	T OF HEALTH AND HU					RM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155335		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMB NO. 0938-039  [X3) DATE SURVEY  COMPLETED  05/09/2025			
NAME OF PROVIDER OR SUPPLIER OSSIAN HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, IN 46777				
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
F 0000 Bldg. 00	Licensure Survey. Residential Licens Survey dates: May Facility number: 00 Provider number: AIM number: 100 Census Bed Type: SNF/NF:83 Total: 83 Census Payor Typ Medicare: 1 Medicaid: 49 Other: 33 Total: 83 These deficiencies accordance with 4	2 5, 6, 7, 8, and 9, 2025.  20228 155335 266650 e:	F 0000				
F 0689 SS=D	483.25(d)(1)(2) Free of Accident						

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

**HFA** 

F 0689

-F689-D

This plan of correction is prepared

required by the provisions of state

Center agrees with the allegations and citations listed. Ossian Health

and federal law and not because Ossian Health and Rehabilitation

and executed because it is

05/22/2025

05/22/2025

Any defiency statement 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 disclodays 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.

Bldg. 00

Tomi Cobb

Hazards/Supervision/Devices

Findings include:

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).

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155335		B. WING 05/09/2025			2025		
		<u> </u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		215 DA			
OSSIAN	HEALTH CARE AN	ID REHABILITATION CENTER			N, IN 46777		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	5/5/25 at 1:24 PM, Resident 78			and Rehabilitation Center		
		388 had entered their room			maintains that the alleged		
	-	ng for their family. Resident 78			deficiencies do not individually		
		388 had entered their bathroom			collectively jeopardize the hea		
		sions and rummaged through			and safety of our residents, no		
	-	nal belongings. Resident 78			are they of such character to l		
	-	activated their call light for			our capability to render adequ	ate	
		ent 388 back to their own			care. As consideration of the		
	room.				survey results the facility		
					respectfully request paper rev	iew	
		valuation, dated 4/23/25,			of the plan of correction.		
		388 had the ability to walk					
	around the facility independently. The evaluation				Resident 388's care plan was		
		388 did not have a history of			updated to reflect current need	ds	
	wandering or search	ning for their family.			and interventions to keep the		
					resident safe as well as other		
		dex (care summary for direct			residents living in the commur	-	
	· ·	the resident's vision was			Resident was added to a 2 ho		
	-	ex indicated Resident 388			toileting program, bowel/bladd	er	
	-	istance or supervision from			and elopement assessments		
		f daily living. The Kardex did			completed, Kardex updated a		
		nt 388 had a cognitive loss.			referral to therapy to help resid		
		not indicate Resident 388 had			become more familiar with her		
	wandered in the fac	ility.			room and personal items. This		
	D:14 2001 C	Diam data 4 4/22/25 1			incident occurred in the past a	na	
		Plan, dated 4/23/25 and			had the potential to affect 1		
	· ·	indicated the resident had a			resident. DON or designee wil		
		nory loss as specified by their			audit documentation and provi		
		rget goal was to minimize fall  5. Interventions included			follow up interventions to ensu	ııe	
	~	blan when the resident was in		all residents remain free from		for 1	
					accidents or incidents weekly		
	pain and placing the resident's call light in reach.				weeks, then monthly for 5 mon Results will be reviewed in	illis.	
	Desident 2001s Care Plan did not in disease the					suro.	
	Resident 388's Care Plan did not indicate the resident wandered or attempted to enter other				monthly QAPI meetings to ens	oul <del>C</del>	
	residents' rooms.	or attempted to effect officer			compliance.		
	restucins rooms.						
	Resident 388's reco	rd was reviewed on 5/6/25 at					
		s included unspecified					
	_	ular degeneration (central					
		5 ( 5 0 11 11 11 11	1		I		1

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Event ID:

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155335	B. WING 05/09/2025				/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3		215 DA			
OSSIAN	HEALTH CARE AN	ID REHABILITATION CENTER			I, IN 46777		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		en angle glaucoma (vision					
	loss).						
	D 11 (200) A 1	· · · · · · · · · · · · · · · · · · ·					
		nission Minimum Data Set,					
		25, indicated their Brief al Status (BIMS) score was 4					
	(severe cognitive lo						
	(SC, CIC SOGMATOR	,.					
	A progress note, da	ated 4/25/25 at 3:16 AM,					
		388 had been confused and					
	had trouble sleeping	g. Resident 388 indicated they					
	wanted to go home.						
	A progress note, dated 4/26/25 at 5:52 AM,						
		388 had been disoriented a few					
		icated Resident 388 was legally ked periodically to ensure					
	safety.	ked periodicarry to ensure					
	Saicty.						
	A progress note, da	ted 4/28/25 at 11:29 PM,					
		388 had been confused and					
	wandering on the u	nit.					
		ted 4/30/25 at 5:30 AM,					
		388 was very confused and					
		lown the hallway asking to go ident 388 indicated they					
	^	police because they didn't					
	belong there.	office because they didn't					
	belong mere.						
	A progress note. da	ted 5/1/25 at 3:53 AM.					
	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,						
		388 had been wandering in the					
	hall attempting to e	nter other residents' rooms.					
	A mma amaza	tod 5/5/05 at 6:54 AM					
		ted 5/5/25 at 6:54 AM,					
	indicated Resident 388 had been confused,						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
155335			B. WING		05/09/2025	
	NAME OF PROVIDER OR SUPPLIER OSSIAN HEALTH CARE AND REHABILITATION CENTER			T ADDRESS, CITY, STATE, ZIP COD DAVIS RD AN, IN 46777		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
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TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE	
	wandering in the ha	all and indicated they were				
	looking for a way to	o call the police.				
		ted 5/5/25 at 11:54 PM, 388 had been wandering on the ir daughter.				
	A progress note, da	ted 5/6/25 at 5:18 PM,				
		388 had been confused at				
	times. The resident	had walked out of their room				
	looking for the bath	room.				
	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				
	· · · · · · · · · · · · · · · · · · ·	N) 35 indicated elopement				
	assessments were co	ompleted upon admission,				
	quarterly and as nee	eded.				
	of Nursing (DON) i wandered when loo blindness. The DON not scored as an elo The DON indicated attempted to leave t	5/9/25 at 9:53 AM, the Director indicated Resident 388 king for the bathroom due to N indicated Resident 388 had openent risk upon admission. If the resident had never the facility. The DON indicated the made aware of possible				
	behavior risks on ea	ach resident's individual				
	Kardex. The DON i	indicated on 5/8/25, Resident				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/09/2025		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, IN 46777				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F 0699 SS=D	wandering at night. 388's Care Plan had resident had made s The DON indicated resident's Care Plan include wandering. evaluation should h resident had been of looking for their far A current facility po Wandering Resident by the DON on 5/8/facility would ident The policy indicated the resident's care p	olicy, titled "Elopements and tts," dated 11/1/23, provided 25 at 10:34 AM, indicated the ify and assess elopement risk. If the risks would be added to lan. The policy indicated the nunicated to the appropriate					
Bldg. 00	failed to ensure trau implemented for 1 c (Resident 53)  Findings include:  Resident 53's record 10:46 AM. The recoincluded major depostress disorder (PTS)  Resident 53's care p	diew and interview the facility ma informed care was of 2 residents reviewed.  I review began on 05/05/25 at ord indicated diagnosis ressive disorder, past traumatic dib), and anxiety disorder.  Ilan had a problem related to enced by angry outbursts,	F 0699	-F699-D This plan of correction is prepand executed because it is required by the provisions of and federal law and not because of the content of the conten	state use tion tions ealth  y or alth or		

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Facility ID: 000228

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PRINTED: 05/28/2025 FORM APPROVED

STATEMENT OF DEPICINES AND PLAN OF CORRECTION DESTIFICATION NUMBER 155335  NAME OF PROVIDER OR SUPPLIER  OSSIAN HEALTH CARE AND REHABILITATION CENTER  OSSIAN IN 46777  OSSIAN, IN 46777  ORPORTING AND ASSOCIATE STATES, CITY, STATE, ZIP COD 215 DAVIS RD  OSSIAN, IN 46777  ORPORTING AND ASSOCIATE STATES, CITY, STATE, ZIP COD 215 DAVIS RD  OSSIAN, IN 46777  OAT. As consideration of the survey review of the plan of correction. DATE  OAT. As consideration of the survey 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 diagnosis. The resident trauma trigger binder will be located at nurses' station with information on interventions and how to prevent trauma response when carring for our res	CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER  OSSIAN HEALTH CARE AND REHABILITATION CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCY  PRETIX  (X5) ID  SUMMARY STATEMENT OF DEFICIENCY MISS HE PRECEDED BY FILL  TAG  REGIOLATION YOU SEE DIPATIFINATION NOTOMATION  TAG  REGIONAL YOUR ALL THE TAGE  TAG  REGIONAL YOUR CORRECTION  TAG  REGIONAL YOU CORRECTION  TAG  REGIONAL YOUR CARGESTERMENCED TO THE APPROPRIANT  (X5)  COMPLETION  DATE  REGIONAL YOUR CARGESTERMENCED TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCED TO THE APPROPRIANT  REGIONAL YOUR CARGESTERMENCED TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCE TO THE APPROPRIANT  TAG  REGIONAL YOUR CARGESTERMENCE T	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, HEALTH CARE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCE (EACH DEPICIENCY MUST BE PRECEDED BY PULL TAG  anxiety, changes in skepting 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 Finourage Resident 53 to participate in activities of my choice. 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 tratuma to avoid re-traumatization. There were no triggers listed. There was no mention of Resident 53's original tratuma 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 ITSD on her hallway (200 hall), CNA 2 vas only aware Resident 45 required a calm approach.  In an interview, on 05/07/25 at 11:20AM, 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 diagnossis of PTSD. She was	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			LETED	
OSSIAN HEALTH CARE AND REHABILITATION CENTER  OSSIAN, HEALTH CARE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  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 11:234 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 adiagnosis of PTSD. She was able to determine after looking in the record; Resident 53 had adiagnosis of PTSD. She was			155335	B. W	ING		05/09	/2025	
OSSIAN HEALTH CARE AND REHABILITATION CENTER  OSSIAN, IN 46777  SUMMARY STATEMENT OF DEFICIENCIE PRETIX TAG  SUMMARY STATEMENT OF DEFICIENCIE PRETIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  and refusing care.  The goal of Resident 53's care plan was I will not display angry outhurst or sadness through the next review. The interventions listed were as follows:  Deficiency of Provide Resident 53 time to express my feelings.  Deficiency of Provide Resident 53 time to talk to social services.  Deficiency of Resident 53's care plan was I will not display angry outhurst or sadness through the next review. The interventions listed were as follows:  Deficiency of Resident 53's care plan was I will not display angry outhurst or sadness through the next review. The interventions listed were as follows:  Deficiency of Resident 53's care plan was I will not display angry outhurst or sadness through the next review. The interventions listed were as follows:  Deficiency of Resident for the Appendiculate Completion 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 with a trauma diagnosis. The resident 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 day. Staff have been educated on triggers and appropriate interventions for each resident with a trauma day. Staff have been educated on triggers and appropriate interventions for each resident with a trauma day. Staff have been educated on triggers and appropriate interventions for each resident with a trauma day. Staff have been educated on triggers and appropriate interventions for each resident with a trauma day and the potential to affect any residents with a trauma day. Staff have been educated on triggers and appropriate interventions for each resident with a trauma day and the potential trauma of the potentia		DD OLUBED OF STATE	<u> </u>		STREET .	ADDRESS, CITY, STATE, ZIP COD			
OX4 ID  SEMMARY STATEMENT OF DEFICIENCIE  PREFIX  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  anxiety, changes in sleeping patterns, depression, emotional swings, history of past traumatic events and critisting 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 talk to social services. o Provide Resident 53 time to talk to social services. 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 TSD or any triggers to be aware of with any of her residents, Sub was able to determine after looking in the record; Resident 53 had a diagnosis of PTSD. She was	NAME OF I	PROVIDER OR SUPPLIE	R		215 DA	VIS RD			
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  Analyse, hanges 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 on hap 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	OSSIAN	HEALTH CARE AN	ND REHABILITATION CENTER		OSSIA	N, IN 46777			
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Resident 53 had a diagnosis of PTSD. She was			-						
unable to indicate any triggers approaches or									
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									

FORM CMS-2567(02-99) Previous Versions Obsolete

nature or what needed to be avoided implemented

to ensure no re-traumatization occurred.

Event ID:

08RD11

Facility ID: 000228

If continuation sheet

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

PRINTED: 05/28/2025 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155335		A. BUILDING  B. WING	00	COMPLETED 05/09/2025		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, IN 46777				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Services Director in 53's care plan on 5/7. Social Services Director any specific triggers interview. The Social Resident 53 became had outbursts. She was triggers or what occ symptoms of Resident 53's triggers or what occ symptoms of Resident 53's at 12:10P procedure titled "Triggers at 12:10P procedure titled "Triggers which are revised by the Administrato the policy of this fact services whichadd survivors by minima re-traumatization Compliance Guidelit triggers which may history of trauma. The will identify ways to exposure to triggers resident, as well as indecrease the effect of the social services which exposure to triggers resident, as well as indecrease the effect of the social services of triggers resident, as well as indecrease the effect of the social services of the socia	PM, a current policy and auma Informed Care" dated on date of 3/4/25, was provided or. The policy indicated; "It is cility to provide care and dress the needs of trauma alizing triggers and Policy Explanation and ines: 6. The facility will identify re-traumatize residents with a trigger specific interventions of decrease the resident's which re-traumatize the identify ways to mitigate or of the trigger on the resident, of the resident's care plan					
R 0000							
Bldg. 00	Survey. This visit in State Licensure Sur	State Residential Licensure acluded a Recertification and vey.  5, 6, 7, 8, and 9, 2025.	R 0000	This plan of correction is prepared executed because it is required by the provisions of sand federal law and not because ossian Health and Rehabilitat Center agrees with the allegat	tate lse ion		

State Form Event ID: 08RD11 Facility ID: 000228 If continuation sheet Page 7 of 9

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

PRINTED: 05/28/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/09/2025	
	ROVIDER OR SUPPLIER HEALTH CARE AN	D REHABILITATION CENTER	215	EET ADDRESS, CITY, STATE, ZIP COD 5 DAVIS RD SIAN, IN 46777	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
	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 He and Rehabilitation Center maintains that the alleged deficiencies do not individuall collectively jeopardize the hea and safety of our residents, ne are they of such character to our capability to render adequate. As consideration of the survey results the facility respectfully request paper revof the plan of correction.	y or alth or limit uate
R 0356 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -				
)	failed to ensure updemergency file bool (Resident 2, Resident Resident 6, Resident 9, Resident 9, Resident 2, Resident 2, Resident 2, Resident 3, Resident 3, Resident 3, Resident 4, Resi	the emergency file book on 8 resident sdid not have a listed on their emergency file: ency file, dated 4/16/25, did not erence listed.  ency file, dated 4/11/25, did not erence listed.  ency file, dated 11/6/24, did not erence listed.  ency file, dated 11/6/24, did not erence listed.	R 0356	-R356 This plan of correction is prepand executed because it is required by the provisions of and federal law and not because of the plan of correction.  Center agrees with the allegal and citations listed. Ossian Health and Rehabilitation Center maintains that the alleged deficiencies do not individuall collectively jeopardize the health and safety of our residents, not are they of such character to our capability to render adequate. As consideration of the survey results the facility respectfully request paper revort the plan of correction.  The face sheets in the emergication because in the emergication of the plan of correction.	state use tion tions ealth  y or alth or limit uate  view  ency with

State Form Event ID: 08RD11 Facility ID: 000228 If continuation sheet Page 8 of 9

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

PRINTED: 05/28/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
155335		B. WING 05/09/2025			2025		
NAME OF PROVIDER OR SUPPLIER OSSIAN HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, IN 46777				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETIO	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ency file, dated 1/24/25, did not			want to decide what hospital to	•	
	have a hospital pref	Perence listed.			to in the event of an emergend	у	
					will also have a (other-please	call	
	_	ency file, dated 1/21/25, did not			family for hospital preference)		
	have a hospital pref	Ference listed.			option added. This practice ha	d	
					the potential to effect 8 out of 3	36	
	Resident 8's emerge	ency file, dated 1/21/25, did not			residents. The AL charge nurse		
	have a hospital pref	Ference listed.			and admissions department will be		
				educated on adding the hospital			
	In an interview, on	5/8/25 at 10:20 AM, the		preference to the face sheet at			
	Administrator indic	ated the facility form does not			admission and quarterly during		
	have anywhere to a	dd the hospital preference.			service care plans. The AL cha	arge	
	Corporate has to give	ve the Fcility access to add the			nurse or HFA will audit all		
	hospital preference.				admissions hospital preference	e's	
					monthly for 6 months.		
	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 lawThe Electronic						
	Medical Records Coordinator (EMRC) will have a						
	binder placed at each	ch nurse's stationThe EMRC					
	will audit and update	te the resident's information in					
	the binder annually	or as needed"					

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