

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155335	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER OSSIAN HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 215 DAVIS RD OSSIAN, IN 46777
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification, State Licensure Survey conducted on 05/16/12 and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/13/12</p> <p>Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this PSR survey, Ossian Health Care and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p>	K0000		

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

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.

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	<p>This one story facility was determined to be of Type II (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 100 and had a census of 78 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. Two detached wood sheds used for storage of bed and wheel chair parts, Christmas decorations and general storage were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/18/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lights for 1 of 1 exits from 100 hall. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect any resident evacuated through the 100 hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/13/12 at 12:30 p.m., the addition of a dining/activity room was under construction at the end of the 100 hall. The new addition was used as an emergency exit from the 100 hall. The addition lacked interior and exterior emergency lights. Based on an interview with the Maintenance Director at 1:00 p.m. during the exit interview, the interior lights of the new addition have not yet</p>	K0046	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <ol style="list-style-type: none"> 1. Facility will have emergency lighting installed at the emergency exit on the end of 100 hall. 2. The alleged deficiency had the potential to affect the 21 residents on 100 hall. 3. The facility will have the emergency lighting installed for the emergency exit of 100 hall. The facility will review all emergency exits to ensure proper emergency lighting is in place. The facility will test all battery operated emergency lighting: Monthly Test will be a 30 sec. test and the Annual Test will be for 90 min. 4. The facility has an audit tool for the Maintenance Supervisor to do the monthly checks. Results will be forwarded quarterly to QA Committee Meeting. 5. To be completed by 8/10/12. 	08/10/2012

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	<p>been wired to the emergency generator and the exterior emergency lights have not been installed.</p> <p>3.1-19(b)</p>				