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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 29, 30, 31, February 1, and 2, 2024 Facility number: 010892 Provider number: 155661 AIM number: 200229560 Census Bed Type: SNF: 2 SNF/NF: 77 Total: 79 Census Payor Type: Medicare: 7 Medicaid: 57 Other: 15 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 6, 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 February 16, 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 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.			

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to electronically submit to the Centers for Medicare and Medicaid (CMS) complete and accurate Registered Nurse (RN) hours based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for quarter 4 of fiscal year 2023 (7/1/23-9/30/23). Findings include: On 2/2/24 at 2:01 p.m., the facility's Payroll Based Journal (PBJ) Staffing Data Report was reviewed. The report indicated the facility had no RN hours for 7/8/23, 7/9/23, 7/16/23, 9/23/23, 9/24/23, and 9/30/23. On 2/2/24 at 2:03 p.m., the staffing sheets and time cards for the above dates were reviewed and indicated the facility did have RN hours for those dates. During an interview at that time with the Director of Nursing (DON), she indicated the Administrator who was working at the facility during CMS quarter 4 of fiscal year 2023, did not put the PBJ hours in correctly for the RN hours. During an interview on 2/2/24 at 2:13 p.m., the DON indicated the facility did not have a policy related to correctly entering the PBJ hours.	F 0851	**F851- Payroll Based Journal** The facility does ensure that a Registered Nurse is available at a minimum of eight hours a day 7 days a week. **1 Corrective Actions taken.** The errors identified on the payroll-based journal have been corrected. The new executive director will receive training to ensure Registered nursing (RN) hours are accurately reported. The following quarter has been reviewed and RN hours were reported as indicated. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** No Residents were affected by this deficient practice. The facility had RN coverage. **3 Measures in place/system changes.** The Senior Executive director will ensure that Payroll Based Journal (PBJ) hours will be submitted accurately. The facility has a contracted vendor who also monitors the reporting of these RN hours. An audit has been	02/16/2024

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	.		developed and the payroll/HR designee will monitor RN hours biweekly when payroll is submitted, the executive director has monthly and quarterly reviews with contracted vendor for any missing PBJ data. **4 Monitoring of corrective action taken.** The Quality Assurance and Improvement committee will review compliance of F 851 Payroll Based Journal RN hours and the corrective actions as indicated at the next quarterly meeting. Following the quarterly quality assurance compliance reviews and no missed RN hours the committee will discontinue audits. The Facility respectfully requests an IDR due to scope and severity of the tag. The facility had RN coverage for everyday during Quarter 4 of 2023. According to the Centers for Medicaid and Medicare Services (CMS), undated training on nursing home staffing. Page 4 indicates" Why is staffing important? …Staffing in nursing homes has a substantial impact on the quality of care and outcomes that residents experience. There is a direct correlation between staffing and quality of care….". The facility is aware that RN hours were not imputed on the PBJ report for the dates indicated in the 2567.	

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Residents were not impacted by this deficient practice as RN hours were provided but were missed upon submission of the PBJ data. This deficient practice did not impact resident care and scope and severity of F is not warranted for this deficient practice. **5 Date of Compliance February 16th, 2024.** **See attached Audit tool.**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment for 3 of 4 units observed. A urine odor was observed and air vents were not clean. (200 unit, 300 unit, 400 unit) Findings include: 1. On the following dates and times, the full length of the 200 unit hallway was observed to have a strong odor of urine: - On 1/29/24 at 11:20 a.m. and 2:40 p.m. - On 1/30/24 at 10:40 a.m., 12:05 p.m., and 3:00 p.m. - On 2/2/24 at 9:45 a.m., 11:10 a.m., and 1:25 p.m. 2. On the following dates and times, the 400 unit hallways and common area were observed to have a strong odor of urine: - On 1/29/24 at 10:20 a.m., 1:30 p.m., and 3:10 p.m. - On 1/30/24 at 10:45 a.m., 1:10 p.m., and 3:20 p.m.	F 0921	**F921-Safe/Functional/Sanitary/ Comfortable Environment** The facility does ensure residents have a safe, functional, sanitary, comfortable environment. **1 Corrective actions taken:** **A** The Environmental service director and team were in serviced on proper use of the carpet shampooer. Professional carpet cleaners were hired and cleaned the areas identified during the survey and once since. The facility will continue to clean carpets when urine odors are identified. **B** The Environmental Services Director (ESD), and team were in serviced on cleaning of vents. Environmental services team will clean at least one vent daily until the six vents are clean on the 100	02/16/2024

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 2/2/24 at 10:05 a.m., 11:30 a.m., and 1:35 p.m. 3. On the following dates and times, the 3 ceiling air vent covers on the 200 unit were observed to have a dark fuzzy substance on them: - On 1/29/24 at 11:21 a.m. and 2:41 p.m. - On 1/30/24 at 10:41 a.m., 12:06 p.m., and 3:01 p.m. - On 2/2/24 at 9:46 a.m., 11:11 a.m., and 1:26 p.m. 4. On the following dates and times, the 3 ceiling air vent covers on the 100 unit were observed to have a dark fuzzy substance on them: - On 1/29/24 at 11:24 a.m. and 2:44 p.m. - On 1/30/24 at 10:44 a.m., 12:09 p.m., and 3:04 p.m. - On 2/2/24 at 9:49 a.m., 11:14 a.m., and 1:29 p.m. During an interview on 2/2/24 at 1:45 p.m., the Maintenance Director indicated the 200 unit and 400 unit emitted an odor of urine, likely from the carpeting, and was in need of extensive cleaning to eliminate the odors. The ceiling air vent covers on the 200 unit and 100 unit had a dark fuzzy substance on them and were in need of cleaning. On 2/2/24 at 2:30 p.m., the Director of Nursing provided the facility's Homelike Environment policy, effective date 12/1/23 and indicated this was the policy currently utilized by the facility. A review of the policy indicated, "...the residents are provided with a safe, clean, comfortable, and homelike environment...pleasant, neutral scents..." 3.1-19(f)		and 200 halls. The Maintenance director will paint any of these vents if stains are identified and can not be removed by cleaning. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** No Residents reported issues with odor or vents. No Residents were affected by this deficient practice. **3 Measures in place/system changes.** The ESD or designee will audit the 3 vents on the 100 and three vents on the 200 halls for cleaning until all vents identified are completed. On going vents will be audited weekly for four weeks and then monthly for four months. **4 Monitoring of corrective action taken.** The Quality Assurance and Improvement committee will review compliance of F 921 Safe/functional/sanitary/comfortable environment and the corrective actions as indicated at the next quarterly meeting. Following the quarterly quality assurance compliance reviews and no odors or dirty vents the committee will discontinue audits. **5 Date of Compliance February 16th, 2024.** **See attached audit tools/in service sheets.** **Invoices attached.**	

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 9999 Bldg. 00	3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquires shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure criminal background checks were completed for 1 of 5 new employee files reviewed. (Housekeeper 1) Findings include: Housekeeper 1's personnel file was reviewed on 2/2/24 at 11:30 a.m. Housekeeper 1's employment start date was 12/27/23. The personnel file lacked documentation of a background check. During an interview on 2/2/24 at 1:30 p.m., the Executive Director (ED) and the Director of Health Services (DHS) indicated Housekeeper 1 did not have a background check in their personnel file because they were under the age of 18. They further indicated they did not know underage employees required a fingerprint check to perform a criminal history screening. On 2/2/24 at 2:30 p.m., the DHS provided the facility policy, "Background Screening," dated 10/9/21, and indicated it was the policy currently	F 9999	**F9999** **1 Corrective action taken:** All minor employees were removed from the schedule until fingerprinting was completed and results were obtained. In servicing completed with Human Resources that all minors will be fingerprinted prior to employment. **2 Measures in place/system changes.** The executive director or designee will audit all new hires to ensure minor employees are fingerprinted prior to employment. **3 Monitoring of corrective action taken:** The Quality Assurance and Improvement committee will review compliance of F9999 hiring of employees who are minors will be fingerprinted prior to employment. Following the quarterly quality assurance compliance reviews and no hiring of minors without fingerprinting the audits will be discontinued. **4 Date of Compliance February 16th, 2024.** **See attached audit tools/in service sheets.**	02/16/2024

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	02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	being used by the facility. A review of the policy indicated, "All individuals seeking a relationship with our facilities shall be subject to a background screening process..." The policy did not indicate information in regard to screening underage staff.			