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	12/09/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00448613 and IN00446806. Complaint IN00448613 - No deficiencies related to the allegations are cited. Complaint IN00446806 - No deficiencies related to the allegations are cited. Survey dates: December 3, 4, 5, 6 and 9 , 2024. Facility number: 010892 Provider number: 155661 AIM number: 200229560 Census Bed Type: SNF: 2 SNF/NF: 73 Total: 75 Census Payor Type: Medicare: 3 Medicaid: 58 Other: 14 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 12, 2024.	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 12/20/2024. 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 0636 SS=E Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing Based on interview and record review, the facility	F 0636	**F 636 Comprehensive**	12/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Patterson	DON	12/17/2024

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	failed to ensure the admission Minimum Data Set (MDS) assessment was completed within 14 calendar days from the admission date for 4 of 4 residents reviewed for Resident Assessment. (Resident 132, Resident 133, Resident 282, Resident 75) Findings include: 1. On 12/9/24 at 11:56 a.m., Resident 132's clinical record was reviewed. The diagnosis included, but was not limited to, urinary tract infection. The resident was admitted to the facility on 11/19/24. The admission MDS assessment for Resident 132 indicated it was still in progress. The completion date should have been on 12/2/24, which was 14 calendar days from the admission date. 2. On 12/9/24 at 12:00 p.m., Resident 133's clinical record was reviewed. The diagnosis included, but was not limited to, clostridium difficile. The resident admitted to the facility on 11/18/24. The admission MDS assessment for Resident 133 indicated it was still in progress. The completion date should have been on 12/1/24, which was 14 calendar days from the admission date. 3. On 12/5/24 at 2:00 p.m., Resident 282's clinical record was reviewed. The diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder, and schizoaffective disorder (a chronic mental illness). Resident 282 was admitted on 11/8/24. Resident 282's admission MDS assessment, dated 11/21/24, indicated it was "still in progress," at the time of record review this indicated it was 28 days past due.		**Assessments & Timing** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 Immediate actions taken for those residents identified: Residents # 132, #133, #282 and #75 Admission assessments were completed on 12/11/2024. 2 How the facility identified other residents: Any residents who had the potential to be affected, however none were identified to have been negatively impacted. 3 Measure put into place/system changes: An In service was conducted with the Minimum Data Set (MDS) coordinator and the Interdisciplinary team (IDT); indicating all admissions assessments are to be completed according to the RAI manual. Any new residents who are admitted to the facility will be audited for completion of the admission assessment by the	

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	During an interview on 12/9/24 at 11:00 a.m., the MDS Coordinator indicated an admission MDS assessment needed to be completed and signed by the 14th calendar day after admission. She indicated the admission assessment for Resident 282 was still in progress and that it was overdue. 4. On 12/5/24 at 11:06 a.m., Resident 75's clinical record was reviewed. The diagnoses included, but were not limited to, encephalopathy (a general term for a brain disorder), urinary tract infection and escherichia coli (type of bacteria). Resident 75 was admitted on 10/3/24. Resident 75's admission MDS assessment, dated 10/14/24, indicated the RN verified and signed the admission assessment on 11/2/24, which was 20 days after admission. During an interview with the MDS Coordinator on 12/9/24 at 11:00 a.m., she indicated the admission assessment for Resident 75 was completed late. During an interview with the MDS Coordinator on 12/9/24 at 11:05 a.m., she indicated the facility did not have a policy for MDS assessments, she indicated they used The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) tool. A review of the RAI User's Manual (v.1.19.1, effective 10/1/24) on 12/9/24 at 12:30 p.m., indicated "...For all non-Admission OBRA [Omnibus Budget Reconciliation Act] and PPS [Prospective Payment System] assessments, the MDS Completion Date must be no later than 14 days after the Assessment Reference Date. For the Admission assessment, the MDS Completion Date must be no later than 13 days after the Entry Date..."		14th day. Audit tool was developed and will be utilized with the new Resident admissions. 4 How the corrective actions will be monitored: The Director of Nursing/designee will review new admissions utilizing the audit tool for completion of MDS according to the RAI manual. · Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the IDT can make recommendations to the plan of care.	

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F 0657 SS=D Bldg. 00	3.1-31(d)(1) 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure residents were invited to participate in the care planning conference for 1 of 1 resident reviewed for care planning. (Resident 67) Findings include: On 12/4/24 at 2:15 p.m., Resident 67 indicated she had not been invited to her care plan conferences. On 12/5/24 at 10:23 a.m., Resident 67's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, dated 10/24/24 indicated Resident 67 had moderate cognitive impairment. The clinical record lacked documentation of Resident 67 having been invited to participate in the care plan conference after the quarterly MDS assessment, dated 10/24/24. On 12/9/24 at 10:46 a.m., the Social Service Designee (SSD) indicated they would invite the resident and/or resident's responsible party to care plan conferences after the comprehensive or quarterly MDS assessment. Resident 67's quarterly MDS assessment was completed in October 2024. The clinical record lacked documentation of an invitation or the care plan conference after the quarterly MDS assessment in	F 0657	**F657 D Care Timing and Revision** **The facility requests paper compliance for this citation** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Identified resident #67 was assessed, and the care plan meeting was scheduled, and resident and representatives were invited. Care plans were reviewed and revised appropriately. 2) How the facility identified other residents:	12/20/2024

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	October 2024. On 12/9/24 at 12:50 p.m., the Director of Nursing (DON) provided a copy of the facility policy, "Baseline Care Plan," dated 10/20/23, and indicated it was the policy currently being used. A review of the the policy lacked documentation of resident and/or resident's representative invitation to care plan meeting after MDS assessments. 3.1-35(d)(2)(B)		Any resident had the potential to be affected, however none were identified to have been negatively impacted. Care plan meetings will be held in conjunction with assessments and residents and representatives will be invited. 3) Measures put into place/ System changes: In-service conducted for the interdisciplinary team to review scheduling and invitations to resident's representatives for participation in the care plan meetings. Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually. Notation will be placed in residents clinical record if the resident and their representative is determined not practicable for the development of the resident's care plan. 4) How the corrective actions will be monitored: The Director of Nursing /designee will randomly review 5 residents 'care plan records weekly ensuring that resident representatives have been invited	

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			to the care plan meeting. Documentation will reflect invitation to resident representative to attend care plan meeting. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the IDT can make recommendations to the plan of care. 5) Date of compliance: 12/20/2024.	