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	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Care Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure bed hold polices were provided to residents/resident representatives (Resident C, Resident D, Resident F and Resident B) discharged to the hospital for 4 of 4 residents reviewed for transfers/discharges. Findings include: 1. The clinical record for Resident C was reviewed on 6/4/25 at 11:31 a.m. The resident's diagnoses included, but were not limited to, paraplegia and neuromuscular dysfunction of the bladder. The progress note, dated 5/26/25 at 1:00 a.m., indicated the resident was very lethargic and the catheter had blood tinged urine in the catheter bag. The physician was notified and a new order was received to send the resident to the hospital for evaluation. The clinical record lacked documentation of the bed hold documentation provided to the resident or the resident's representative at the time of discharge. 2. The clinical record for Resident D was reviewed on 6/4/25 at 2:49 p.m. The resident's diagnoses included, but were not limited to, dementia and subdural hemorrhage with loss of consciousness. The progress note, dated 5/29/25 at 11:14 a.m., indicated Resident D's son was at the facility and requested the resident be sent to the hospital for evaluation. They physician was notified with a new order to send the resident to the hospital for evaluation. The clinical record lacked documentation of bed hold documentation provided to the resident or the resident's family member at the time of discharge. 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 disease, chronic obstructive pulmonary disease and infection/inflammatory reaction due to joint prosthesis. The progress note, dated 5/27/25 at 8:30 p.m., indicated the resident was found with cyanotic finger tips and the resident's oxygen saturation was not registering. When the oxygen did register, saturation was in the 50's. Oxygen was placed on the resident per nasal cannula at 4 liters per minute. The resident's oxygen came up to 93%. The physician was notified with a new order to send to the hospital for evaluation. (continued on next page)

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documentation of bed hold documentation provided to the resident or resident's representative at the time of discharge. 4. The clinical record for Resident B was reviewed on 6/4/25 at 9:54 a.m. The resident's diagnoses included, but were not limited to, cerebral infarction and convulsion. The progress note, dated 12/25/24 at 3:55 p.m., indicated the resident was not responding, eyes were deviated and sternal rubs were ineffective. The family member was at bedside, the physician was notified with a new order to send the resident to the emergency department for evaluation. The transfer form and clinical record lacked documentation of bed hold documentation provided to the resident/resident representative at the time of discharge. The resident readmitted to the facility on [DATE]. The progress note, dated 1/17/25 at 12:57 p.m., indicated the resident's oxygen saturation was very low, ineffective sternal rubs, and breathing with his abdominal muscles. The resident was placed on oxygen. The physician was notified with a new order to send the resident to the emergency department and report was called to the hospital. The clinical record lacked documentation of bed hold documentation being provided to the resident prior to discharge. During an interview on 6/4/25 at 3:10 p.m., the Director of Nursing (DON) indicated she was aware the bed hold had to be sent with the resident, but if there was an emergent situation, it may not be done. On 6/4/25 at 3:28 p.m., the DON provided a current copy of the document titled Discharge Process and Bed Holds dated 1/3/22. It included, but was not limited to, Notice of bed-hold policy and returns .Bed-hold notice upon transfer .At the time of transfer of a resident for hospitalization .a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy This Citation relates to Complaint IN00458882 3.1-12(a)25(A) 3.1-12(a)25(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the physician's orders were in place for weekly maintenance of nebulizer equipment and failed to ensure nebulizer respiratory assessments were completed prior and after administration for 1 of 3 residents reviewed for respiratory care. Findings include: The clinical record for Resident B was reviewed on 6/4/24 at 9:54 a.m. The resident's diagnosis included, but was not limited to, chronic obstructive pulmonary disease. Review of the December 2024 medication administration record (MAR) indicated the resident received pulmicort 0.5 mg (milligrams)/2 ml (milliliters). The resident was to received 2 ml, via nebulizer, twice daily. The resident's clinical record lacked documentation of the December weekly replacement of the nebulizer respiratory equipment. Review of the January 2025 MAR indicated the resident received pulmicort 0.5 mg (milligrams)/2 ml (milliliters). The resident received 2 ml, via nebulizer, twice daily upon readmission on [DATE]. The resident's clinical record lacked documentation of the January completed respiratory assessments and the weekly replacement of the nebulizer respiratory equipment. During an interview on 6/4/25 at 2:23 p.m., Licensed Practical Nurse (LPN) 3 indicated to ensure the effectiveness of a nebulizer treatment, a respiratory assessment should be completed prior to and after completion of the treatment. The nebulizer equipment should be changed out weekly. On 6/4/25 at 3:09 p.m., the Director of Nursing provided a current, undated copy of the document titled Nebulizer Treatment, small volume. It included, but was not limited to, Please included the following information when completing the procedure .Entire setup should be changed weekly .Implementation . Monitor the patient's heart rate and respiratory status during the procedure .After treatment, turn off the nebulizer, obtain the patients' vital signs, assess the respiratory status This Citation relates to Complaint IN00458882 3.1-47(a)(6)