PRINTED: 01/03/2025 FORM APPROVED OMB NO. 0938-039

12/17/2024

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD	
GREEN \	VALLEY CARE CEN	NTER		LBANY, IN 47150	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0000		
	Survey Date: 12/02	/24			
	Valley Care Center Emergency Prepare	155070			
	and Suppliers, 42 C The facility has 141 census of 113. Quality Review con	certified beds, with a current			
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 12/02 Facility Number: 0 Provider Number: 1002 At this Life Safety 0	00028 155070	K 0000		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

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.

Greg Dattilo

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Executive Director

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OBITIER TOT	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155070	B. WING		12/02/2024
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	T	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code (I Health Care Occupa This one story facil determined to be of was fully sprinklere system with hard w corridors and space battery powered sm sleeping rooms. Th and had a census of All areas where resi were sprinklered an services were sprinklered an	articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. Type V (000) construction and ed. The facility has a fire alarm ired smoke detectors in the s open to the corridors, plus toke alarms in all resident the facility has a capacity of 141 That at the time of this survey. Idents have customary access and all areas providing facility			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors				
	failed to ensure 1 or readily accessible a This deficient pract residents in the faci Findings include: Based on observation between 11:15 a.m. the facility with the the Laundry double open easily on the f	on and interview, the facility f over 8 exterior exit doors were nd able to open on first try. ice could affect 8 staff and lity. ons and interview on 12/02/24 and 1:45 p.m. during a tour of Maintenance Director (MD), door exit door set would not irst try when tested. The MD tried to open the door, and	K 0222	K222 – Egress Doors What corrective actions will accomplished for those residents found to have been affected by the deficient practice? New doors have been installe replace the defective doors. How other residents have th potential to be affected by the same deficient practice will lidentified and what corrective actions will be taken?	n d to e e e e e e e e e e e e e e e e e e

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the MD was able, after several tries and

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8 Laundry members have the

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

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IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/02/2024
PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD LBANY, IN 47150	
SUMMARY (EACH DEFICIEN REGULATORY OR considerable effort The Maintenance D an intention to repla exit door set. This finding was ac time of observation		STREET 3118 G	REEN VALLEY RD	(X5) COMPLETION DATE Deen nto peen put ee to or nn on will be
			months and then quarterly thereafter for a total of 6 months. Frequency and duration of rewill be increased as needed it areas of noncompliance are identified during the auditing process.	views

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/02/2024
	PROVIDER OR SUPPLIEF		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0232 SS=E Bldg. 01	failed to meet the cover 5 corridors or 19.2.3.4(5). LSC 1 corridor width is at the required width is furniture, provided conditions are met: (a) the fixed furniture floor or to the wall. (b) the fixed furniture floor or to the wall. (b) the fixed furniture floor or to the wall. (c) the fixed furniture floor or to the fixed furniture floor or to the wall. (d) the fixed furniture floor flo	on and interview, the facility lear width requirement for 1 of met an exception per 9.2.3.4(5) states where the least 8 feet, projections into shall be permitted for fixed that all of the following re is securely attached to the are does not reduce the clear for width to less than six feet, by 19.2.3.4(2). The is located only on one side are is grouped such that each exceed an area of 50 square are groupings addressed in separated from each other by a 10 feet. The is located so as to not uilding service and fire	K 0232	K232 – Aisle, Corridor, or Rar Width What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Maintenance Director immedi removed chair. How other residents have th potential to be affected by the same deficient practice will identified and what correctiv actions will be taken? Residents, staff, and visitors to reside on that side of the hall the potential to be affected. Maintenance Director audited corridors to ensure that no furniture that was not securely attached to the floor was exterinto the corridor. All Staff to be educated on Corridor Width What measures will be put in 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	be en diately de he be ve that have diall y ended

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This deficient practice could affect 20 residents in

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How will the corrective actions

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/02/2024
NAME OF P	ROVIDER OR SUPPLIER	-		ADDRESS, CITY, STATE, ZIP COD	
GREEN \	VALLEY CARE CEN	NTER		LBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	between 11:15 a.m. the facility with the in the corridor by R extended about two not affixed to the fle Based on interview observations, the M the chair was not se to the wall when testhere to do one on o	ons and interview on 12/02/24 and 1:45 p.m. during a tour of Maintenance Director (MD), esident Room #417 a chair feet into the corridor and were corror to the wall when tested. at the time of the aintenance Director agreed curely attached to the floor or sted and that the staff place it one with a resident nearby.		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/Designe complete auditing of all Corrid to ensure there nothing project 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 we discussed at the monthly facil QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months.	ee to lors string vill be ity
K 0321	conference with the present. 3.1-19(b) NFPA 101	and again at the exit Executive Director and MD		Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.	
SS=E Bldg. 01	failed to ensure 1 of door in the kitchen closing. This deficie in the kitchen. Findings include: Based on observation between 11:15 a.m. the facility with the the Kitchen storage	on and interview, the facility I Hazardous storage room was not obstructed from ent practice could affect 8 staff ons and interview on 12/02/24 and 1:45 p.m. during a tour of Maintenance Director (MD), room in the kitchen contained was greater than 50 square feet	K 0321	K321 – Hazardous Area - Enclosure What corrective actions will accomplished for those residents found to have beer affected by the deficient practice? No residents were affected. How other residents have th potential to be affected by th same deficient practice will I identified and what corrective actions will be taken?	e ne oe

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155070	A. BUILDING B. WING	01	COMPLETED 12/02/2024
	PROVIDER OR SUPPLIER		3118 G	ADDRESS, CITY, STATE, ZIP COD GREEN VALLEY RD JLBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	storage room was reposition. The aforer self-close. The Main storage room contain combustible storage feet, and was open to this finding was actime of observation.	dous area. The door to the insted and stuck in the open mentioned door did not intenance Director agreed the ned large amounts of it, was larger than 50 square to the kitchen. In the instead of the kitchen. In the instead of the		8 staff have the potential to be affected. Maintenance Director audited doors that require Self-Closin Devices to ensure they worked properly New door installed. Maintenance Director and Maintenance assistant have be educated on Hazardous Area Enclosures. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director and Maintenance assistant have be educated on Self Closing Door How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/Design complete auditing of all hazar areas and ensure all doors associated with hazardous ar are self-closing. Auditing will occur 4 x's/weekly x's 4 week x's monthly x's 5 months. The results of these reviews will discussed at the monthly for 3 months and then quarterly thereafter for a total of 6 mon Frequency and duration of rewill be increased as needed in will be increased as needed in the monthly for 3 months and then quarterly thereafter for a total of 6 mon Frequency and duration of rewill be increased as needed in the monthly for 3 months and then quarterly thereafter for a total of 6 months and then quarterly thereafter for a total of 6 months and then quarterly thereafter for a total of 8 months and then quarterly thereafter for a total of 8 months and then quarterly thereafter for a total of 8 months and then quarterly thereafter for a total of 8 months and then quarterly the end of the property and duration of rewill be increased as needed in the following months and the property and duration of rewill be increased as needed in the following months and the property and duration of rewill be increased as needed in the following months and the property and duration of rewill be increased as needed in the following months and the property and duration of rewill be increased as needed in the following months and the property and duration of the following months and th	all g d d peen — nto peen prs. put ee to dous eas s, 4 vill be ity ths. views

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155070	B. W	ING		12/02/2024
	PROVIDER OR SUPPLIER			3118 G	ADDRESS, CITY, STATE, ZIP COD SREEN VALLEY RD ILBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					areas of noncompliance are identified during the auditing process.	
K 0324	NFPA 101					
SS=E	Cooking Facilities					
	Cooking radiities					
Bldg. 01	failed to provide an returning cooking a when the kitchen he was designed and ir extinguishing system. Ventilation Control Commercial Cooking Edition Section 12.1 requiring protection or rearranged without fire-extinguishing some servicing agent, at the design of the fire Section 12.1.2.3 The shall not require ree appliances are move maintenance and cleappliances are return location prior to cooking a servicing agent, and the design of the fire Section 12.1.2.3 The shall not require ree appliances are move maintenance and cleappliances are return location prior to cooking a servicing agent, and the servicing agent, and the servicing agent, and the servicing agent agent and the servicing agent and the servicing agent agent and the servicing agent	approved method for ppliances to where they were pod extinguishing equipment installed for 1 of 1 kitchen hood in. NFPA 96 Standard for and Fire Protection of ing Operations Section 2011 1.2.2* Cooking appliances in shall not be moved, modified, but prior re-evaluation of the system by the system installer unless otherwise allowed by the extinguishing system. The fire-extinguishing system the evaluation where the cooking the dot of the purposes of the purposes of the purposes of the purposes of the purpose of the purposes of the purpose of the purposes of the purpose of	K 0	324	K324 – Cooking Facilities What corrective actions will accomplished for those residents found to have been affected by the deficient practice? Nozzle of the Suppression wa adjusted to face the stove, so cover the entire stove. Red Tape was placed on the fit 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 poten to be affected	s to floor e le be
		iances are reconnected in			Maintenance Director staff and	d all
		e manufacturer's listed design			kitchen have been educated o	
		1.2.3.1 An approved method			Kitchen Facilities related to	711
		at will ensure that the			placement of the stove and	
		d to an approved design			location of the Suppression	
		ient practice affected 6 staff.			Nozzle.	
	Tocation. The delic	iem praetice arrected 0 starr.			What measures will be put in	nto
	Findings include:				place or what systemic	110
	i mamga metade.				changes will be made to	
	Based on observation	ons and interview on 12/02/24			ensure that the deficient	
		and 1:45 p.m. during a tour of			practice does not recur?	
		Maintenance Director (MD),			Red tape placed to show prop	er
	1	,	1		1	· · ·

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	X3) DATE SURVEY		
						COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01		
		155070	B. W	ING		12/02	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					REEN VALLEY RD		
GREEN \	VALLEY CARE CE	NIER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ige and grill which was located			placement for the Stove		
	_	under the hood in the kitchen			Maintenance Director staff and	d all	
	_	ith an approved method that			kitchen have been educated o	n	
		he appliance was returned to			Kitchen Facilities related to		
		location after it had been			placement of the stove and		
		ance and cleaning. Based on			location of the Suppression		
		Maintenance Director, the			Nozzle.		
	-	are an approved method should					
	-	re that the appliance was			How will the corrective actio	ns	
		oved design location after			be monitored to ensure the		
	maintenance or clea	_			deficient practice will not		
		knowledged by the MD at the			recur, i.e., what quality		
	time of observation	and again at the exit			assurance programs will be	put	
	conference with the	Executive Director and MD			into place?		
	present.				Maintenance Director/Designe	ee to	
					complete auditing of Stove an	d	
	2. Based on observa	ation and interview, the facility			Suppression placement. Audi	iting	
	failed to ensure 1 of	f 1 kitchen range hood			will occur 4 x's/weekly x's 4		
	extinguishing system	ms was maintained in proper			weeks, 4 x's monthly x's 5		
	working order. NFF	PA 96, 2011 edition, Section			months.		
	10.1.2 requires cool	king equipment that produces			The results of these reviews w	vill be	
	grease-laden vapors	s and that might be a source of			discussed at the monthly facili	ity	
	ignition of grease ir	the hood, grease removal			QAPI meeting monthly for 3		
	device, or duct shal	l be protected by			months and then quarterly		
	fire-extinguishing e	equipment. Section 11.1.6 states			thereafter for a total of 6 mont	hs.	
	cooking equipment	shall not be operated while its			Frequency and duration of rev	views	
	fire-extinguishing s	ystem or exhaust system is			will be increased as needed if	any	
	nonoperational or in	mpaired. The deficient practice			areas of noncompliance are		
	affected 6 staff.				identified during the auditing		
					process.		
	Findings include:						
	Dogad on absor-4	ons and interview on 12/02/24					
		and 1:45 p.m. during a tour of					
	-	Maintenance Director (MD),					
	_	ood extinguishing system					
	_	operly positioned over the					
		under the hood. The MD					
		ed the range had been moved					
	to the left and was r	no longer positioned as					

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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 12/02/2024

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY RD

TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 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	GREEN	VALLEY CARE CENTER		GREEN VALLEY RD ALBANY, IN 47150	
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 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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
SS=E Bldg. 01 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		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.			
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. This deficient practice could affect 5 residents and staff. 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. 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 may 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 found to have been affected by the deficient practice? The following areas door stops were moved Rehab Gym corridor door. Business Office Copy Room How other residents have the potential to be affected by the same deficient practice? The following areas door stops were affected. All staff to be in-serviced on not propping open corridor doors would not close unless the door stops were what systemic changes will be made to	SS=E				
conference with the Executive Director and MD present. practice does not recur? All staff to be in-serviced on not propping open corridor doors 3.1-19(b) How will the corrective actions		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.	K 0363	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	12/18/2024

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	ONSTRUCTION 01	(X3) DATE COMPL	ETED
		155070	B. W			12/02/	/2024
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD		
GREEN \	VALLEY CARE CEI	NTER			LBANY, IN 47150		,
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
					be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/Design complete auditing of all Corric Doors to ensure doors had not impediment to closing. Auditi will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months. The results of these reviews will discussed at the monthly facil QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 monifrequency and duration of rewill be increased as needed if areas of noncompliance are identified during the auditing process.	ee to dor o ng will be ity ths.	
K 0741 SS=F Bldg. 01	failed to ensure 1 or maintained by dispo or noncombustible	ons on and interview, the facility f 1 smoking areas were osing cigarette butts in a metal container with self-closing deficient practice could affect	K 0	741	K741 – Smoking Regulations What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? Cigarette Butts were picked u and new noncombustible con placed near cigarette area.	be n	12/18/2024
	between 11:15 a.m.	ons and interview on 12/02/24 and 1:45 p.m. during a tour of Maintenance Director (MD),			How other residents have the potential to be affected by the same deficient practice will	ne	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155070	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/02/2024
	PROVIDER OR SUPPLIEF		3118 0	ADDRESS, CITY, STATE, ZIP CO GREEN VALLEY RD ALBANY, IN 47150	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	CCTION (X5) ULLD BE PROPRIATE COMPLETION DATE
	the ground near and the smoking area. E of observations, the 100 cigarette butts aforementioned loc This finding was ac time of observation	Decigarette butts disposed on against the building exit to assed on interview at the time and agreed there were over on the ground in the ation. It is a substituted by the MD at the and again at the exit are Executive Director and MD.		identified and what cor actions will be taken? Residents that smoke he potential to be affected New Non-combustible of was added All staff in-serviced on precision disposal of cigarette but what measures will be place or what systemic changes will be made the ensure that the deficient practice does not recur all staff in-serviced on precision disposal of cigarette but the deficient practice will in recur, i.e., what quality assurance programs with into place? Executive Director/Design complete auditing of Cigarette auditing of Cigarette auditing of Cigarette auditing will occur 4 x's/x's 4 weeks, 4 x's month months. The results of these revidiscussed at the monthly from the auditing will occur and duration will be increased as need areas of noncompliance identified during the auditing the auditing the auditing the auditined to the process.	ave the ontainer roper ts. put into co nt r? roper ts. actions e the not fill be put gnee to garette igarette igarette operly. weekly nly x's 5 fews will be y facility or 3 rly months. of reviews ded if any are

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED		
		155070	B. WI	NG		12/02/	/2024	
	PROVIDER OR SUPPLIER			3118 G	ADDRESS, CITY, STATE, ZIP COD REEN VALLEY RD LBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	

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