PRINTED: 06/27/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2025		
	PROVIDER OR SUPPLIER			3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150		
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(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
F 0000	REGULATORY OF	CLSC IDENTIFYING INFORMATION		IAG			DATE
Bldg. 00 F 0628 SS=E	This visit was for the Investigation of Complaints IN00458882. Complaint IN00458882 - Federal/State deficiencies related to the allegations are cited at F628 and F695. Survey date: June 4, 2025 Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 119 Total: 119 Census Payor Type: Medicare: 6 Medicaid: 85 Other: 28 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 6, 2025. 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process		F 00	000	This Plan of Correction is to serve as Green Valley Care Center's credible allegation of compliance. By submitting the enclosed materials, Green Valley Care Center nor its management company are admitting the truth or accuracy of any specific findings or allegations. Green Valley Care Center reserves the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 6/20/2025 to the state findings of the Complaint Survey conducted on 6/4/2025 Green Valley Care Center respectfully requests a desk review.		
Bldg. 00	failed to ensure bed residents/resident re Resident D, Residen	and record review, the facility hold polices were provided to epresentatives (Resident C, nt F and Resident B) ospital for 4 of 4 residents	F 00	628	F628 – Discharged Process What corrective actions will accomplished for those residents found to have bee affected by the deficient		06/16/2025

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

reviewed for transfers/discharges.

(X6) DATE

Greg Dattilo **Executive Director** 06/16/2025

practice?

TITLE

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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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 00 COMPLETED 155070 B. WING 06/04/2025 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 No resident had any negative Findings include: outcomes related to this deficient practice. Resident C, Resident D, 1. The clinical record for Resident C was reviewed Resident F and Resident B were on 6/4/25 at 11:31 a.m. The resident's diagnoses all discharged from the facility included, but were not limited to, paraplegia and prior to survey. How other residents have the neuromuscular dysfunction of the bladder. potential to be affected by the The progress note, dated 5/26/25 at 1:00 a.m., same deficient practice will be indicated the resident was very lethargic and the identified and what corrective catheter had blood tinged urine in the catheter actions will be taken? bag. The physician was notified and a new order Any resident that is Discharged for was received to send the resident to the hospital Transferred could be affected by for evaluation. the deficient practice. An in-house audit has been The clinical record lacked documentation of the conducted of residents who have bed hold documentation provided to the resident been discharged or transferred in the last 30 days to identify if a bed or the resident's representative at the time of discharge. hold policy was given. What measures will be put into 2. The clinical record for Resident D was reviewed place or what systemic on 6/4/25 at 2:49 p.m. The resident's diagnoses changes will be made to included, but were not limited to, dementia and ensure that the deficient subdural hemorrhage with loss of consciousness. practice does not recur? Nursing management will provide The progress note, dated 5/29/25 at 11:14 a.m., education ensuring residents who indicated Resident D's son was at the facility and are transferred or discharged from requested the resident be sent to the hospital for the facility will be given the Indiana evaluation. They physician was notified with a Notification of Transfer or new order to send the resident to the hospital for Discharge form and facility Bed evaluation. Hold Policy will to be provided to all nursing staff. No staff will work The clinical record lacked documentation of bed past date of compliance without hold documentation provided to the resident or this education completed. the resident's family member at the time of Residents who are discharged or discharge. transferred will be discussed at morning and afternoon meetings to

3. The clinical record for Resident F was reviewed

on 6/4/25 at 2:58 p.m. The resident's diagnoses

included, but were not limited to, Parkinson's

ensure that Bed Hold Policy were

uploaded into the clinical record.

given and documentation has been

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very low, ineffective sternal rubs, and breathing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2025		
	PROVIDER OR SUPPLIEI		3118 G	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 APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE	
	placed on oxygen. with a new order to emergency department the hospital. The clinical record hold documentation resident prior to discovered by the prior of Nursing aware the bed hold resident, but if ther may not be done. On 6/4/25 at 3:28 propy of the document and Bed Holds and Bed Holds and Bed Holds are time of transfer of a nursing facility must the resident represents specifies the duration.	muscles. The resident was The physician was notified a send the resident to the nent and report was called to lacked documentation of bed a being provided to the scharge. I won 6/4/25 at 3:10 p.m., the g (DON) indicated she was had to be sent with the e was an emergent situation, it I m., the DON provided a current ent titled "Discharge Process ted 1/3/22. It included, but was tice of bed-hold policy and notice upon transferAt the a resident for hospitalizationa st provide to the resident and entative written notice which on of the bed-hold policy" Is to Complaint IN00458882					
F 0695 SS=D Bldg. 00	Suctioning Based on observative review, the facility orders were in place	neostomy Care and on, interview and record failed to ensure the physician's e for weekly maintenance of nt and failed to ensure nebulizer	F 0695	F695 – Respiratory/Tracheosto Care and Suctioning What corrective actions will b accomplished for those		06/16/2025	

respiratory assessments were completed prior and

after administration for 1 of 3 residents reviewed

residents found to have been

affected by the deficient

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155070 B. WING 06/04/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER

GKEEN	VALLEY CARE CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	for respiratory care.		practice?	
			Resident B did not have any	
	Findings include:		negative outcomes related to the	
			deficient practice. An order to	
	The clinical record for Resident B was reviewed		replace the nebulizer respiratory	
	on 6/4/24 at 9:54 a.m. The resident's diagnosis		equipment weekly was placed on	
	included, but was not limited to, chronic		Resident B's clinical record.	
	obstructive pulmonary disease.		Before and after respiratory	
			assessments were placed on	
	Review of the December 2024 medication		Resident B's clinical record in	
	administration record (MAR) indicated the		relation to the nebulizer order.	
	resident received pulmicort 0.5 mg (milligrams)/2		How other residents have the	
	ml (milliliters). The resident was to received 2 ml,		potential to be affected by the	
	via nebulizer, twice daily.		same deficient practice will be	
			identified and what corrective	
	The resident's clinical record lacked		actions will be taken?	
	documentation of the December weekly		Current in-house residents with	
	replacement of the nebulizer respiratory		orders for nebulizers could be	
	equipment.		affected by the deficient practice.	
			An in-house audit has been	
	Review of the January 2025 MAR indicated the		completed by nursing	
	resident received pulmicort 0.5 mg (milligrams)/2		management/designee on current	
	ml (milliliters). The resident received 2 ml, via		in-house residents to ensure	
	nebulizer, twice daily upon readmission on 1/5/25.		nebulizer orders have before and	
			after respiratory assessments and	
	The resident's clinical record lacked		an order to change the nebulizer	
	documentation of the January completed		respiratory equipment weekly.	
	respiratory assessments and the weekly replacement of the nebulizer respiratory		What measures will be put into	
			place or what systemic	
	equipment.		changes will be made to	
			ensure that the deficient	
	During an interview on 6/4/25 at 2:23 p.m.,		practice does not recur?	
	Licensed Practical Nurse (LPN) 3 indicated to		Nursing management will provide	
	ensure the effectiveness of a nebulizer treatment,		education on before and after	
	a respiratory assessment should be completed		respiratory assessments when	
	prior to and after completion of the treatment. The		administering nebulizer treatments	
	nebulizer equipment should be changed out		and weekly replacement of	
	weekly.		nebulizer respiratory equipment to	
			nursing staff by date of	
	On 6/4/25 at 3:09 p.m., the Director of Nursing		compliance. No staff will work	I

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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>00</u>		COMPLETED		
155070		B. WING			06/04/	/2025	
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			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	provided a current,	undated copy of the document			past date of compliance witho	ut	
	titled "Nebulizer Tr	reatment, small volume". It		this education completed.			
	included, but was n	ot limited to, "Please included			How will the corrective actio	ns	
	the following inform	nation when completing the			be monitored to ensure the		
	_	etup should be changed			deficient practice will not		
	weeklyImplementationMonitor the patient's				recur, i.e., what quality		
	_	ratory status during the			assurance programs will be		
	procedureAfter treatment, turn off the nebulizer,				into place?		
	obtain the patients' vital signs, assess the				DON/Designee will audit clinic		
	respiratory status"				record of current residents with		
					nebulizer treatments for before		
	This Citation relates to Complaint IN00458882				after respiratory assessments		
					weekly replacement of nebulizer		
	3.1-47(a)(6)				respiratory equipment daily x	5	
					days for 4 weeks and 1 x wee	k for	
					5 months.		
					The results of these reviews w	/ill be	
					discussed at the monthly facili	ty	
					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.		

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