

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/02/2011
NAME OF PROVIDER OR SUPPLIER  OSSIAN HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 DAVIS RD OSSIAN, IN46777		
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/02/11</p> <p>Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code 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> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridor. The facility has a capacity of 100 and had a census of</p>	K0000	<p>We are in receipt of the electronic version of the 2567 Report resulting from the Life Safety Survey conducted by Amy Kelly on March 2, 2011. Ossian Health &amp; Rehabilitation Center has actively addressed the concerns raised in the survey and continues to provide quality care to its residents. We hereby assert that we are in substantial compliance with the requirements of participation. The enclosed plan of correction outlines our plans to correct the findings of the survey team. If you have any questions or need additional information, please don't hesitate to contact me personally by telephone at (260) 622-7821. Respectfully, Dave McMahan H.F.A. Ossian Health &amp; Rehabilitation Center</p>		

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><b>77 at the time of this survey.</b></p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/09/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0017 SS=E	<p>Based on observation and interview, the facility failed to ensure 1 of 1 weight scale rooms was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect the 28 residents in the 300 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator on 03/02/11 at 12:52 p.m., the corridor door has been removed from the weight scales room. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the weight scales room was not protected</p>	K0017	<p>The alleged deficiency has been addressed. A door was reinstalled at the site found to be deficient on March 15, 2011 by the Maintenance Director. The facility sought and recieved a quote for the cost associated with the installation of a smoke detector. The final determination was to reinstall the door as the use of that space within the facility will be redefined in the near future. All residents have the potential to be affected by the deficiency documented in the 2567 report. In the future before removing a door, wall, etc. from any space within the facility, the H.F.A. or Maintanancer Director will contact the organizations consultant for facility maintenance and the Life Safety division of the Indiana State Department of Health. The Safety Committee, lead by the Maintenance Director, will continue to convene a monthly Safety Committee meeting. During that meeting all safety concerns will be addressed in an ongoing fashion. The facility is in compliance at this time.</p>	04/01/2011	

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	<p>by an electrically supervised automatic smoke detection system. Based on an interview with the Administrator at the time of observation, he stated the door was removed for resident safety.</p> <p>3.1-19(b)</p>				

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K0018 SS=E	<p>Based on observation and interview, the facility failed to ensure 2 of 50 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 54 of 77 residents.</p> <p>Findings include:</p> <p>Based on observations with the Administrator on 03/02/11 from 11:56 a.m. to 12:55 p.m., the corridor doors to resident room 213 and 308 failed to latch into the door frames. This was acknowledged by the Administrator at the time of observations.</p> <p>3.1-19(b)</p>	K0018	<p>Doors of the resident rooms noted in the 2567 Report, Room 213 and 308, have been adjusted by the Maintenance Director and now latch in accordance with Indiana State Department of Health regulations. The doors were repaired on March 3, 2011. Over time all residents have the potential to be affected by the alleged deficiency. The Maintenance Director will speak to the consultant for facility maintenance in an effort to add this potential problem to the standard form referred to as Monthly Room Inspections. Adding this feature to the Maintenance Director's assigned duties will eliminate this issue. In the interim the Maintenance Director has voluntarily added this feature to his list of responsibilities as he completes his Monthly Room inspections. The Maintenance Director will complete this task on a monthly basis. That is to say that the Maintenance Director will check the doors of each resident room to ensure the door latches. In addition the Maintenance Director will address this concern in the monthly Safety Committee meeting in an ongoing fashion. The facility is in compliance at this time.</p>	04/01/2011	

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K0029 SS=E	<p>Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the Laundry room, a hazardous area, was provided with a door equipped with a self closing device causing the door to automatically close and latch into the door frame. This deficient practice could affect all residents evacuated through the service exit in the event of emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 03/02/11 at 1:42 p.m., the corridor door entering the dryer area of the Laundry room did self close, but it did not latch into the frame. This was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>	K0029	<p>The Laundry Room door noted in the 2567 Report has been repaired. The Maintenance Director addressed this concern on March 3, 2011. Over time all residents could be affected by the deficiency noted in the 2567 Report. The Maintenance Director will inspect the doors of the Laundry Room as he completes other assigned tasks in the Laundry Room. This is accomplished on a weekly basis. Each week as the Maintenance Director cleans behind laundry machines, lubricate washing machines, etc. will inspect the doors to ensure the doors latch properly. As the Maintenance Director presides over the Safety Committee he will educate committee representatives and others on the significance of monitoring doors and whether the doors latch properly. The facility is in compliance at this time.</p>	04/01/2011	

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K0144 SS=C	<p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply.</li> </ol>	K0144	<p>The annunciator panel is in the process of being installed. An electrician from the organization's construction crew has been assigned to the job of installing the panel. The panel will be installed on March 24 or 25, 2011 by this electrician. All residents have the potential to be affected by the alleged deficiency. All new safety related mandates from the Life Safety division of the Indiana State Department of Health will be addressed in accordance with the new regulatory language. The consultant for facility maintenance is routinely made aware of changes in safety regulations by the Indiana State Department of Health. That information is then communicated to each facility. Once installed, the task of monitoring the function and maintenance of the annunciator panel will be assigned to the Maintenance Director. The HFA will contact the consultant for facility maintenance to request that this task be added to the Maintenance Director's list of responsibilities. The facility will be in compliance by April 1, 2011.</p>	04/01/2011	

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	<p>5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an observation with Administrator on 03/02/11 at 2:05 p.m., the emergency generator did not have a remote annunciator panel. Based on an interview with the Administrator at the time of observation, he stated the facility is in the process of installing an annunciator panel but have not finished.</p> <p>3.1-19(b)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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