STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155070	A. BUILDING -- B. WING	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN VALLEY CARE CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/11/22 Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370 At this Emergency Preparedness survey, Green Valley Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 141 certified beds, with a current census of 102. Quality Review completed on 10/14/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/11/22 Facility Number: 000028 Provider Number: 155070 AIM Number: 100275370 At this Life Safety Code survey, Green Valley Care Center was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 102 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/14/22			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 3 of 16 exit discharge areas. This deficient practice could affect at least 45 residents, as well as staff and visitors in the 400 and 500 halls. Findings include:	K 0271	K – 271 – Discharge from Exits **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	01/11/2023

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	Based on observations on 10/11/22 between 12:45 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The 400 hall east exit had a two inch level change between the concrete stoop and the connecting sidewalk. b. The 400 hall west exit had a one inch level change between the concrete stoop and the connecting sidewalk. c. The 500 hall south exit had side walk connected to the stoop that was unlevel/slanted for approximately 15 feet. The level changes at the two 400 hall exit discharges could be a tripping hazard while exiting from these areas in the event of an emergency, furthermore, the unlevel/slanted sidewalk at the 500 hall exit discharge could be very difficult for residents and staff to traverse by walking, in wheelchairs or be taken out in beds in the event of an evacuation emergency. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the level changes and unlevel/slanted side walks at the exit discharges. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		- We have received a quote to fix both 400 Hall exits and 500 Hall exit to eliminate tripping hazards and Un-Level/Slanted areas on ramps. - Contractor will complete work based on weather and contract availability due commitment on other jobs. - A Waiver Request will be completed and submitted with POC. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** - This could potentially affect 45 residents as well as visitors, but none have been affected. - The East 400 Hall Exit will be raised 2 inches so the concrete stoop will connect to sidewalk and eliminate the potential tripping hazard. - The West 400 Hall Exit will be raised 1 inch so the concrete stoop will connect to sidewalk and eliminate the potential tripping hazard. - The South 500 Hall Exit will be completely removed and will build new exit to meet Life Safety Criteria of not being un-level/slanted.	

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K 0291 SS=B	NFPA 101 Emergency Lighting		**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 Assistant were educated that if they observe Level Changes and un-level/slanted sidewalks that they are to report to the ED. - Immediate action will be taken if Level Changes and Un-Level/Slanted sidewalks are reported to ED. **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 exits to ensure that there not any changes in levels between stoops and sidewalks 1 x monthly x 6 months The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 6 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.	

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Bldg. 01	Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of over 10 battery powered emergency light sets were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect at least 10 residents, as well as staff and visitors in the facility in the west 400 hall. Findings include: Based on observations on 10/11/22 between 12:45 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the battery backup light set located on the wall at the west end of the 400 hall did not illuminate when tested several times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the battery backup light set did not work when tested several times. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0291	K – 291 – Emergency Lighting **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Problem was identified and fix. Ran all new wire from breaker box from 400 basement to Exit lights. All Exit Lights are working. **How other residents have the potential to be affected by the same deficient practice will be will be identified and what corrective actions will be taken?** All residents in the areas where the Emergency Lights didn't work have the potential to be affected. No residents were effected. Maintenance Director was educated on test Battery Backup weekly. This task is set up in TELs and will automatically trigger when it's due to be completed weekly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** This task is set up in TELs and will automatically trigger when it's due to be completed weekly.	11/10/2022

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			ED will audit TELs system at a minimum of 1 x per month to ensure all tasks are completed timely x 6 months **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 Emergency Light Sets monthly. The results of these reviews will be 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.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of over 30 exit signs were continuously illuminated. This deficient practice	K 0293	K – 293 – Exit Signage **What corrective actions will be**	11/10/2022

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	could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 10/11/22 between 12:45 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the two exit signs at the west end of the 400 hall were not illuminated. Based on interview at the time of observation, the Maintenance Supervisor said he was not aware that the exit signs were not illuminated. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1.19(b)		**accomplished for those residents found to have been affected by the deficient practice?** Problem was identified and fix. Ran all new wire from breaker box from 400 basement to Exit lights. All Exit Lights are working. **How other residents have the potential to be affected by the same deficient practice will be will be identified and what corrective actions will be taken?** All residents in the areas where the Emergency Lights didn't work have the potential to be affected. No residents were effected. Maintenance Director was educated on test Battery Backup as needed This task is set up in TELs and will automatically trigger when it's due to be completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** This task is set up in TELs and will automatically trigger when it's due to be completed. ED will audit TELs system at a minimum of 1 x per month to ensure all tasks are completed timely. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance programs will be put into place? Maintenance Director/Designee to complete auditing of all Emergency Light Sets monthly. The results of these reviews will be 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.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25	K 0353	K – 353 – Maintenance and Testing **What corrective actions will be**	11/10/2022

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	for 3 of 3 dry sprinkler systems during 40 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 10/11/22 between 9:00 a.m. and 12:45 p.m. with the Maintenance Supervisor present, there was documentation available to show the facility's sprinkler system gauges were inspected, however, the documentation only indicated the inspections were performed monthly instead of weekly as required for dry pipe sprinkler systems. Based on interview at the time of record review, the Maintenance Supervisor said he inspects the gauges and control valves almost daily but only documents the gauge readings on a monthly basis. Based on observations with the Maintenance Supervisor during a tour of the facility between 12:45 p.m. and 3:30 p.m. the facility had two pressure gauges at each of the three sprinkler risers. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice?** 3 of 3 Dry Sprinkler systems have been checked weekly. **How other residents have the potential to be affected by the same deficient practice will be will be identified and what corrective actions will be taken?** All Residents had the potential to be effect. No residents were affected Maintenance Director and Assistant were educated that Dry Sprinkler Systems need to be checked and documented weekly **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 has contacted TELs Rep to change audit from monthly to weekly. **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 Dry-Sprinkler Systems. Auditing will occur 1x/weekly x's 4 weeks, 4 x's monthly x's 6 months. The results of these reviews will be discussed at the monthly facility	

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			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.	
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 2 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect at least 16 residents, staff and visitors in the 500 hall. Findings include: Based on observations on 10/11/22 between 12:45 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the two fuel-fired water heaters in the 500 hall Mechanical Room had certificates with expiration dates of 12/30/19. Based on interview at the time of observation, the Maintenance Supervisor confirmed the expiration dates of the two fuel-fired water heaters.	K 0500	K500 – Building Services – Other **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director had already scheduled Boiler Inspector prior to Life Safety Survey. Boiler Inspection completed on 10/17/2022 **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 15 Residents had the potential to be effected. No residents were effected. **What measures will be put into place or what systemic**	11/10/2022

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	This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur?** Boiler Inspection to be placed on ED and Maintenance Outlook Calendar 6 months before inspection is due, to ensure compliance. **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 Boilers to ensure they're inspected on a timely manner. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 6 months. The results of these reviews will be 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.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected			

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	and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 10/11/22 between 9:00 a.m. and 12:45 p.m. with the Maintenance Supervisor present, the facility did have documentation of 12 fire drills during the past 12 month period, however, the facility lacked fire drill documentation for the following shifts and quarters: a. Third shift (night) of the fourth quarter (October, November, and December) of 2021 b. Second shift (evening) of the second quarter (April, May, and June) of 2022 Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of a fire drill reports for the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0712	K -712 – Fire Drills **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Fire Drills since the start of the 3rd Quarter of 2022 have been completed and documented. **How other residents have the potential to be affected by the same deficient practice will be will be identified and what corrective actions will be taken?** All residents have the potential to be affected but none were effected. Maintenance Director and Assistant were educated on doing 1 fire drill per-month on 3 different shifts per Quarter, while maintaining a 2 hour gap between last Fire Drills. **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 will follow preventative maintenance	11/10/2022

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			schedule for Fire Drill maintaining the 2 hour gap between previous Fire Drill and on 3 different shifts per quarter. **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?** ED/Designee to complete auditing of all completed monthly Fire drill and will be reviewed during facility monthly QAPI Meeting. Auditing will occur 1/month for 6 months. The results of these reviews will be 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.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.			

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	(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were smoked by residents and staff. This deficient practice could affect at least 3 residents and staff. Findings include: Based on observations on 10/11/22 between 12:45 p.m. and 3:30 p.m. during a tour of the facility with the Maintenance Supervisor, the smoking area had hundreds of cigarette butts on the ground close to and up against the two sided plywood framed smoke structure, furthermore, there were at least 10 cigarette butts in the trash can along with paper trash. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the cigarette butts on the ground and mixed in with the paper trash in the trash can. This finding was reviewed with the Executive Director and Maintenance Supervisor during the	K 0741	K – 741 – Smoking Regulations **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All cigarette butts were cleaned and trash can was removed. **How other residents have the potential to be affected by the same deficient practice will be will be identified and what corrective actions will be taken?** 4 residents and staff have the potential to be effected. No residents were effected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	11/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING 01 B. WING	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	exit conference. 3.1-19(b)		All staff were educated that cigarette butts are to be disposed of in Smoking Post. Trash can removed from Smoke Area. Departments responsible for taking resident smokers out for smoke breaks, will ensure that all cigarette butts will be disposed of correctly 1 more Smoking Post will be purchased and put in place in designated smoking area. **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?** Executive Director/Designee will audit Designated Smoking area 3x/weekly for 4 weeks. 1x/weekly for 4 weeks, and 1/monthly for 4 months. The results of these reviews will be 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.	