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	01/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure kitchen equipment, floors, ceiling vents were clean and in good condition and expired food was disposed of during 3 of 3 kitchen observations. This deficient practice affected 122 of 122 residents who received meals from the kitchen.Findings include:1.During the initial tour of the kitchen with [NAME] 1, on 1/5/26 at 10:00 a.m., the following concerns were observed:There were yellow/brown food particles in the fryer oil with a heavy accumulation of brown food particles on the inside shelf. Cook,1 indicated the fryer was last used the night before.Both stove ovens had cream colored food particles on the inside bottom. The outside doors of the oven and handles were sticky to the touch and had a heavy accumulation of white streaks running down the front doors.Around 3 sides of the fryer there were white and brown sticky streaks.The left side of the convection oven had yellow grease particles on it and felt greasy to the touch.The top and bottom of the convection ovens had brown and white streaks running down the front. The area underneath the door openings and the inside of the doors had a heavy accumulation of black and brown grease which was able to be scrapped.The floor under the convection ovens had a heavy accumulation of black and dark brown substance. This was also present under the fryer, under the left side of the stove, and under the 3 compartment sinks.The shelf under the slicer had a moderate amount of yellow/brown food particles and grease.One ceiling air vent directly above the pot and pan and steam table rack had a heavy accumulation of black substance on it.The dish machine switch below the rinse cycle section had a heavy accumulation of pinkish brown food particles which were able to be removed when touched.The ceiling air vent above the dish machine had a heavy accumulation of black greasy particals on it.The top and front of the dish machine had a heavy number of white streaks running down.One of two large ceiling air vents above the tray counter and steam table had a heavy flaking of black paint in the center.Two of three ceiling air vents had a heavy amount of greasy substance on them. This was above the preparation counter and clean pot and pan shelving.One of two ceiling air vents above the counter where the toaster and coffee machine were and the heated plate holder in which dishes were present had a heavy accumulation of black greasy substance.2. During a kitchen observation, on 1/7/26 at 10:05 a.m., the following concerns were observed:The same issues identified on 1/5/26 at 10:00 a.m. remained a concern.The shelf inside the fryer had a heavy accumulation of brown food particles. The [NAME] indicated at this time, the oil would be normally changed on Fridays, but after each use, the shelf inside was supposed to be wiped off.The grease trap on the flat top was full to the top with yellow and brown food particles. Per the Cook, it was supposed to be emptied after each use. It was the scrapings from whatever was cooked on the flat top.A container of fruit cocktail in the right side of the reach-in refrigerator had a use by date of 12/29/25.In the left side of the reach-in refrigerator were two five (5) pound containers of cottage cheese with a best by date of 12/26/25 and 12/13/25. Dietary aide 2 indicated the small dishes of cottage cheese on the shelf were not dipped from the outdated containers of cottage cheese.The ceiling vent above the salad dressing and condiment shelf in the dry storage were pulling loose with pieces of plaster hanging loose and was black in color.The dishwasher had lime streaks running down the length of the door in front.At the end of the clean side (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the dishwasher shelf, there was a heavy amount of moist beige and green food particles in the end corner. There was also a light accumulation of dried green food particles on the edges.3. During an observation of the kitchen, on 1/9/26 at 9:40 a.m., the following concerns were observed:Both stove ovens had a moderate amount of cream-colored food particles on the inside bottom.The outside doors of the oven and handles were sticky to the touch and had a heavy accumulation of white streaks running down the front doors.Around 3 sides of the fryer had white and brown sticky streaks.The left side of the convection oven had yellow grease particles which felt greasy to the touch.The top and bottom of the convection ovens had brown and white streaks running down the front. The area under the door openings and inside the doors, there was a heavy accumulation of black and brown grease which was able to be scrapped.The floor under the convection ovens had a heavy accumulation of black and dark brown substance. This was also present under the fryer, under left side of the stove, and under the 3 compartment sinks.The shelf under the slicer had a moderate amount of yellow/brown food particles and grease.One ceiling air vent directly above the pot and pan and steam table rack had a heavy accumulation of black greasy dust on it.The ceiling air vent above the dish machine had a heavy accumulation of black greasy dust on it.The top and front of the dish machine had heavy number of white streaks running down.One of two large ceiling air vents above the tray counter and steam table had a heavy flaking of black paint in the center.Two of 3 ceiling air vents had a heavy amount of greasy substance on them. This was above the prep counter and clean pot and pan shelving.One of two ceiling air vents above the counter where the toaster and coffee machine were and the heated plate holder in which dishes were present, had a moderate accumulation of black greasy particles on it.The ceiling vent above the salad dressing and condiment shelf in the dry storage was pulling loose with pieces of plaster hanging loose and was black in color.The dishwasher had lime streaks running down the length of the door in front.Review of the AS-COMPLETED Daily cleaning schedule, dated 1/4/26 to 1/9/26, indicated the stove top, grill and the floors were cleaned every shift.Review of the AS COMPLETED Weekly cleaning schedule indicated the ovens were cleaned on Week 1 and 3 on Tuesdays; the reach In refrigerator was cleaned on Week 1 and 3 on Fridays; the fryer was cleaned on Week 2 and 4 on Tuesdays; and the dishwasher was cleaned on Week 4 on Fridays.Review of the Weekly cleaning list for the cooks indicated in the a.m. on Mondays the table under the Cooks preparation areas were cleaned, the deep fryer was cleaned on Fridays; the top over of the double stack ovens was cleaned in the p.m. on Monday; the bottom oven of the double stack ovens was cleaned on Tuesday; the bottom left oven was cleaned on Wednesday; and the stove top and bottoms right oven were cleaned on Fridays. Review of the Food Safety policy, dated 5/1/25, included, but was not limited to: Policy: Food is stored and maintained in a clean, safe, and sanitary manner following federal. state and local guidelines to minimize contamination and bacterial growth .Cold Food Storage: 10. Leftovers are dated properly and discarded after 72 hours unless otherwise indicated .Review of the Cleaning Schedule, dated 4/30/25, included, but were not limited to: Policy: The Director of Food and Nutrition Services shall develop a routine cleaning schedule to ensure that the Food and Nutrition Services Department is maintained in a clean and sanitary manner in accordance with regulation requirements . The facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety .Procedure: 1. The Director of Food and Nutrition Services establishes a regular cleaning schedule to include equipment .3.1-21(i)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure proper labeling on 6 of 24 residents receiving insulin during the review of medication storage. (Residents 28, 9, 2, 4, 115 and 23) Findings include: 1. During an observation of the 300 Hall medication cart, on 1/7/26 at 8:41 a.m., the following concerns were identified for Resident 28: a. Resident 28's Lispro (rapid acting insulin) had no pharmacy label with the KwikPen in the medication cart or in the refrigerator. b. Resident 28's Rezvoglar (long-acting insulin) had no pharmacy label with the KwikPen in the medication cart or in the refrigerator. The record for Resident 28 was reviewed on 1/8/26 at 10:08 a.m. The diagnoses included, but were not limited to, protein-calorie malnutrition, type 2 diabetes mellitus with diabetic neuropathy, stage 3 chronic kidney disease, and anemia. The care plan, dated 12/18/25, indicated the resident had a diabetes mellitus diagnosis and was at risk for abnormal blood sugar readings. The interventions, dated 12/18/25, included, but were not limited to, blood sugar checks as ordered, medications as ordered, observe and report as needed (PRN) any signs and symptoms of hyperglycemia, and observe and report PRN any signs and symptoms of hypoglycemia. The physician's order, dated 12/18/25, indicated staff were to administer the resident's 15 units of lispro subcutaneously with meals for diabetes mellitus. The physician's order, dated 12/18/25, indicated staff were to administer the resident's 30 units of Lantus SoloStar (Rezvoglar) subcutaneously, a long-acting insulin, in the morning. The Comprehensive Minimum Data Set (MDS) assessment, dated 12/30/25, indicated the resident was moderately cognitively impaired. The resident received insulin in the last 7 days prior to the assessment. 2. During an observation of the 400 Hall medication cart on 1/7/26 at 9:28 a.m., the following concerns were identified for Resident 9: a. Resident 9's Basaglar (long-acting insulin) had no pharmacy label with the KwikPen in the medication cart of in the refrigerator. b. Resident 9's Humalog (fast acting insulin) had no pharmacy label with the KwikPen in the medication cart of in the refrigerator. The record for Resident 9 was reviewed on 1/8/26 at 10:27 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and schizophrenia. The physician's order, dated 2/15/25, indicated staff were to administer the resident's 17 units of Basaglar KwikPen at bedtime for diabetes mellitus. The physician's order, dated 4/8/25, indicated staff were to administer the resident's Novolog (Humalog) KwikPen subcutaneously every morning and at bedtime per sliding scale: if the resident's blood sugar results were 251 to 300 milligrams per deciliter (mg/dL), staff were to administer 6 units; 301 to 350 mg/dL, staff were to administer 8 units; 351 to 400 mg/dL, staff were to administer 10 units; 401 to 450 mg/dL , staff were to administer 12 units for 451 for diabetes mellitus. The care plan, dated 10/17/25 and revised 11/25/25, indicated the resident was at risk for complications associated with hyper or hypoglycemia related to the diagnosis of diabetes mellitus. The Quarterly MDS assessment, dated 11/27/25, indicated the resident was severely cognitively impaired. The resident received insulin in the 7 days prior to the assessment. 3. During an observation of the 400 Hall medication cart on 1/7/26 at 9:28 a.m., the following concerns were identified for Resident 2: a. Resident 2's Glargine (long-acting insulin) had no pharmacy label with the KwikPen in the medication cart of in the refrigerator. b. Resident 2's Lispro (rapid acting insulin) had had no pharmacy label with the KwikPen in the medication cart of in the refrigerator. The record for Resident 2 was reviewed on 1/8/26 at 11:03 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, protein-calorie malnutrition, iron deficiency, dementia, and dysphagia. The care plan, dated 8/19/25 and revised 12/2/25, indicated the resident had a diabetes mellitus diagnosis and was at risk for abnormal blood sugar readings, The interventions, dated 8/19/25, included, but were not limited to, obtain blood sugar readings as ordered, administer medications as ordered, observe and report PRN any signs or symptoms of hyperglycemia, observe and report PRN any signs or symptoms (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of hypoglycemia. The physician's order, dated 11/24/25, indicated staff were to administer the resident's 5 units of glargine KwikPen subcutaneously, one time daily for diabetes mellitus. The physician's order, dated 11/25/25, indicated to administer Humalog KwikPen (insulin lispro) subcutaneously per sliding scale; if the resident's blood sugar results were 151 to 200 mg/dL, staff were to administer 2 units; 201 to 250 mg/dL, staff were to administer 4 units; 251 to 300 mg/dL, staff were to administer 6 units; 301 to 350 mg/dL, staff were to administer 8 units; 351 to 400 mg/dL, staff were to administer 10 units; Over 400 mg/dL, staff were to Call the MD; before meals and at bedtime. The Comprehensive MDS assessment, dated 12/2/25, indicated the resident was moderately cognitively impaired. The resident received insulin in the 7 days prior to the assessment. During an interview, on 1/7/26 at 9:35 a.m., Qualified Medication Aide (QMA) 6 indicated she was unsure why the labels were not with the insulin. 4. During an observation of the 500 Hall medication cart on 1/7/25 at 9:50 a.m., the following concerns were identified for Resident 4: Resident 4's Tresiba had no pharmacy label with the KwikPen in the medication cart or in the refrigerator. The record for Resident 4 was reviewed on 1/8/26 at 1:46 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperglyceridemia, history of diabetic foot ulcer, and protein-calorie malnutrition. The record lacked documentation of a care plan for diabetes mellitus. The physician's order, dated 10/13/25, indicated to administer to the resident, aspart KwikPen subcutaneously, per sliding scale; if the resident's blood sugar results were 151 to 200 mg/dL, staff were to administer 2 units; 201 to 250 mg/dL, staff were to administer 4 units; 251 to 300 mg/dL , staff were to administer 5 units; 301 to 350 mg/dL, staff were to administer 6 units; 351 to 400 mg/dL, staff were to administer 7 units; 401 to 999 mg/dL, staff were to administer 7 units and call the md; before meals and at bedtime for diabetes. The Quarterly MDS assessment, dated 12/23/25, indicated the resident was moderately cognitively impaired. The resident received insulin in the 7 days prior to the assessment. 5. During an observation of the 500 Hall medication cart on 1/7/25 at 9:50 a.m., the following concerns were identified for Resident 115. Resident 115's Aspart (rapid acting insulin) had no pharmacy label with the KwikPen in the medication cart or in the refrigerator. The record for Resident 115 was reviewed on 1/8/26 at 2:29 p.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus. The care plan, dated 7/14/25 and revised 12/23/25, indicated the resident had diabetes mellitus diagnosis and was at risk for abnormal blood sugar readings. The interventions, dated 7/14/25, included, but was not limited to, blood sugar checks as ordered, diet as ordered, medication as ordered, observe and report PRN any signs and symptoms of hyperglycemia, observe and report PRN any signs and symptoms of hypoglycemia. The physician's order, dated 12/18/24, indicated the staff were to administer the resident's 10 units of Basaglar KwikPen (Tresiba) subcutaneously at bedtime. The Quarterly MDS assessment, dated 12/23/25, indicated the resident was moderately cognitively impaired. The resident received insulin in the 7 days prior to the assessment. During an interview, on 1/7/26 at 9:57 a.m., Licensed Practical Nurse (LPN) 7 indicated the pharmacy labels were discarded upon receiving and not placed on the medications. 6. During an observation of the 100 Hall medication cart on 1/7/26 at 9:55 a.m., the following concerns were identified for Resident 23: Resident 23's Lispro (rapid acting insulin) had no pharmacy label with the KwikPen or in the refrigerator. The record for Resident 23 was reviewed on 1/8/26 at 9:42 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, cognitive communication deficit, and protein-calorie malnutrition. The care plan, dated 8/17/25 and last revised on 12/1/25, indicated the resident had diabetes mellitus and was at risk for abnormal blood sugar readings. The interventions, dated 8/17/25, included, but were not limited to, obtain the resident's blood sugar readings as ordered, administer medications as ordered, observe and report as needed (PRN) any signs or symptoms of hyperglycemia, and observe and report PRN any signs or symptoms of hypoglycemia. The physician's orders, dated 11/16/25, indicated staff were to administer the resident's Humalog (insulin lispro) KwikPen subcutaneously per sliding scale, if the resident's blood sugar reading was 151 to 200 mg/dL, staff were to administer 2 units; 201 to 250 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg/dL, staff were to administer 4 units; 251 to 300 mg/dL, staff were to administer 6 units; 301 to 350 mg/dL, staff were to administer 8 units; 351 to 400 mg/dL , staff were to administer 10 units; 401 to 450 mg/dL, staff were to administer 12 units; 451 to 500 mg/dL, staff were to administer 14 units. Anything greater than 500 staff were to notify the MD; for diabetes daily and at bedtime for diabetes mellitus. The Quarterly MDS assessment, dated 12/2/25, indicated the resident was cognitively intact. The resident received insulin in the 7 days prior to the assessment. During an interview, on 1/8/26 at 2:27 p.m., LPN 3 indicated she did not know why the pharmacy label was not with the insulin. The Storage and Expiration Dating of Medications and Biologicals policy, last revised 6/30/25, included, but was not limited to, . 12. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels or cautionary instructions. 3.1-25(k)(2)3.1-25(k)(5)3.1-25(k)(7)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure proper Personal Protective Equipment (PPE) was applied and the catheter bag drainage valve was kept off of the floor to prevent infection during 2 of 3 observations of care. (Residents 7 and 82) and to ensure glucometers were cleaned per guidelines for infections control when obtaining blood sugar readings for 2 of 2 residents observed. (Residents 32 and 2)Findings include:1. During an observation, on 1/6/26 at 9:38 a.m., Certified Nurse Aide (CNA) 5 entered Resident 7's room to empty the catheter bag, which was full of light-yellow urine and bulging. The urine was visible in the line leading up to the resident. She emptied the bag four to five times before it was empty. She applied gloves but did not apply a gown for Enhanced Barrier Precautions (EBP). There was signage on the entry door indicating the resident was in EBP related to wound and catheter care. The equipment to be worn during care, were indicated on the signage for gloves and a gown. During an interview, on 1/6/26 at 9:41 a.m., Resident 7 indicated the staff did not always wear gowns when they were performing his wound treatment. Staff didn't wear a gown when emptying the catheter bag. During an interview, on 1/6/26 at 10:30 a.m., CNA 5 indicated when a resident was in Enhanced Barrier Precautions (EBP), the staff put on the equipment they needed. She would apply gloves and if there was a risk of fluid splash you should wear a gown. She indicated she did not wear a gown when she emptied Resident 7's catheter bag. She indicated there was a chance of being splashed when she emptied the catheter bag. During a confidential interview, between 1/5/26 and 1/9/26, Staff A indicated there had been two instances where staff had not capped the catheter tubing on the catheter bag well enough. The record for Resident 7 was reviewed on 1/6/26 at 4:04 p.m. The resident's diagnoses included, but were not limited to, stage 3 chronic kidney disease, anemia, and need for assistance with personal care. The care plan, dated 5/16/25, indicated the resident had an indwelling catheter for urinary retention and presence of wounds to scrotum or perineal area. He was at risk for infection and injury with ongoing use of the catheter. The interventions, dated 5/16/25, included, but was not limited to, the use of Enhanced Barrier Precautions. The physician's order, dated 8/4/25, indicated the resident was in Enhanced Barrier Precautions for the diagnosis of a catheter and wounds. The Quarterly Minimum Data Set (MDS) assessment, dated 12/20/25, indicated the resident was cognitively intact. 2. During an observation, on 1/7/26 at 8:41 a.m., Licensed Practical Nurse (LPN) 8 entered Resident 82's room to apply oxygen to the resident. She placed the nasal cannula into the resident's nose. As the LPN was washing her hands, the resident requested to have a jacket applied. The LPN applied the jacket and performed hand washing. She looked over at the entry door at the signage for Contact Isolation and EBP. During an interview, on 1/7/26 at 8:45 a.m., LPN 8 indicated she was in the resident's room before (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she thought about the resident being in contact isolation. She indicated she had not applied the PPE and the resident was in isolation for Clostridium Difficile (C-Diff) and had a wound. The record for Resident 82 was reviewed on 1/9/26 at 8:38 a.m. The resident's diagnoses included, but were not limited to, enterocolitis due to clostridium difficile and sepsis. The physician's order, dated 12/15/25, indicated staff were to use Contact Precautions for C-Diff. The care plan, dated 12/16/25, indicated the resident was prescribed an antibiotic for C. Difficile. The interventions, dated 12/16/25, included, but was not limited to, Contact Precautions were in place. The Quarterly MDS assessment, dated 12/23/25, indicated the resident was moderately cognitively impaired. The skilled note, dated 1/4/26 at 1:26 a.m., indicated the resident received oral Vancomycin liquid related to C-Diff continues per order with no adverse side effects (ASE). The resident remained in isolation per order. Oral antibiotics were continued related to a UTI with no adverse side effects (ASE). Oral fluids were encouraged with fair results. The Foley catheter (F/C) was patent to the bedside drain (BSD) with clear yellow urine. The treatment was performed as per orders and tolerated well by the resident. The resident was compliant with heel protector boots. Turning and repositioning every 2 hours while abed. The skin-wound note, dated 1/7/26 at 3:00 p.m., indicated the resident was admitted with a pressure area to the left lateral foot. The Enhanced barrier Precautions policy, last revised 8/19/25, included, but was not limited to, . EBP are indicated for residents with any of the following. b. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. Examples of high-contact resident care activities requiring gown and glove use include. d. Providing hygiene. g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator h. Wound care: any skin opening requiring a dressing. 3.a. During an observation of LPN 3, after the use of a glucometer with Resident 32, on 1/7/26 at 11:20 a.m., the LPN 3 cleaned the glucometer by first performing hand hygiene. She then wiped all exterior surfaces with a Super Sani Cloth for approximately 30 seconds and then placed the glucometer on top of the medication cart to dry. The glucometer was not covered and left open to the air after it was wiped off. The glucometer had no visible containments. An interview, on 1/7/26 at 11:21 a.m., LPN 3 indicated proper clean of the glucometer was for the unit to remain wet for two minutes. 3.b. During an observation of LPN 4, after the use of a glucometer for Resident 2, on 1/8/26 at 11:05 a.m., the LPN 4 completed hand hygiene and then cleaned the glucometer by wiping all exterior surfaces for approximately 30 seconds with a Super Sani Cloth and then the glucometer was placed on a paper towel on top of the medication cart. The glucometer had no visible containments. An interview, on 1/8/26 at 10:18 a.m., with LPN 4 indicated that the glucometer needed to be cleaned for 2 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The manufacturer guidelines indicated that any hard nonporous surface needed 2 minutes of wet contact time prior to letting the device air dry. Review of the infection control logs indicated the facility had no pattern of specific infections or blood borne pathogens. The current policy included, titled Cleaning and disinfection of the Glucometer, was provided by the Director of Nursing (DON) on 1/9/26 at 12:20 PM. The policy included, but was not limited to, Policy: To prevent the spread of infection.Procedure: This facility will utilize the Lippincott procedure.Glucometer- Assure Prism quality control checks and cleaning procedures. 3.1-18 (j) 3.1-18 (l)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with a history of Urinary Tract Infection (UTIs) was provided proper management of the urinary catheter drainage system by maintaining the drainage system with sufficient emptying of the drainage system for 1 of 1 residents reviewed for catheter care. (Resident 7) Findings include:During an observation, on 1/5/26 at 10:01 a.m., Resident 7's catheter bag was full of urine and bulging. Urine was observed leading up the tubing to the resident. The urine was clear light yellow. The floor was sticky when walking on it. During an interview, on 1/6/26 at 9:24 a.m., Resident 7 indicated the catheter bag broke open and the urine was everywhere. The staff had mopped up the urine on the floor today. During an observation, on 1/6/26 at 9:38 a.m., Certified Nurse Aide (CNA) 5 entered the resident's room to empty the catheter bag which was full of light-yellow urine and bulging. The urine was visible in the line leading up to the resident. She emptied the bag four to five times before it was empty. She applied gloves but did not apply a gown for enhanced barrier precaution (EBP - infection control intervention designed to reduce transmission of multi drug-resistant organisms). There was signage on the entry door indicating the resident was in EBP and the equipment to be worn during care. During an interview, on 1/6/26 at 10:30 a.m., CNA 5 indicated this was the first time this morning she had emptied it. She felt the night shift had to have emptied the catheter bag during the night. During a confidential interview, between 1/5/26 and 1/9/26, Staff A indicated there had been two instances where staff had not capped the catheter tubing on the catheter bag well enough. There were two other instances where the catheter bag broke open because it was too full (one occurrence was the night before). The floor was sticky due to urine being on the floor. The record for Resident 7 was reviewed on 1/6/26 at 4:04 p.m. The resident's diagnoses included, but were not limited to, Stage 3 chronic kidney disease, anemia, and need for assistance with personal care. The care plan, dated 5/7/25 and revised 5/16/25, indicated the resident had a history of urinary tract infection and was at risk for recurrence. The interventions, dated 5/7/25, included, but were not limited to, report to the nurse practitioner (NP) if symptoms worsen, and conduct laboratory work and diagnostic work as ordered. report the results to the medical doctor (MD) and follow up as indicated, observe for and report to MD as needed (PRN) for signs and symptoms of a UTI. The care plan, dated 5/16/25, indicated the resident had an indwelling catheter for urinary retention and presence of wounds to the scrotum or perineal area. The resident was at risk for infection and injury with ongoing use of the catheter. The interventions, dated 5/16/25, included, but were not limited to, catheter care every shift, check the tubing for kinks and ensure that urine was free flowing, enhanced barrier precautions, observe for and document for pain or discomfort due to the catheter, observe for and report to the MD for signs or symptoms of a UTI, observe for signs or symptoms of discomfort on urination and frequency. The resident's urinalysis results, dated 6/19/25, indicated 4 plus glucose, 1 plus blood, 3 plus leukocytes. There was mucous, budding yeast, and WBC clumps present. The culture indicated 60,000 to 70,000 CFU/mL of pseudomonas. The nurse's note, dated 6/20/25 at 11:57 a.m., indicated the NP was at the facility and saw the resident and reviewed the final UA with culture and sensitivity. No new orders were received. The nurse's note, dated 7/2/25 at 1:24 a.m., indicated the indwelling urinary catheter was changed. The resident complained of pain with pressure and the catheter tubing showed signs of sediment. The resident indicated immediate relief after the change and immediate return of approximately 750 mL of dark yellow cloudy urine with sediment. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact. The Indwelling Urinary Catheter (Foley) Management policy, last reviewed 9/4/25, included, but was not limited to, . Additional care practices related to catheterization. 3. Use personal protective equipment, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system. a. Empty the collecting bag (continued on next page)

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	01/09/2026

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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container. 3.1-41(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on interview, observation, and record review, the facility failed to ensure residents were free of a medication error rate greater than 5 percent for 2 of 24 opportunities, resulting in a medication error rate of 8.33%. (Resident 32 and Resident 2)Findings include:1. During an interview, on 1/7/26 at 11:15 a.m., the Licensed Practical Nurse (LPN) 3 indicated that she had already checked Resident 32's blood glucose. She indicated the reading was 244 milligrams per deciliter (mg/dL) and after reviewing the physician's order it was determined that the resident would get 4 units of insulin Lispro Injection subcutaneously. During an observation, on 1/7/26 at 11:25 a.m., LPN 3 performed hand hygiene, primed the Lispro Insulin pen with 2 units without the needle intact at the time of priming. The needle was then put on the insulin pen; the LPN went to the resident's room and cleaned the lower right abdomen with alcohol and did not allow it to dry. LPN 3 injected the insulin and left it place for only 4 seconds before retracting the insulin pen. Review of the manufacturer requirements for Lispro indicated during the administration Lispro insulin required 5 seconds for the insulin to remain injected prior to retracting the insulin pen.The record for Resident 32 was reviewed on 1/9/26 at 11:52 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, dementia, peripheral vascular disease, and chronic kidney disease stage 3.A physician's order, dated 8/4/25, indicated the resident was to have Lispro Injection Solution. The instructions were as followed: Inject subcutaneously with meals as per sliding scale: if 151 to 200 mg/dL, staff were to administer 2 units; 201 to 250 mg/dL, staff were to administer 4 units; 251 to 300 mg/dL, staff were to administer 6 units; 301 to 350 mg/dL, staff were to administer 8 units; 351 to 400 mg/dL, staff were to administer 10 units; and If greater than 400 mg/dl, staff were to call the physician.The Quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, indicated the resident had moderate cognitive impairment.2. During an observation of Resident 2, on 1/8/26 at 11:00 a.m., LPN 4 performed hand hygiene, applied the needle and primed the insulin pen with 2 units for a glucose of 249 mg/dL. The LPN went to Resident 2's room and cleaned the abdomen with alcohol. The nurse injected the insulin and left it place for 3 seconds before retracting the insulin pen. Review of the manufacturer requirements for Lispro insulin indicated during administration the Lispro insulin required 5 seconds for the insulin to remain injected prior to retracting the insulin pen.The record for Resident 2 was reviewed on 1/8/26 at 8:30 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, dementia, alcoholic cirrhosis of liver with ascites, chronic kidney disease stage 4, cognitive communication deficit, hypertension, and ileostomy status.A physician's order, dated 11/25/25, indicated the resident was to have Humalog Kwik Pen subcutaneously. The instructions were as followed: Inject subcutaneously with meals and at bedtime as per sliding scale: If the resident's glucose was 151 to 200 mg/dL, the staff were to administer 2 units; 201 to 250 mg/dL, the staff were to administer 4 units; 251 to 300 mg/dL, the staff were to administer 6 units; 301 to 350 mg/dL, the staff were to administer 8 units; 351 to 400 mg/dL, the staff were to administer 10 units; and over 400 mg/dL, staff were to call the physician.The Significant Change MDS assessment, dated 11/30/25, indicated Resident 2 had moderate cognitive impairment.During an interview, 1/9/26 at 11:50 p.m., the Director of Nursing indicated she would provide the policy on insulin administration.The current policy included, titled Guidance for using Insulin Products, was provided by the DON on 1/9/26 at 12:20 PM. The policy included, but was not limited to, . 5. Clean the injection site with alcohol and allow to completely dry. 9. After injection, hold the needle in the skin in to ensure complete delivery of the dose. Needle should remain in the skin for 5 seconds after injection for Insulin Lispro . 3.1-48(c)(1)