STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 00 B. WING	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00411250. Complaint IN00411250 - Federal/State deficiencies related to the allegations are cited at F580 and F776. Survey date: June 29, 2023 Facility number: 010892 Provider number: 155661 AIM number: 200229560 Census Bed Type: SNF/NF: 72 SNF: 2 Total: 74 Census Payor Type: Medicare: 2 Medicaid: 56 Other: 16 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 30, 2023.	F 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective July 12th, 2023. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Angela Patterson | DON | 07/15/2023

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the residents family of an accident for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: On 6/29/23 at 12:00 p.m., Resident B's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 4/10/23, indicated Resident B had severe cognitive impairment. The progress notes included, but were not limited to: - On 6/25/23 at 2:21 p.m., Resident B was witnessed in the dining room standing, attempting to ambulate away from his wheelchair. Resident B tripped over his foot pedals and landed on his right side. Resident B was assessed and placed back in his wheelchair. Resident B requested to go back to bed. Physician was notified and mobile x-rays were ordered. The clinical record lacked family notification of the new orders for x-ray's following Resident B's fall until 6/26/23 at 8:30 a.m. During an interview on 6/29/23 at 2:30 p.m., the ADON (Assistant Director of Nursing) and ADM (Administrator) indicated Resident B resided at a group home and his aunt was his emergency contact. This Federal tag relates to Complaint IN00411250.	F 0580	**F580-Notification of changes. This facility does ensure that families are notified of Residents change in condition.** **1. Corrective actions taken:** In servicing was completed for nursing staff on notification of resident changes and completing documentation of responsible party notification. **2. How other residents were identified:** Residents who have a new fall will be monitored for responsible party notification and documentation of notification. **3. Measures in place/system changes:** The DON/Designee will audit new falls for responsible party notification and documentation of, for a period of four months. **See attached audit form and in servicing.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F580 Notification of resident changes and corrective actions as indicated at least quarterly during the scheduled quarterly meetings and as needed. Following the quarterly quality assurance	07/12/2023

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	3.1-5(a)(1)		meeting and no facility inaccuracies in family notification related to falls the committee will discuss removing from QA. **5.** Date of Compliance: July 12, 2023.	
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility failed to ensure an x-ray was completed in a timely manner for 1 of 3 residents reviewed for accidents. (Resident B) Finding includes: On 6/29/23 at 12:20 p.m., Resident B's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 4/10/23, indicated Resident B had severe cognitive impairment.	F 0776	**F 776-Radiology Services. This facility does ensure that residents have ordered radiology exams as indicated.** **1. Corrective actions taken:** Notification was provided to the vendor due to the untimeliness of the completion of the radiology exam that had been ordered for Resident B. If radiology service is not completed in a timely manner, facility staff are aware to notify physician for new orders. In	07/12/2023

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	The Progress Notes included, but were not limited to: - On 6/25/23 at 2:21 p.m., Resident B was witnessed in the dining room standing, attempting to ambulate away from his wheelchair. Resident B tripped over his foot pedals and landed on his right side. Resident B was assessed and placed back in his wheelchair. Resident B requested to go back to bed. Physician was notified and mobile x-rays were ordered. - On 6/26/23 at 8:30 a.m., called mobile x-ray company for estimated time of arrival and could not get the x-ray companies dispatch to answer. Resident B continued to rest in bed, with complaint of mild pain to right leg. - On 6/27/23, at 9:30 a.m., called the mobile x-ray company for the estimated time of arrive and was informed the order was re-scheduled for today (6/27/23) secondary to x-ray technician unable to complete within business hours yesterday. Facility expressed to x-ray company the importance of getting the x-ray completed due to Resident B's increased pain and notable bruising and upgraded to stat (immediately). - On 6/27/23 at 10:57 a.m., the x-ray company called to inform the facility the x-ray would be completed either late afternoon or evening, and there was a slight possibility that it would not be done today. - On 6/27/23 at 11:21 a.m., the physician was notified of the status of the x-ray order. A new order was received to send resident to the ER for evaluation. On 6/29/23 at 2:30 p.m., the ADON indicated the		servicing was completed with nursing staff. **2. How other residents were identified:** Residents who have a new fall will be audited for timeliness of completion of radiology exam if indicated. **3. Measures in place/system changes:** The Director of Nursing (DON)/designee will audit residents with a new fall for a period of (4) months. **See attached DON/designee audits and in servicing.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance at F776 as indicated at the scheduled quarterly meeting. Following the quarterly quality assurance compliance reviews and no resident with untimely radiology exam the QA committee will discontinue the monitoring. **5.** Date of Compliance: July 12, 2023.	

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	x-ray was not completed and the physician notified the x-ray was not completed until 6/27/23. This Federal tag relates to Complaint IN00411250. 3.1-49(g)			