		
					QAPI meeting monthly for 3	· y	
					months and then quarterly		
					thereafter for a total of 6 mont	he	
ı	i e		1		r increaller for a lotal of 6 Mont	uo. I	

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Facility ID: 000028

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DEPARTMENT CENTERS FOR	FORM APPROVED OMB NO. 0938-039						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/19/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150				
(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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
K 0711 SS=F Bldg. 01	patients and for to fan emergency Employees are page kept informed with and a copy of the with telephone opplan addresses to	Relocation Plan plan for the protection of all heir evacuation in the event		Frequency and duration of revital be increased as needed if areas of noncompliance are identified during the auditing process.			
	18/19.2.2. 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2 Based on record re interview; the facil plan that addressed written fire plans.	view, observation and ity failed to provide a written I all components in 1 of 1 LSC 19.7.2.2 requires a written ncy fire safety plan that shall	K 0711	K711 Evacuation and relocati Plan What corrective actions will accomplished for those residents found to have bee	be	11/18/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

(1) Use of alarms

(4) Response to alarms

(6) Evacuation of immediate area

(7) Evacuation of smoke compartment

(8) Preparation of floors and building for

(5) Isolation of fire

(2) Transmission of alarm to fire department

(3) Emergency phone call to fire department

Event ID:

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Facility ID: 000028

practice?

Binder

Policy and Procedure placed in

the Emergency Preparedness

How other residents have the

potential to be affected by the

same deficient practice will be

identified and what corrective

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070		lì í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/19/2023		
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
			3118 GREEN VALLEY RD				
GREEN	VALLEY CARE CE	NIER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	evacuation	6.6			actions will be taken?		
	(9) Extinguishment				0 residents, staff, and visitors	were	
	· ·	Projections into the required			affected.		
	_	nitted for wheeled equipment, The following conditions are			Executive Director ensured al		
	met:	the following conditions are			Policy and Procedure were plant the Emergency Property of		
		uipment does not reduce the			in the Emergency Preparedne Binder	555	
		corridor width to less than 60			All staff assistant have been		
	inches.	corridor within to less than oo			educated on relocation of whe	eled	
		occupancy fire safety plan and			equipment during a fire or sim		
		ddress the relocation of the			emergency.		
	wheeled equipment during a fire or similar				What measures will be put in	ıto	
	emergency.				place or what systemic		
	(c) The wheeled equipment is limited to the				changes will be made to		
	following:				ensure that the deficient		
	i. Equipment in use	and carts in use			practice does not recur?		
	ii. Medical emerger	ncy equipment not in use			All staff have been educated on		
		ransport equipment			relocation of wheeled equipment		
	This deficient pract	tice could affect all occupants.			during a fire or similar emerge	ncy.	
	Findings include:				How will the corrective actio	ns	
	D 1	NIE D			be monitored to ensure the		
		"Emergency Preparedness			deficient practice will not		
	Manual: Facility Fi	re" documentation dated			recur, i.e., what quality		
		ou Discover a Fire" n the Administrator and the			assurance programs will be	put	
		tor during record review from			into place? Executive Director/Designee t		
		a.m. on 10/19/23, the written fire			complete auditing of Emerger		
		address the relocation of			Preparedness Binder to ensur		
		t during a fire or similar			p/p for relocation of wheeled		
		on interview at the time of			equipment during a fire or sim	ilar	
		Executive Director agreed the			emergency. Auditing will occu		
	1	olan did not address the			x's/weekly x's 4 weeks, 4 x's		
		ed equipment during a fire or			monthly x's 5 months.		
		Based on observations with			The results of these reviews v	/ill be	
	the Maintenance D	irector during a tour of the			discussed at the monthly facil	ty	
	facility from 1:30 p	o.m. to 4:15 p.m. on 10/19/23,			QAPI meeting monthly for 3		
	Hoyer lifts were sto	ored in the corridor up against			months and then quarterly		
		om 502, 513, 514 and Room 609.			thereafter for a total of 6 mont	hs.	
	A wheelchair not in	use was stored in the corridor			Frequency and duration of rev	riews	

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Event ID:

5ZXV21 Facility ID: 000028

If continuation sheet Page 44 of 53

LENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039				
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155070	A. BUILDING B. WING	<u>01</u>	COMPLETED 10/19/2023			
		.550,0		ADDRESS CITY STATE ZIP COP	. 5, 10,2020			
NAME OF F	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD				
GREEN V	VALLEY CARE CE	NTER	NEW ALBANY, IN 47150					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	TAG		5.112			
		Wheeled blood pressure cuff		will be increased as needed if a	ny			
		in the corridor and plugged		areas of noncompliance are				
	and Room 316.	outlet boxes outside Room 206		identified during the auditing				
	and Room 316.			process.				
	These findings were	e reviewed with the Executive						
	_	aintenance Director during the						
	exit conference.							
	3.1-19(b)							
K 0753	NEDA 101							
SS=E	NFPA 101 Combustible Deco	prations						
Bldg. 01	Combustible Deco							
blag. UT	-	orations shall be prohibited						
	unless one of the							
		ant or treated with approved						
		ing that is listed and labeled						
	for product.							
	o Decorations r	neet NFPA 701.						
		exhibit heat release less						
		in accordance with NFPA						
	289.							
		such as photographs, er art are attached to the						
		I non-fire-rated doors in						
	-	8.7.5.6(4) or 19.7.5.6(4).						
		ons in existing occupancies						
		I quantities that a hazard of						
		or spread is not present.						
	19.7.5.6							
		on and interview, the facility	K 0753	K753 Combustible Decorations				
		f 1 Activities Director's Office		What corrective actions will be	e			
		maintained in accordance with		accomplished for those				
		states combustible decorations		residents found to have been				
	_	in any health care occupancy,		affected by the deficient				
		llowing criteria is met: retardant or are treated with		practice? Plastic Sheeting was removed				
	•	dant coating that is listed and		from Activity Room door				

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Event ID:

labeled for application to the material to which it is

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Facility ID: 000028

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How other residents have the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COM			
		155070	B. W	ING		10/19/2023	
			<u> </u>	CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
CDEENLY	VALLEY CARE OF	NITED					
GKEEN V	VALLEY CARE CE	NIER		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETIO	N
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	applied.				potential to be affected by the	e	
	1 1	meet the requirements of			same deficient practice will be	oe e	
		rd Methods of Fire Tests for			identified and what correctiv	e	
		of Textiles and Films.			actions will be taken?		
	` '	exhibit a heat release rate not			5 residents, staff, and visitors	have	
		when tested in accordance with			the potential to be affected.		
		rd Method of Fire Test for			Maintenance Director audited		
		kages, using the 20 kW			doors to ensure there no plast		
	ignition source.				sheeting or any other material	that	
	1 1	s, such as photographs,			is not approved to be on the		
		r art, are attached directly to			resident and staff doors.		
	_	nd non-fire-rated doors in			Maintenance Director and		
	accordance with the	C			Maintenance assistant have b	een	
		non-fire-rated doors do not			educated on combustible		
		peration or any required			decorations shall be prohibited	d in	
	_	and do not exceed the area			any health care occupancy.		
	limitations of 19.7.				What measures will be put ir	ito	
	1 1	not exceed 20 percent of the			place or what systemic		
	_	oor areas inside any room or			changes will be made to		
		ompartment that is not			ensure that the deficient		
		ut by an approved automatic			practice does not recur?		
		accordance with Section 9.7.			Maintenance Director and		
		not exceed 30 percent of the			Maintenance assistant have b	een	
		oor areas inside any room or			educated on combustible		
		ompartment that is protected			decorations shall be prohibited	d in	
		pproved supervised automatic			any health care occupancy.		
		accordance with Section 9.7.					
	` ′	not exceed 50 percent of the			How will the corrective actio	ns	
	I -	oor areas inside patient			be monitored to ensure the		
		ing a capacity not exceeding			deficient practice will not		
	_	moke compartment that is			recur, i.e., what quality		
		ut by an approved, supervised			assurance programs will be	put	
	_	system in accordance with			into place?		
	Section 9.7.				Executive Director/Designee t		
		ations, such as photographs			complete auditing of all reside		
		ch limited quantities that a			and staff office door to ensure		
		opment or spread is not			there is no combustible		
	present.				decorations on resident and s		
	_	ice could affect over 5			office doors. Auditing will occu	r 4	
	residents, staff and	visitors in the vicinity of the	1		x's/weekly x's 4 weeks, 4 x's		

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155070			JILDING	01	COMPL 10/19/	ETED	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
GREEN \	VALLEY CARE CEN	ITER		NEW AI	LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Activities Director's Findings include: Based on observation Director during a too to 4:15 p.m. on 10/1 affixed to the corrid Director's Office and corridor side of the contrider of the contribution	office. In swith the Maintenance or of the facility from 1:30 p.m. 9/23, plastic sheeting was or door to the Activities of covered the entire face of the door. The plastic sheeting did cumentation indicating the ardant or fire retardant treated.			monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of revision will be increased as needed if areas of noncompliance are identified during the auditing process.	ty ns. iews	
K 0754 SS=E Bldg. 01	shall not exceed 3 average density of room or space sha gallons/square fee capacity of 32 gallwithin any 64 squalinen or trash colle capacities greater located in a room parea when not atternorman average capacity of the same parea when not atternorman parea when not atternorman parea when same parea	rash Containers ch collection receptacles 2 gallons in capacity. The container capacity in a container capacity in a container capacity in a container capacity in a container cons shall not be exceeded container capacity in a container cons shall not be exceeded container capacity in a container cons shall not be exceeded container cons shall not be exceeded container cons shall not be exceeded container cons shall solled container cons shall shall be container					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5ZXV21 Fa

Facility ID: 000028

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLET			ETED	
		155070	B. WING 10/19/2023				2023
		<u> </u>	l s	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			REEN VALLEY RD		
GREEN '	VALLEY CARE CEI	NTER			LBANY, IN 47150		
	T						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	CAG	DEFICIENCY /		DATE
		cluded from the above					
		ere each container is less					
		6 gallons unless attended,					
		r combustibles are labeled					
		ting FM Approval Standard					
	6921 or equivalen						
	1	on and interview, the facility	K 075	₁	K754 Soiled Linen and Trash		11/18/2023
		attended trash receptacles in 1	K 0/3	4	Containers		11/16/2023
		rere stored in a room protected			What corrective actions will	ho	
		in accordance with Section			accomplished for those	DC .	
		cient practice could affect over			residents found to have been	1	
		and visitors in the vicinity of			affected by the deficient	•	
	the service hall.				practice?		
					55 gallon capacity trash cart a	nd	
	Findings include:				96 gallon recycling cart were		
					removed from the Service Hal	lway.	
	Based on observation	ons with the Maintenance			How other residents have the	•	
	Director during a to	our of the facility from 1:30 p.m.			potential to be affected by th	е	
	to 4:15 p.m. on 10/	19/23, one unattended partially			same deficient practice will b	ре	
	filled 55 gallon cap	acity trash cart and one			identified and what correctiv	е	
	unattended partially	filled 96 gallon capacity			actions will be taken?		
	recycling cart were	stored near one another in the			10 residents, staff, and visitors	3	
		employee time clock. The			have the potential to be affect	ed.	
		of the carts exceeded 32			Maintenance Director audited		
	-	ee hall was open to the corridor			ensured all containers 32 Gall	ons	
		to the service hall was not			or more were stored in the pro	per	
		sitive latching device to latch			areas.		
		oor frame. Based on interview			Maintenance Director and		
		oservations, the Maintenance			Maintenance assistant have b		
		aforementioned receptacles			educated on unattended trash		
		ed in a room protected as a			receptacles are stored in a roo		
	hazardous area whe	en unattended.			protected as a hazardous area		
	TEI C' 1'				accordance with Section 19.7.	• • • • • • • • • • • • • • • • • • • •	
		e reviewed with the			What measures will be put in	ito	
		ger and the Building Services			place or what systemic		
	Coordinator during	the exit conference.			changes will be made to		
	2.1.10(b)				ensure that the deficient		
	3.1-19(b)				practice does not recur?		
	Ī				Maintenance Director and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 155070	A. BUILDING <u>01</u> B. WING		COMPLETED 10/19/2023			
		100010	<i>5.</i> ***		DDDEGG GITW OTHER TWO CON	10/13/		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD			
GREEN \	VALLEY CARE CEN	NTER			LBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
IAU	REGULATORY OR	LSC IDENTIFYING INFORMATION		IAU	Maintenance assistant have be educated on unattended trash receptacles are stored in a rooprotected as a hazardous area accordance with Section 19.7. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Executive Director/Designee to complete auditing of all unattended trash receptacles stored in a room protected as hazardous areas. Auditing will occur 4 x's/weekly x's 4 weeks x's monthly x's 5 months. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 mont Frequency and duration of revwill be increased as needed if areas of noncompliance are identified during the auditing	om a in 5.7. ns put o are a s, 4 vill be ty hs. iews	DATE	
					process.			
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying servic 10-second criterio monthly test, a pro-	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to nis capability for the life						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO		COMPI	COMPLETED			
15		155070	B. WING		10/19/2023				
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER									
GREEN VALLEY CARE CENTER				3118 GREEN VALLEY RD NEW ALBANY, IN 47150					
ONLLIN				I IVEVV /					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	1	branches. Maintenance							
		generator and transfer							
		ormed in accordance with							
	NFPA 110.								
		e inspected weekly,							
		oad 30 minutes 12 times a							
	, ,	intervals, and exercised							
		onths for 4 continuous hours.							
		nder load conditions include							
		ated cold start and							
		ual transfer of all EES							
		nducted by competent							
	l ·	enance and testing of stored							
		rces (Type 3 EES) are in NFPA 111. Main and feeder							
		re inspected annually, and a							
		dically exercising the tablished according to							
		uirements. Written records							
		nd testing are maintained							
		ble. EES electrical panels							
		arked, readily identifiable,							
		n normal power circuits.							
		ssibility of damage of the							
		r source is a design							
	consideration for	<u> </u>							
		(NFPA 99), NFPA 110,							
	NFPA 111, 700.1	,							
		on and interview, the facility	K 0	918	Waiver has been requested		01/31/2024		
		f 2 emergency generators was	110	,10	K918 – Electrical Systems –		01/31/2021		
		nce with the provisions of			Essential Electrical System				
		110, Standard for Emergency			What corrective actions will	be			
	and Standby Power	Systems, 2010 Edition,			accomplished for those				
	_	the Emergency Power Supply			residents found to have been	า			
	(EPS) shall be insta	alled in a separate room for			affected by the deficient				
	Level 1 installation	s or be located in an adequate			practice?				
	enclosure located o	utside the building capable of			Nameplate for Generator 1 did	Ł			
		ce of snow or rain at a			contain manufactured date				
		ocity required by local building			Generator Doors have signage	e to			
	codes. Section 7.2.	1.2 states no other equipment,			identify				

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PREFIX

TAG

PRINTED: 12/07/2023

COMPLETION

DATE

EPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB	NO. 0938-039	
STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED		
		155070	B. WIN	NG		10/19/2023		
			Щ.			<u> </u>		
NAME OF PROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP COD			
White of the viber or best elek				3118 GREEN VALLEY RD				
GREEN VALLEY CARE CENTER				NEW ALBANY, IN 47150				
					,			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTL				(X5)	

PREFIX

TAG

REGULATORY OR LSC IDENTIFYING INFORMATION including architectural appurtenances, except that service this space, shall be permitted in this room. Section 7.7.1 states with the EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1 states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. This deficient practice could affect all residents, staff, and visitors.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

Findings include:

Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 10/19/23, one of two emergency generators for the facility is located inside the building and is accessed from the laundry room. The emergency generator is identified as Generator #1 and is propane fired. The affixed manufacturer's nameplate rating for the generator was 40 kW but the manufacture date could not be determined. Access to the generator room from the laundry is through an unlabeled set of double doors. Neither door was self-closing, and each door had an open louver installed in the bottom of the door. Two separate louvers were installed in the outside wall of the room but each motor for the louvers had been disconnected which caused the louvers to not be operable. Each wall mounted louver was covered over with a compressed particle board. Four severed open ended pipes in the ceiling exposed the space above the room and three other separate holes in the ceiling were not firestopped. In addition, combustible materials were stored in the center of the room. Based on interview at the time of the

self-closing Generator Room will be supplied with outdoor air How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents, staff, and visitors have the potential to be affected. Maintenance Director and Maintenance assistant have been educated on EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer. Section 7.7.2.1 states ventilation air shall be supplied directly from a source outside the building by an exterior wall opening or from a source outside the building by a 2-hour fire rated air transfer system. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance assistant have been

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Doors will be replaced to be

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educated on EPS running at rated

load, ventilation air flow shall be

temperature in the EPS room to

temperature required by the EPS

manufacturer. Section 7.7.2.1

the maximum ambient air

provided to limit the maximum air

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
		155070	B. WING			
[STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				REEN VALLEY RD		
GREEN \	VALLEY CARE CEI	NTER		LBANY, IN 47150		
				, 	OVE	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
IAU		laintenance Director stated he	IAG	states ventilation air shall be	DATE	
	, , , , , , , , , , , , , , , , , , ,	old the generator was or when		supplied directly from a source	_	
		_		outside the building by an exte		
	it was installed and agreed the room was not separated from other spaces and the room was not			wall opening or from a source		
	supplied with outdoor air.			outside the building by a 2-hor		
	supplied with outdoor all.			fire rated air transfer system.		
	This finding was re	viewed with the Executive		How will the corrective actio	ns	
	-	aintenance Director during the		be monitored to ensure the		
	exit conference.	-		deficient practice will not		
				recur, i.e., what quality		
	3.1-19(b)			assurance programs will be	put	
				into place?		
				Maintenance Director/Designe	e to	
				complete auditing of Generato		
				Room for e EPS running at ra		
				load, ventilation air flow shall t		
				provided to limit the maximum		
				temperature in the EPS room	to	
				the maximum ambient air		
				temperature required by the E	PS	
				manufacturer. Section 7.7.2.1		
				states ventilation air shall be		
				supplied directly from a source		
				outside the building by an extermal opening or from a source		
				outside the building by a 2-hou		
				fire rated air transfer system.	A1	
				Auditing will occur 4 x's/weekl	v	
				x's 4 weeks, 4 x's monthly x's		
				months.		
				The results of these reviews w	vill be	
				discussed at the monthly facili	ty	
				QAPI meeting monthly for 3		
				months and then quarterly		
				thereafter for a total of 6 mont	hs.	
				Frequency and duration of rev	riews	
				will be increased as needed if		
				areas of noncompliance are		
				identified during the auditing		

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Event ID:

5ZXV21

Facility ID: 000028

process.

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/19/2023	
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 3118 GREEN VALLEY RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE

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