STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	215 DAVIS RD OSSIAN, IN 46777

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 5, 6, 7, 8, and 9, 2025. Facility number:000228 Provider number: 155335 AIM number: 100266650 Census Bed Type: SNF/NF:83 Total: 83 Census Payor Type: Medicare: 1 Medicaid: 49 Other: 33 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed May 14, 2025	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure accident risks were identified and interventions put into place to prevent accidents for 1 of 1 resident reviewed (Resident 388). Findings include:	F 0689	-F689-D This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Ossian Health and Rehabilitation Center agrees with the allegations and citations listed. Ossian Health	05/22/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tomi Cobb	HFA	05/22/2025

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.

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	In an interview, on 5/5/25 at 1:24 PM, Resident 78 indicated Resident 388 had entered their room multiple times asking for their family. Resident 78 indicated Resident 388 had entered their bathroom on 2 different occasions and rummaged through Resident 78's personal belongings. Resident 78 indicated they had activated their call light for staff to assist Resident 388 back to their own room. A Quarterly Risk Evaluation, dated 4/23/25, indicated Resident 388 had the ability to walk around the facility independently. The evaluation indicated Resident 388 did not have a history of wandering or searching for their family. Resident 388's Kardex (care summary for direct care staff) indicated the resident's vision was adequate. The Kardex indicated Resident 388 required limited assistance or supervision from staff for activities of daily living. The Kardex did not indicate Resident 388 had a cognitive loss. The evaluation did not indicate Resident 388 had wandered in the facility. Resident 388's Care Plan, dated 4/23/25 and revised on 4/29/25, indicated the resident had a fall risk due to memory loss as specified by their BIMS score. The target goal was to minimize fall risk through 7/22/25. Interventions included following the care plan when the resident was in pain and placing the resident's call light in reach. Resident 388's Care Plan did not indicate the resident wandered or attempted to enter other residents' rooms. Resident 388's record was reviewed on 5/6/25 at 1:03 PM. Diagnoses included unspecified disorientation, macular degeneration (central		and Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate care. As consideration of the survey results the facility respectfully request paper review of the plan of correction. Resident 388's care plan was updated to reflect current needs and interventions to keep the resident safe as well as other residents living in the community. Resident was added to a 2 hour toileting program, bowel/bladder and elopement assessments completed, Kardex updated and referral to therapy to help resident become more familiar with her room and personal items. This incident occurred in the past and had the potential to affect 1 resident. DON or designee will audit documentation and provide follow up interventions to ensure all residents remain free from accidents or incidents weekly for 4 weeks, then monthly for 5 months. Results will be reviewed in monthly QAPI meetings to ensure compliance.	

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	vision loss) and open angle glaucoma (vision loss). Resident 388's Admission Minimum Data Set, (MDS) dated 4/30/25, indicated their Brief Interview for Mental Status (BIMS) score was 4 (severe cognitive loss). A progress note, dated 4/25/25 at 3:16 AM, indicated Resident 388 had been confused and had trouble sleeping. Resident 388 indicated they wanted to go home. A progress note, dated 4/26/25 at 5:52 AM, indicated Resident 388 had been disoriented a few times. The note indicated Resident 388 was legally blind and was checked periodically to ensure safety. A progress note, dated 4/28/25 at 11:29 PM, indicated Resident 388 had been confused and wandering on the unit. A progress note, dated 4/30/25 at 5:30 AM, indicated Resident 388 was very confused and had been walking down the hallway asking to go to the hospital. Resident 388 indicated they wanted to call the police because they didn't belong there. A progress note, dated 5/1/25 at 3:53 AM, indicated Resident 388 had been very confused and was knocking on other residents' doors. A progress note, dated 5/3/25 at 4:05 AM, indicated Resident 388 had been wandering in the hall attempting to enter other residents' rooms. A progress note, dated 5/5/25 at 6:54 AM, indicated Resident 388 had been confused,			

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	wandering in the hall and indicated they were looking for a way to call the police. A progress note, dated 5/5/25 at 11:54 PM, indicated Resident 388 had been wandering on the unit looking for their daughter. A progress note, dated 5/6/25 at 5:18 PM, indicated Resident 388 had been confused at times. The resident had walked out of their room looking for the bathroom. A progress note, dated 5/7/25 at 12:47 AM, indicated Resident 388 had continued to be confused and often needed redirection. A progress note, dated 5/8/25 at 6:54 AM, indicated Resident 388 had indicated they needed to go somewhere and die and not be a bother to anyone. In an interview, on 5/8/25 at 9:07 AM, the Administrator indicated Resident 388 did not have a history of wandering when they were admitted. In an interview, on 5/8/25 at 10:29 AM, Licensed Practical Nurse (LPN) 35 indicated elopement assessments were completed upon admission, quarterly and as needed. In an interview, on 5/9/25 at 9:53 AM, the Director of Nursing (DON) indicated Resident 388 wandered when looking for the bathroom due to blindness. The DON indicated Resident 388 had not scored as an elopement risk upon admission. The DON indicated the resident had never attempted to leave the facility. The DON indicated direct care staff were made aware of possible behavior risks on each resident's individual Kardex. The DON indicated on 5/8/25, Resident			

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	388 had been ordered to have a sleep aid due to wandering at night. The DON indicated Resident 388's Care Plan had been updated after the resident had made statements of wanting to die. The DON indicated they were not aware of the resident's Care Plan having been updated to include wandering. The DON indicated a new risk evaluation should have been completed when the resident had been observed wandering and looking for their family. A current facility policy, titled "Elopements and Wandering Residents," dated 11/1/23, provided by the DON on 5/8/25 at 10:34 AM, indicated the facility would identify and assess elopement risk. The policy indicated the risks would be added to the resident's care plan. The policy indicated the risk would be communicated to the appropriate staff. 3.1-45(a)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care Based on record review and interview the facility failed to ensure trauma informed care was implemented for 1 of 2 residents reviewed. (Resident 53) Findings include: Resident 53's record review began on 05/05/25 at 10:46 AM. The record indicated diagnosis included major depressive disorder, past traumatic stress disorder (PTSD), and anxiety disorder. Resident 53's care plan had a problem related to past trauma as evidenced by angry outbursts,	F 0699	-F699-D This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Ossian Health and Rehabilitation Center agrees with the allegations and citations listed. Ossian Health and Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate	05/22/2025

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	anxiety, changes in sleeping patterns, depression, emotional swings, history of past traumatic events and refusing care. The goal of Resident 53's care plan was I will not display angry outburst or sadness through the next review. The interventions listed were as follows: o Encourage Resident 53 to participate in activities of my choice. o Provide Resident 53 time to express my feelings. o Provide Resident 53 time to talk to social services. o Consult with Psych Services and LCSW as needed. o When talking to Resident 53, allow her enough time to process the information. There were no triggers listed. There was no mention of Resident 53's original trauma to avoid re-traumatization. In an interview, on 05/07/25 at 11:20AM, Certified Nursing Assistant (CNA) 2 indicated to her knowledge no one had p PTSD on her hallway (200 hall). CNA 2 was only aware Resident 45 required a calm approach. In an interview, on 05/07/25 at 11:34 AM, Licensed Practical Nurse (LPN) 3, was not able to indicate anyone on the 200 hall with PTSD or any triggers to be aware of with any of her residents. She was able to determine after looking in the record; Resident 53 had a diagnosis of PTSD. She was unable to indicate any triggers, approaches, or actions to avoid doing or saying. LPN 3 was unaware of what Resident 53's trauma was in nature or what needed to be avoided implemented to ensure no re-traumatization occurred.		care. As consideration of the survey results the facility respectfully request paper review of the plan of correction. The facility SSD added triggers to care plans and interventions for residents who are trauma survivors. This deficient practice had the potential to affect any residents with a trauma diagnosis. The resident trauma trigger binder will be located at nurses' station with information on triggers and appropriate interventions for each resident with a trauma dx. Staff have been educated on triggers and binder placement with more information on interventions and how to prevent trauma response when caring for our residents. SSD/MDS will audit all new admissions for the next 6 months to ensure we are adding triggers to the care plan and finding interventions to prevent any traumatization. Results will be reviewed in monthly QAPI meetings for 6 months to ensure compliance.	

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	In an interview, on 5/7/25 at 2:17PM, the Social Services Director indicated she changed Resident 53's care plan on 5/7/25 after doing an audit. The Social Services Director was unable to indicate any specific triggers for Resident 53 at the time of interview. The Social Service Director indicated Resident 53 became anxioux, restless, and at times had outbursts. She was unable to determine exact triggers or what occurred prior to behaviors or symptoms of Resident 53's PTSD. On 5/7/25 at 12:10PM, a current policy and procedure titled "Trauma Informed Care" dated 3/5/24 with a revision date of 3/4/25, was provided by the Administrator. The policy indicated; "It is the policy of this facility to provide care and services which ...address the needs of trauma survivors by minimalizing triggers and re-traumatization ...Policy Explanation and Compliance Guidelines: 6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan ... No state rule applies.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 5, 6, 7, 8, and 9, 2025.	R 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Ossian Health and Rehabilitation Center agrees with the allegations	

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	Facility number: 000228 Residential Census: 36 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 14, 2025		and citations listed. Ossian Health and Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate care. As consideration of the survey results the facility respectfully request paper review of the plan of correction.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure updated information in the emergency file book, for 8 of 8 Residents reviewed (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8) Findings include: During a review of the emergency file book on 5/8/25 at 9:30 AM, 8 resident sdid not have a hospital preference listed on their emergency file: Resident 2's emergency file, dated 4/16/25, did not have a hospital preference listed. Resident 3's emergency file, dated 4/11/25, did not have a hospital preference listed. Resident 4's emergency file, dated 11/6/24, did not have a hospital preference listed. Resident 5's emergency file, dated 1/21/25, did not have a hospital preference listed.	R 0356	-R356 This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Ossian Health and Rehabilitation Center agrees with the allegations and citations listed. Ossian Health and Rehabilitation Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate care. As consideration of the survey results the facility respectfully request paper review of the plan of correction. The face sheets in the emergency binder have all been updated with a hospital preference. For residents and family members that	05/22/2025

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	Resident 6's emergency file, dated 1/24/25, did not have a hospital preference listed. Resident 7's emergency file, dated 1/21/25, did not have a hospital preference listed. Resident 8's emergency file, dated 1/21/25, did not have a hospital preference listed. In an interview, on 5/8/25 at 10:20 AM, the Administrator indicated the facility form does not have anywhere to add the hospital preference. Corporate has to give the Fcility access to add the hospital preference. A current facility policy, titled Emergency Binder, dated 5/2019, was provided by the Administrator on 5/8/25 at 10:20 AM. The policy indicated..."It is the policy of this facility to maintain resident information in a location that is easily accessible in the case of an emergency or evacuation in accordance with state law...The Electronic Medical Records Coordinator (EMRC) will have a binder placed at each nurse's station...The EMRC will audit and update the resident's information in the binder annually or as needed...."		want to decide what hospital to go to in the event of an emergency will also have a (other-please call family for hospital preference) option added. This practice had the potential to effect 8 out of 36 residents. The AL charge nurse and admissions department will be educated on adding the hospital preference to the face sheet at admission and quarterly during service care plans. The AL charge nurse or HFA will audit all admissions hospital preference's monthly for 6 months.	