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	12/02/2024

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: 12/02/24 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 113. Quality Review completed on 12/04/24	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: 12/02/24 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
Greg Dattilo	Executive Director	12/17/2024

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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	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 113 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 12/04/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure 1 of over 8 exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect 8 staff and residents in the facility. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD), the Laundry double door exit door set would not open easily on the first try when tested. The Surveyor, then the MD tried to open the door, and the MD was able, after several tries and	K 0222	K222 – Egress Doors **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** New doors have been installed to replace the defective doors. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 8 Laundry members have the	12/18/2024

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	considerable effort to open the double exit doors. The Maintenance Director stated that there was an intention to replace the aforementioned double exit door set. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)		potential to be affected. Maintenance Director and Maintenance assistant have been educated on Doors with self-closing devices **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 educated on Doors with self-closing devices **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 exterior doors to ensure that door open on first try. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 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.	

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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Based on observation and interview, the facility failed to meet the clear width requirement for 1 of over 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 residents in	K 0232	K232 – Aisle, Corridor, or Ramp Width **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director immediately removed chair. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents, staff, and visitors that reside on that side of the hall have the potential to be affected. Maintenance Director audited all corridors to ensure that no furniture that was not securely attached to the floor was extended into the corridor. All Staff to be educated on Corridor Width **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Staff to be educated on Corridor Width **How will the corrective actions**	12/18/2024

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	the 400 hall. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD), in the corridor by Resident Room #417 a chair extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Maintenance Director agreed the chair was not securely attached to the floor or to the wall when tested and that the staff place it there to do one on one with a resident nearby. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)		**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 to ensure there nothing projecting more than 2 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 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 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of 1 Hazardous storage room door in the kitchen was not obstructed from closing. This deficient practice could affect 8 staff in the kitchen. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD), the Kitchen storage room in the kitchen contained over 20 boxes and was greater than 50 square feet	K 0321	K321 – Hazardous Area - Enclosure **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**	12/18/2024

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	making this a hazardous area. The door to the storage room was rusted and stuck in the open position. The aforementioned door did not self-close. The Maintenance Director agreed the storage room contained large amounts of combustible storage, was larger than 50 square feet, and was open to the kitchen. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)		8 staff have the potential to be affected. Maintenance Director audited all doors that require Self-Closing Devices to ensure they worked properly New door installed. Maintenance Director and Maintenance assistant have been educated on Hazardous Area – Enclosures. **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 educated on Self Closing Doors. **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 hazardous areas and ensure all doors associated with hazardous areas are self-closing. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 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	

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			areas of noncompliance are identified during the auditing process.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD),	K 0324	K324 – Cooking Facilities **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Nozzle of the Suppression was adjusted to face the stove, so to cover the entire stove. Red Tape was placed on the floor to mark where stove is to be placed after maintenance and cleaning. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 6 Kitchen staff have the potential to be affected Maintenance Director staff and all kitchen have been educated on Kitchen Facilities related to placement of the stove and location of the Suppression Nozzle. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Red tape placed to show proper	12/18/2024

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	the gas wheeled range and grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. The deficient practice affected 6 staff. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD), the kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood. The MD stated that it appeared the range had been moved to the left and was no longer positioned as		placement for the Stove Maintenance Director staff and all kitchen have been educated on Kitchen Facilities related to placement of the stove and location of the Suppression Nozzle. **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 Stove and Suppression placement. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 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.	

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	engineered under the suppression system. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 5 residents and staff. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD), the corridor doors to the following were propped open. A) The Rehab Gym corridor door. B) Business office. C) Copy Room. Based on interview at the time of observation, the MD acknowledged the aforementioned corridor doors would not close unless the door stops were moved first. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)	K 0363	K363 – Corridors - Doors **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The following areas door stops were removed Rehab Gym corridor door. Business Office Copy Room **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** 5 residents and staff have the potential to be affected. All staff to be in-serviced on not propping open corridor doors **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff to be in-serviced on not propping open corridor doors **How will the corrective actions**	12/18/2024

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			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 Corridor Doors to ensure doors had no impediment to closing. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 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=F Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect everyone. Findings include: Based on observations and interview on 12/02/24 between 11:15 a.m. and 1:45 p.m. during a tour of the facility with the Maintenance Director (MD),	K 0741	K741 – Smoking Regulations **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Cigarette Butts were picked up and new noncombustible container placed near cigarette area. **How other residents have the potential to be affected by the same deficient practice will be**	12/18/2024

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	there were over 100 cigarette butts disposed on the ground near and against the building exit to the smoking area. Based on interview at the time of observations, the MD agreed there were over 100 cigarette butts on the ground in the aforementioned location. This finding was acknowledged by the MD at the time of observation and again at the exit conference with the Executive Director and MD present. 3.1-19(b)		**identified and what corrective actions will be taken?** Residents that smoke have the potential to be affected New Non-combustible container was added All staff in-serviced on proper disposal of cigarette butts. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff in-serviced on proper disposal of cigarette butts. **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 to complete auditing of Cigarette Area to ensure that all cigarette butts are disposed of properly. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 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.	

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