STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Owen Valley Rehabilitation and Healthcare Center	920 W Highway 46 Spencer, IN 47460

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a new PASARR (Preadmission Screening and Resident Review) Level 1 was completed when a new mental health diagnosis and new psychoactive medications were added for 1 of 3 residents reviewed for PASARR. (Resident 8)Findings include: On 2/20/26 at 9:55 a.m., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, bipolar disorder (a chronic mental health condition characterized by intense mood shifts between extreme highs and lows), hoarding disorder (a mental health condition characterized by persistent, extreme difficulty discarding possessions), obsessive-compulsive disorder (a chronic mental health condition characterized by uncontrollable, recurring thoughts (obsessions) and repetitive behaviors (compulsions) performed to reduce anxiety), and post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events, such as abuse, accidents, or combat).A PASARR Level I, dated 2/8/22, indicated the resident had no mental health disorders and no mental health medications. The Level I screen indicated there was no evidence of any PASARR condition or disability. If changes occurred or new information refuted these findings, a new screen must be submitted. The MAR (Medication Administration Record) indicated the following orders:Quetiapine (antipsychotic medication) 25 milligrams (mg), 1 tablet twice daily for schizoaffective disorder, initiated 8/27/22 and discontinued 4/9/23.Quetiapine 25 mg, 1 tablet twice daily for bipolar disorder, initiated 4/9/23 and discontinued 11/16/23.Quetiapine 25 mg, 2 tablets twice daily for bipolar disorder, initiated 11/16/23 and discontinued 5/3/24.Effexor (antidepressant medication) XR (extended release) 37.5 mg, 1 capsule daily for hoarding disorder, initiated 4/15/24 and discontinued 5/22/24.Quetiapine 25 mg, 2 tablets daily for bipolar disorder, initiated 5/3/24 and discontinued 12/4/25.Effexor XR 37.5 mg, 1 capsule daily for obsessive-compulsive disorder, initiated 5/22/24 with no end date.Quetiapine 25 mg, 1 tablet daily for bipolar disorder, initiated 12/4/25 with no end date. A review of Resident 8's care plan indicated the resident has/is at risk for: impaired psychosocial well-being, sensory deficits, communication deficits, cognitive deficits related to: Behaviors, Bipolar disorder, Hoarding items in room, Insomnia/sleep disorder, Refuses or resistant to care showers and labs, Verbally/Physically [sic] aggression towards others. Resident has episodes of becoming hyper-focused on past injuries to ankle and ribs, refusing therapy services. The care plan was revised on 8/26/25.During an interview with the Social Services Director (SSD) on 2/23/26 at 10:00 a.m., she indicated a new significant mental health disorder or new psychotropic medication would trigger a new PASARR Level 1 review. The SSD indicated there was not a new PASARR Level 1 on file for Resident 8. The SSD indicated they would review new diagnoses and new psychotropic medications monthly at the pharmacy review meetings.On 2/23/26 at 3:00 p.m., the Director of Nursing (DON) provided a copy of admission Criteria, dated March 2019, she indicated this was a current policy used by the facility. The policy indicated .10. All new admissions and readmissions are screened for mental disorders (MD).per the Medicaid PASARR process.On 2/23/26 at 3:43 p.m., the Administrator provided the policy labeled Resident Assessment-Coordination with PASARR Program, dated 5/10/25, he indicated this was an active policy used by the facility. The policy indicated the following .i. Negative Level I Screen - (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later.6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority.9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. Examples include: a. A resident who exhibits behavioral psychiatric or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a resident with significant weight loss was weighed as ordered by the physician for 1 of 2 residents reviewed for nutrition. (Resident 51)Findings include:On 2/18/26 at 10:10 a.m., Resident 51's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia and osteoporosis. The resident was not on a physician prescribed weight loss program.On 1/5/26, the resident weighed 138.6 pounds. On 2/5/26, the resident weighed 124.6 pounds, which was a 10.1 percent weight loss in 30 days.A care plan, revised on 2/17/26, indicated the resident was at risk for malnutrition. The interventions included, but were not limited to, Obtain weight as indicted report to RD [Registered Dietician], physician .A physician's order with a start date of 2/11/26 and an end date of 3/11/26 indicated, Weekly weights x [times] 4 weeks for 4 weeks.The clinical record lacked weights for the resident after 2/5/26During an interview on 2/23/26 at 2:20 p.m., the Dementia Care Director indicated she was unaware the resident had triggered for weight loss, and there was no record of the resident being weighed after 2/5/26.During an interview on 2/23/26 at 3:05 p.m., the Director of Nursing indicated the 2/11/26 physician's order for weighing the resident was entered into the clinical record in a manner that prevented staff from seeing it as a task to be completed, and staff would not have known to weigh the resident as ordered. 3.1-46(a)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure, a resident's medical record was complete and accurately documented (Resident 40).During an interview on 2/23/26 at 11:55 a.m., LPN 1 indicated Resident 40's fentanyl patch (a strong opioid medicine prescribed by doctors for severe pain) was out of stock. When she went to do a lunch medication administration, the medication administration record (MAR) indicated another nurse had placed a new patch on the resident's left chest. During an observation at that time, a patch was observed on the resident's right side of his chest, signed by LPN 3, and dated for 2/20/26. The nurse further indicated no patches were administered from the emergency drug kit (EDK) because the pharmacy needed a new prescription from the prescriber. On 2/23/26 at 12:01 p.m., the resident's clinical record was reviewed. The diagnoses included, but were not limited to Parkinson's disease, catatonic disorder (a condition that changes how a person's brain controls their body, affecting how they move, talk, and behave), and pain. A 12/10/25 physician's order, indicated the resident was prescribed a 25 microgram (mcg) fentanyl patch to be applied to the skin every 72 hours for pain at 6:00 a.m., and the old patch was to be removed at 5:59 a.m. A progress note, dated 2/23/26 at 1:44 p.m., indicated the resident's fentanyl patch was due to be changed on LPN 1's shift. She called the pharmacy to request a refill and obtain an authorization code for the EDK. The pharmacy technician told her a new prescription was needed and they were unable to provide an authorization code. She contacted the prescriber for a new prescription. A review of the resident's MAR indicated the following:- On 2/20/26 at 5:01 a.m., LPN 3 removed and applied a new fentanyl patch. - On 2/23/26 at 5:34 a.m., LPN 2 applied a new fentanyl patch. The resident's record lacked documentation the 2/20/26 patch was removed. During an interview on 2/23/26 at 4:04 p.m., the Director of Nursing (DON) indicated LPN 2 had erroneously charted she gave the resident a new patch, when she should have charted she removed the 2/20/26 patch. The facility had not applied a new patch because they had to get a new prescription from the doctor. On 2/23/26 at 4:20 p.m., the DON provided the facility policy Charting and Documentation, revised 7/2017, and indicated it was the policy currently being used. A review of the policy indicated, . 7. Documentation of . treatments will include care-specific details, including: a. The date and time the prodecure/treatment was provided . 3.1-50(a)(1)3.1-50(a)(2)