STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING -- B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/03/25 Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650 At this Emergency Preparedness survey, Ossian Health Care and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 100 and had a census of 83 at the time of this survey. Quality Review completed on 06/09/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/25 Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650 At this Life Safety Code survey, Ossian Health Care and Rehabilitation Center was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tomi Cobb	HFA	06/24/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). This one-story facility is made up of four buildings. (Bldg 1) original facility, (Bldg 2) dining and lounge, (Bldg 3) Kitchen addition, and (Bldg 4) rehabilitation addition. Building One 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, areas open to the corridor, and in the resident rooms. The facility was surveyed with Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 100 and had a census of 83 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two sheds used for maintenance storage. Quality Review completed on 06/09/25			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing #1.) Based on record review and interview, the facility failed to conduct the required testing for 1 of 1 dry sprinkler systems. NFPA 25 section 13.4.4.2.2.2 states every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 13.4.4.2.9 states dry pipe systems shall be tested once every 3 years for air leakage, using one of the following test methods:	K 0353	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	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(1) A pressure test at 40 psi (3.2 bar) shall be performed for 2 hours. (a) The system shall be permitted to lose up to 3 psi (0.2 bar) during the duration of the test. (b) Air leaks shall be addressed if the system loses more than 3 psi (0.2 bar) during this test. (2) With the system at normal system pressure, the air source (compressor or shop air) shall be shut off for 4 hours. If the low air pressure alarm goes off within this period, the air leaks shall be addressed. #2.) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments In Building One. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. The deficient practices could affect all residents, staff, and visitors in Building One. Findings include: #1.) Based on records review with the Maintenance Director and Administrator on 06/03/25 at 11:00 a.m., the dry sprinkler system 3-year air leakage test for Buildings One and Two was past due. The sprinkler inspection documentation shows the last air leak test was conducted on 01/03/22. Based on an interview at 11:00 a.m., the Maintenance Director stated the air leak test was past due. #2.) Based on observation with the Administrator and the Maintenance Director on 06/03/25 at 12:30		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. #2 Facility repaired small hole in the ceiling of riser room using fire caulk to ensure ceiling construction is maintained. This deficiency happened in the past and is already corrected. Maintenance personnel were educated on using fire caulk on any openings or penetrations in our smoke barriers. HFA and maintenance director will survey fire barriers monthly for 6 months and review in QAPI to ensure compliance. Date of compliance June 20, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., in the sprinkler riser room there was an 8x12 inch hole in the ceiling around a sprinkler supply line. This condition could delay the activation of the sprinklers installed in the ceiling. Based on an interview at 12:30 p.m., the Maintenance Director agreed there was an 8x12 inch hole in the ceiling. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observations, records review, and interviews, the facility failed to ensure 2 of 5 smoke barrier walls in Building One were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice affects all residents in Building One. Findings include: Based on observation with the Administrator and the Maintenance Director on 06/03/25 at 1:30 p.m. and 1:35 p.m., around pipes above the ceiling tiles	K 0372	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. Facility replaced gray caulk with red fire caulk. This deficiency happened in the past and is already corrected. Maintenance personnel were educated on using fire caulk on any openings or	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the100-hall and 200-hall smoke barrier walls, penetrations were sealed with grey caulk. Based on records review at 1:47 p.m., there was no documentation to show if the grey caulk meets ASTM E 814. Based on interviews at 1:30 p.m. and 1:47 p.m., the Maintenance Director agreed that penetrations were sealed with grey caulk and stated the listing of the caulk was unknown. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)		penetrations in our smoke barriers. HFA and maintenance director will survey fire barriers monthly for 6 months and review in QAPI to ensure compliance. Date of compliance June 20, 2025.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observations, records review, and interviews, the facility failed to ensure the annual inspection and testing of 1 of 1 oxygen room fire doors were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door	K 0761	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. Maintenance director relabeled all doors with fire rating and created a map of all locations of fire doors. Maintenance director also	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

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	assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 25 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and the Administrator on 06/03/25 at 12:11 p.m., the oxygen transfilling room door was rated as a 45-minute fire door. Based on records review at 11:04 p.m., the documentation of the		inspected all fire doors and documented for our updated annual inspections. IDT will review fire door audits 2x a year in QAPI to ensure all doors are labeled and inspected properly. Date of compliance June 20, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 01 B. WING	06/03/2025

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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	annual fire door inspections listed seven cross-corridor fire door assemblies in Building One were inspected, but the oxygen-transfilling room fire door was not listed as inspected. Based on an interview at 12:11 p.m., the Maintenance Director stated the oxygen-transfilling room fire door was not inspected. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/25 Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650 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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). This one-story facility is made up of four buildings. (Bldg 1) original facility, (Bldg 2) dining and lounge, (Bldg 3) Kitchen addition, and (Bldg 4) rehabilitation addition.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 02 B. WING	06/03/2025

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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	Building Two 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 was surveyed with Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 100 and had a census of 83 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two sheds used for maintenance storage. Quality Review completed on 06/09/25			
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to conduct the required testing for 1 of 1 dry sprinkler systems. NFPA 25 section 13.4.4.2.2.2 states every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 13.4.4.2.9 states dry pipe systems shall be tested once every 3 years for air leakage, using one of the following test methods: (1) A pressure test at 40 psi (3.2 bar) shall be performed for 2 hours. (a) The system shall be permitted to lose up to 3 psi (0.2 bar) during the duration of the test. (b) Air leaks shall be addressed if the system loses more than 3 psi (0.2 bar) during this test. (2) With the system at normal system pressure, the air source (compressor or shop air) shall be shut off for 4 hours. If the low air pressure alarm goes off within this period, the air leaks shall be	K 0353	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. #2 Facility repaired small hole in the ceiling of riser room using fire	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 02 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	addressed. This deficient practice could affect all residents, staff, and visitors in Building Two. Findings include: Based on records review with the Maintenance Director and Administrator on 06/03/25 at 11:00 a.m., the dry sprinkler system 3-year air leakage test for Buildings One and Two was past due. The sprinkler inspection documentation shows the last air leak test was conducted on 01/03/22. Based on an interview at 11:00 a.m., the Maintenance Director stated the air leak test was past due. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)		caulk to ensure ceiling construction is maintained. This deficiency happened in the past and is already corrected. Maintenance personnel were educated on using fire caulk on any openings or penetrations in our smoke barriers. HFA and maintenance director will survey fire barriers monthly for 6 months and review in QAPI to ensure compliance. Date of compliance June 20, 2025.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/25 Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650 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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 03 B. WING	06/03/2025

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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	Life Safety Code (LSC). This one-story facility is made up of four buildings. (Bldg 1) original facility, (Bldg 2) dining and lounge, (Bldg 3) Kitchen addition, and (Bldg 4) rehabilitation addition. Building Three was determined to be of Type V (111) 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 was surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 100 and had a census of 83 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two sheds used for maintenance storage. Quality Review completed on 06/09/25			
K 0761 SS=F Bldg. 03	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observations, records review, and interviews, the facility failed to ensure the annual inspection and testing of 4 of 5 fire doors in the separation fire barrier between Building Three and Assisted Living were completed in accordance of LSC 18.1.1.4.1.1 Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware,	K 0761	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	06/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 03 B. WING	06/03/2025

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	including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all Staff in		care. As consideration of the survey results the facility respectfully request paper review of the plan of correction. Maintenance director relabeled all doors with fire rating and created a map of all locations of fire doors. Maintenance director also inspected all fire doors and documented for our updated annual inspections. IDT will review fire door audits 2x a year in QAPI to ensure all doors are labeled and inspected properly. Date of compliance June 20, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 03 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Building Three. Findings include: Based on observations with the Maintenance Director and the Administrator on 06/03/25 at 12:21 p.m., the five fire doors in the separation fire barrier between Building Three and Assisted Living were rated as 45-minute fire doors. There was one set of cross-corridor fire doors that were inspected, but there were four other fire doors in the wall to facility rooms that were not inspected. Based on records review at 11:04 p.m., the documentation of the annual fire door inspections only listed the cross-corridor fire door assembly for Building Three, but the other four fire doors were not listed as inspected. Based on an interview at 12:11 p.m., the Maintenance Director stated the other four fire doors in the fire wall of Building Three were not inspected. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference at 2:00 p.m. 3.1-19(b)			
K 0000 Bldg. 04	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/25 Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 04 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). This one-story facility is made up of four buildings. (Bldg 1) original facility, (Bldg 2) dining and lounge, (Bldg 3) Kitchen addition, and (Bldg 4) rehabilitation addition. Building Four was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor, and in the resident rooms. The facility was surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility has a capacity of 100 and had a census of 83 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two sheds used for maintenance storage. Quality Review completed on 06/09/25			