

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 08/21/2024
NAME OF PROVIDER OR SUPPLIER Green Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3118 Green Valley Rd New Albany, IN 47150	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34231</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>During a telephone interview on 8/20/24 at 9:26 p.m., RN 5 indicated she was at the nurses' 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.</p> <p>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</p> <p>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 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).</p> <p>This Citation relates to Complaint IN00439581</p> <p>3.1-27(a)(1)</p>		