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 _____	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00439581. Complaint IN00439581 - Federal/State deficiency related to the allegation is cited at F600. Survey dates: August 20 and 21, 2024 Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 7 Medicaid: 86 Other: 29 Total: 122 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 26, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff to resident abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 8/20/24 at 11:43 a.m. The resident's diagnosis included, but was not limited to, dementia. The incident report, dated 6/24/24 at 11:20 p.m., indicated Resident B was being assisted with toileting needs by CNA 4 when Resident B bit the side of CNA 4's arm. CNA 4 reported she made contact with Resident B's facial area in an attempt to stop the biting process. The written statement from CNA 4, dated 6/25/24 at 11:07 a.m., indicated Resident B was sitting in the dining room eating a snack and had been restless. On 6/24/24 at 11:30 p.m., CNA 4 tried to get the resident up to provide incontinent care but the resident was resistant and held onto the chair arms. CNA 4 waited a couple of minutes and tried again. CNA 4 leaned in and put her hand on the resident's waistline to help her up at that time the resident bit her right inner upper arm. Out of reflex, CNA 4 slapped Resident B's face.	F 600	Past noncompliance: no plan of correction required.	

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 _____	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 600	Continued From page 2	F 600		

The written statement from CNA 3, dated 6/25/24 at 11:31 a.m., indicated CNA 3 was sitting in the dining room at another table when CNA 4 attempted to get Resident B up from the chair. Resident B was resistant to getting up. CNA 3 heard CNA 4 yell out and say "she bit me" and at that time, observed CNA 4 slap the resident. CNA 3 went to the nurses station and reported to RN 5 and both CNA 3 and RN 5 went to the dining room and removed the resident.

The written statement from RN 5, dated 6/25/24 at 11:41 a.m., indicated around 11:30 p.m., CNA 3 came to nurses station and stated "I need your help, [CNA 4] slapped a resident". They both immediately (CNA 3 and RN 5) removed the resident from the dining room and RN 5 assessed the resident for injury and distress. There were no marks, injury or distress. CNA 4 was instructed to clock out and go home.

During a telephone interview on 8/20/24 at 1:43 p.m., CNA 3 indicated CNA 4 was trying to get the resident either changed or lay her down. Resident B was somewhat resistive. CNA 3 heard CNA 4 say "ouch", she looked up and witnessed CNA 4 slap B on the left side of the face. Resident B then placed her hand on her left cheek. CNA 3 indicated "It was not slap like you would do to a child's hand, it was a slap, slap." She had immediately got up, went to the nurses' station and told RN 5 she needed her help with Resident B because CNA 4 had just slapped her. Both CNA 3 and RN 5 immediately removed Resident B and took her to bed. After that, RN 5 went and spoke with CNA 4.

During a telephone interview on 8/20/24 at 9:26 p.m., RN 5 indicated she was at the nurses'

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 _____	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 600	Continued From page 3	F 600		

station charting. CNA 3 came up to the nurses' station and told her to come with her. RN 5 asked if everything was ok and CNA 3 said "no, [CNA 4] had just slapped [Resident B]." Once RN5 entered the dining room, CNA 4 broke down and said it was a reflex. RN 5 and CNA 3 took Resident B to her room, assessed her and together, She and CNA 3 changed her. RN 5 immediately call the Executive Director and sent CNA 4 home.

On 8/20/24 at 12:17 p.m., the Executive Director provided a current copy of the document titled "Abuse - Prevention" dated 10/4/2022. It included, but was not limited to, "Policy...It is the policy of this facility to prevent and prohibit all types of abuse...Physical Abuse...includes, but is not limited to...slapping...."

The Past noncompliance began on 6/24/24. The deficient practice was corrected by 6/26/24 after the facility implemented a systemic plan that included the following actions: A one-time review of progress notes over the past 30 days to validate no other issues (6/25/24); A one-time interview process completed with residents with a BIMS (brief interview of mental status) of 10 or higher to validate no other concerns not previously identified (6/25/24); Skin assessments completed for residents with moderately to severely impaired cognition to validate no signs of unreported issues (6/25/24); A one-time review of dementia care training completed to ensure up to date (6/25/24); Regional Director of Clinical Operations provided all staff re-education on abuse prevention, unusual occurrences, Elder Justice Act, reporting criteria and timeliness of reporting, notification to regional/division support, and re-education on behavior management

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 _____	C 08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 600	Continued From page 4 interventions for residents with dementia (6/26/24); All facility staff were re-educated on abuse prevention, definitions of unusual occurrences, reporting immediately to abuse coordinator, and timeliness of reporting (6/25/24). This Citation relates to Complaint IN00439581 3.1-27(a)(1)	F 600		