PRINTED: 08/15/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00		COMPLETED	
		155070	B. WING		07/25/2024		
			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	R		REEN VALLEY RD			
GREEN'	VALLEY CARE CE	NTER	NEW A	LBANY, IN 47150			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
F 0000							
Bldg. 00							
Diag. 00	This visit was for the investigation of Complaint		F 0000				
	IN00437132.		1 0000				
	_	7132 - Federal/State deficiency					
	related to the allega	ations is cited at F812.					
	Survey date: July 2	5, 2024.					
	Facility number: 00	00028					
	Provider number: 1						
	AIM number: 1002	275370					
	Cansus Rad Type						
	Census Bed Type: SNF/NF: 120 Total: 120						
	Census Payor Type	<b>::</b>					
	Medicare: 6						
	Medicaid: 98						
	Other: 16 Total: 120						
	10tal. 120						
	This deficiency refl	lects State Findings cited in					
	accordance with 41	0 IAC 16.2-3.1.					
	Quality review com	apleted on July 30, 2024.					
F 0812 SS=E	483.60(i)(1)(2) Food						
33-⊑ Bldg. 00		re/Prepare/Serve-Sanitary					
2.a.g. 00		afety requirements.					
	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained						
	(1) This may includ	ae 1000 items obtailled					

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

(X6) DATE

**Greg Dattilo Executive Director** 08/09/2024

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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TITLE

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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 00 CC			COMPL	COMPLETED	
		155070	B. WING			07/25/2024		
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
GREEN VALLEY CARE CENTER				3118 GREEN VALLEY RD				
GREEN	VALLET CARE CEI	NIER		NEW ALBANY, 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	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	directly from local	producers, subject to						
	applicable State a	ind local laws or						
	regulations.							
	(ii) This provision does not prohibit or prevent							
	facilities from using produce grown in facility							
	gardens, subject t	o compliance with						
	applicable safe gr	owing and food-handling						
	practices.							
		does not preclude residents						
	from consuming for	oods not procured by the						
	facility.							
	- ',','	ore, prepare, distribute and						
		ordance with professional						
	standards for food	-						
		on, record review and	F 08	812	This plan of correction is to se		08/14/2024	
		ty failed to ensure the kitchen			as Green Valley Care Center's			
	equipment and floor was clean and free from				credible allegation of compliar	ice.		
	grease and food particles for 2 of 3 kitchen				Submission of this plan of			
	observations. This deficient practice had the				correction does not constitute			
	_	20 residents currently residing			admission by Green Valley Ca	are		
	in the facility.				Center or its management			
	F' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				company that the allegations			
	Findings Include:				contained in the survey report			
					true and accurate portrayal of			
	During an observation of the facility kitchen the			provision of dietary department				
	following was obse	iveu.			and other services in this facili	ııy,		
	The deep force he	d grease and a brown black			nor does this submission			
		on the fryer baskets, and the			constitute an agreement or			
	top and sides of the	_			admission of the survey			
	top and sides of the	11 y C1.			allegations. Green Valley Care Center wor	uld		
	- The gas stove kno	bs had a grease and food			like to request paper complian			
	debris buildup.	os nad a grease and 1000			via a desk review.	10 <del>0</del>		
	acons oundup.				F 812 Food Procurement,			
	- The cart sitting beside the stove, had a sheet				store/prepare/serve/sanitary			
	_	helf with a greasy food			What corrective actions will	he		
	buildup on the uten				accomplished for those			
	oundap on the atensiis.				residents found to have been	า		
	- The employee sink had a black substance in the				affected by the deficient	•		
- The employee shik had a black substance in the		1		and clear by the delicient		I		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER				UILDING	00	COMPLETED		
155070			B. W	ING		07/25	/2024	
NAME OF PROVIDER OR SUPPLIER			•	STREET .	ADDRESS, CITY, STATE, ZIP COD	-		
					REEN VALLEY RD			
GREEN '	VALLEY CARE CEI	NTER		NEW ALBANY, IN 47150				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIATE OF THE PROPRIAT			COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	sink bowl, and on t	he front and sides of the sink.			practice?			
	- The kitchen floor	felt greasy and was slippery.			On 7/26/24 Dietary Man	ager		
		with grime and food debris		On 7/26/24, Dietary Man- completed a thorough cleaning		-		
	I -	re various items of trash laying		kitchen to include: deep fryer		-		
	on the floor.	, ,		stove knobs, employee sink,		<b>3</b>		
					refrigerator doors, kitchen floo	or,		
	- Sitting on a table	near the dishwasher there was		tables, pots/pans, linens listed on				
	a large bowl with a	brown thick substance inside.			2567 was completed.			
		up the sides of the bowl and						
		y. Beside the large bowl was a			Cleaning schedules			
		w substance and the top of the			immediately posted.			
	yellow substance was dried.							
					How other residents have t			
	- The handle on the refrigerator door was missing.				potential to be affected by the			
	- The refrigerator doors had food debris and				same deficient practice will identified and what corrective			
	smudges.				actions will be taken?	76		
	Silidages.				dottono win bo takon.			
	- The stainless steel tables had dark brownish spots, food debris and grease on the shelves.				Residents who receive for	ood		
					from Dietary Department have	e the		
					potential to be affected			
	The cleaning schedule was not posted and the Assistant Dietary Manager could not find the							
					ED/Designee will provide			
	schedule.			education to the Dietary Ma		-		
	Daning on internion	7/25/24 -4 0:20 41 -			and the dietary dept associate			
	_	v on 7/25/24 at 9:30 a.m., the			proper cleaning of the kitcher			
	Assistant Dietary Manager indicated she did not know where the cleaning schedules were.			other dietary related areas, kitchen equipment. Dietary		ıu		
	know where the ele	anning senedules were.			Manager and dietary dept			
	During an observat	ion and interview on 7/25/24 at			associates educated on clear	nina		
	_	Aide 5 and Dietary Aide 6,			schedules and where they are	_		
		not know what the brown			posted.			
	substance was in the large bowl. They did not				[ '			
		bowl had been sitting on the			What measures will be put			
	table. Dietary Aide	5 indicated whatever it was, it			into place and what systemi	С		
	looked old to her.				changes will be made to			
					ensure that the deficient			

During an interview on 7/25/24 at 9:45 a.m.,

Dietary Aide 5 indicated the Dietary Manager

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practice does not occur.

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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 00 COMPLETED 155070 B. WING 07/25/2024 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 took the cleaning schedules down. She thought Daily, Weekly, and Monthly he was going to update them. She presented a Cleaning schedules were put into weekly cleaning schedule that was dated for the place and will be signed off to months of December 2023 to March 2024. She validate that cleaning was indicated she tried to clean up after she got done completed. with her duties. She did not know how often the kitchen was deep cleaned and when the kitchen ED to educate Dietary was last cleaned. The Dietary Aide indicated she Manager and Dietary Department thought the kitchen was dirty and needed Associates on proper cleaning and cleaned. The night shift came in from 11:00 a.m. to cleaning schedules by date of 8:00 p.m. She indicated the staff was supposed to compliance. clean after dinner, but they were not cleaning. She indicated the staff had complained to the Dietary RD to continue to complete Manager, but nothing had been done about the sanitation audit monthly during problem. She indicated the Dietary Manager let facility visit. the evening staff get away with not cleaning. How will the corrective During a return visit to the kitchen on 7/25/24 at actions be monitored to ensure 11:00 a.m., the same issues were observed as well the deficient practice will not as the following: recur, i.e., what quality assurance program will be put - A towel was laying on top of the silverware table into place? with a large amount of a light brown substance. The substance appeared to be oatmeal. Executive Director/Designee will complete auditing to ensure - Plastic cup lids were laying on the floor beside dietary kitchen is clean, the tray racks. equipment is properly cleaned, and cleaning schedules are During an interview on 7/25/24 at 11:30 a.m., the posted and being followed. Dietary Manager indicated the kitchen would be Auditing to occur 5x/week for 4 cleaned daily. Deep cleaning would be done weeks, then twice weekly for 4 weekly. If he observed something dirty he would weeks, then monthly for 4 months clean it up. The dietary staff had individual for a total of 6 months of cleaning duties and they had to sign off when the monitoring, job was completed. He indicated the facility used a cleaning service to clean the stove hoods, but The results of these reviews he wasn't sure when the last time they were will be discussed at the monthly cleaned. The floor would be mopped 2 to 3 times a facility Quality Assurance day especially after meals. The floor was old and it Committee meeting monthly for

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would probably help if they had new flooring. He

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three months and then quarterly

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/25/2024			
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	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)	TE	(X5) COMPLETION DATE	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				thereafter for a total of 6 mont Re-education, frequency and/duration of reviews will be increased as needed if any ard of noncompliance are identified uring the auditing process uncompliance has been reached.  Date of Compliance: 8/14/20  The Administrator at Green V Care Center is responsible in ensuring compliance in this Pl of Correction.	eas d titil 24		

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