STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/03/2025	
	PROVIDER OR SUPPLIE HEALTH CARE AI	R ND REHABILITATION CENTER	215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, IN 46777	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, and the second	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
E 0000	REGUENTORT	K ESC IDENTIF TING IN ORIMITION	1710		DATE
Bldg	conducted by the I accordance with 42		E 0000		
	Facility Number: 06/0 Provider Number: AIM Number: 100	000228 155335			
	Health Care and R in compliance with Requirements for Participating Provides 483.73. The facilit census of 83 at the	Preparedness survey, Ossian ehabilitation Center was found a Emergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR y has a capacity of 100 and had a time of this survey.			
K 0000					
Bldg. 01	Licensure Survey Department of Hea 483.90(a).  Survey Date: 06/0  Facility Number: 06/0  Provider Number: AIM Number: 100  At this Life Safety Care and Rehability	000228 155335	K 0000		
	Compliance with N	oquitoniono for farticipation in			
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
Tomi Cobl	0		HFA		06/24/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 08RD21 Facility ID: 000228 If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/03/2025	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, IN 46777	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fi	, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, .SC).			
	buildings. (Bldg 1)	ity is made up of four original facility, (Bldg 2) dining ) Kitchen addition, and (Bldg dition.			
	(000) construction a facility has a fire ala detection in the corr corridor, and in the was surveyed with 0 Care Occupancies a	determined to be of Type V and was fully sprinklered. The arm system with smoke ridors, areas open to the resident rooms. The facility Chapter 19, Existing Health and 410 IAC 16.2. The facility of and had a census of 83 at rey.			
	access were sprinkle	residents have customary ered. All areas providing re sprinklered, except two ttenance storage.			
K 0353 SS=F Bldg. 01	NFPA 101	npleted on 06/09/25 - Maintenance and Testing			
	facility failed to cor of 1 dry sprinkler sy 13.4.4.2.2.2 states e system is altered, th tested with the cont quick-opening device 13.4.4.2.9 states dry	d review and interview, the aduct the required testing for 1 ystems. NFPA 25 section every 3 years and whenever the dry pipe valve shall be trip rol valve fully open and the cee, if provided, in service. To pipe systems shall be tested for air leakage, using one of methods:	K 0353	This plan of correction is prep and executed because it is required by the provisions of s and federal law and not becau Ossian Health and Rehabilitat Center agrees with the allegat and citations listed. Ossian Health and Rehabilitation Center maintains that the alleged deficiencies do not individually	state use cion tions ealth

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

Event ID:

08RD21

Facility ID: 000228

If continuation sheet

Page 2 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155335	B. W	ING		06/03/	2025
		<u> </u>		CTREET (	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIEF	3		215 DA	ADDRESS, CITY, STATE, ZIP COD		
OCCIAN	LIEALTH CADE AN	ID DELIABILITATION CENTED					
USSIAN	TEALTH CAKE AN	ID REHABILITATION CENTER		USSIAI	N, 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1) A pressure test a	at 40 psi (3.2 bar) shall be			collectively jeopardize the hea	lth	
	performed for 2 hou	urs.			and safety of our residents, no		
	(a) The system shall be permitted to lose up to 3				are they of such character to l		
	psi (0.2 bar) during	the duration of the test.			our capability to render adequ		
	(b) Air leaks shall b	be addressed if the system			care. As consideration of the		
	loses more than 3 p	si (0.2 bar) during this test.			survey results the facility		
	(2) With the system	at normal system pressure,			respectfully request paper revi	iew	
		pressor or shop air) shall be			of the plan of correction.		
	shut off for 4 hours	. If the low air pressure alarm			#2 Facility repaired small hole	in	
	goes off within this	period, the air leaks shall be			the ceiling of riser room using		
	addressed.				caulk to ensure ceiling		
					construction is maintained. Th	is	
	#2.) Based on observation and interview, the				deficiency happened in the pa	st	
	facility failed to ma	intain the ceiling construction			and is already corrected.		
	in 1 of 6 smoke con	npartments In Building One.			Maintenance personnel were		
	The ceiling traps ho	ot air and gases around the			educated on using fire caulk o	n	
	sprinkler and cause	s the sprinkler to operate at a			any openings or penetrations	in	
	specified temperatu	re. NFPA 13, 2010 edition,			our smoke barriers. HFA and		
	8.5.4.1.1 states the	distance between the sprinkler			maintenance director will surv	ey	
	deflector and the ce	eiling above shall be selected			fire barriers monthly for 6 mon	ths	
	based on the type o	f sprinkler and the type of			and review in QAPI to ensure		
	construction.				compliance. Date of complian	ce	
					June 20, 2025.		
	The deficient practi	ices could affect all residents,					
	staff, and visitors in	n Building One.					
	Findings include:						
	#1.) Based on recor	rds review with the					
	Maintenance Direct	tor and Administrator on					
		.m., the dry sprinkler system					
		est for Buildings One and Two					
	was past due. The sprinkler inspection						
	documentation show	ws the last air leak test was					
	conducted on 01/03/22. Based on an interview at						
	11:00 a.m., the Mai	intenance Director stated the air					
	leak test was past due.						
	·						
	#2.) Based on obser	rvation with the Administrator					
	and the Maintenance	ce Director on 06/03/25 at 12:30					

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

Event ID:

08RD21 Facility ID: 000228

If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	
		155335	B. WI	NG		06/03/	/2025
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0372 SS=E Bldg. 01	inch hole in the ceil line. This condition the sprinklers instal interview at 12:30 pagreed there was an This finding was re and the Maintenanc conference at 2:00 p 3.1-19(b)  NFPA 101  Subdivision of Buil Barrie  Based on observation interviews, the facil smoke barrier walls constructed to requiauthority having jurn states the fire resists and building assemble accordance with test E 119, Standard Test Building Constructed to F Construction and Momethods; or analytic AHJ. The AHJ requiparriers to be sealed device tested in accordance on the sealed device tested in accordance of the sealed device tested in accordance on the sealed device tested in accordance of the sealed device tested in acco	er riser room there was an 8x12 ling around a sprinkler supply could delay the activation of led in the ceiling. Based on an o.m., the Maintenance Director 8x12 inch hole in the ceiling.  viewed with the Administrator be Director during the exit p.m.  filding Spaces - Smoke  ons, records review, and lity failed to ensure 2 of 5 in Building One were irements according to the risdiction (AHJ). LSC 8.2.3.1 ance of structural elements blies shall be determined in strength for the procedure set forth in ASTM and Materials, or ANSI/UL ire Tests of Building Interials; other approved test cal methods approved by the ures penetrations in smoke d with a firestop system or ordance with ASTM E 814. ice affects all residents in	K 0:	372	This plan of correction is prepared executed because it is required by the provisions of sand federal law and not because it is and federal law and not because it is required by the provisions of sand federal law and not because of the sand federal law and Rehabilitation Center agrees with the allegate and citations listed. Ossian Heand Rehabilitation Center maintains that the alleged deficiencies do not individually collectively jeopardize the heand safety of our residents, not are they of such character to lour capability to render adequicare. As consideration of the survey results the facility respectfully request paper reviof the plan of correction.  Facility replaced gray caulk wered fire caulk. This deficiency happened in the past and is already corrected. Maintenance.	state use ion tions ealth  or imit ate  iew	06/20/2025
		on with the Administrator and frector on 06/03/25 at 1:30 p.m.			already corrected. Maintenand		

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

and 1:35 p.m., around pipes above the ceiling tiles

Event ID:

08RD21

Facility ID: 000228

If continuation sheet Page 4 of 13

fire caulk on any openings or

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		f 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155335	A. BU B. W		01	COMPLETED 06/03/2025	
		155555	D. W.			00/03/	2023
NAME OF P	ROVIDER OR SUPPLIER			215 DA	ADDRESS, CITY, STATE, ZIP COD		
OSSIAN	HEALTH CARE AN	D REHABILITATION CENTER			N, IN 46777		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION 200-hall smoke barrier walls,		TAG	penetrations in our smoke		DATE
		ealed with grey caulk. Based			barriers. HFA and maintenand	e:	
	on records review a	t 1:47 p.m., there was no			director will survey fire barriers	\$	
		now if the grey caulk meets			monthly for 6 months and revi		
	ASTM E 814. Based on interviews at 1:30 p.m. and				QAPI to ensure compliance. D	ate	
	1:47 p.m., the Maintenance Director agreed that				of compliance June 20, 2025.		
	penetrations were sealed with grey caulk and stated the listing of the caulk was unknown.						
	stated the fisting of	the cauk 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)						
K 0761	NFPA 101						
SS=E Bldg. 01	_	pection & Testing - Doors					
g	Based on observation	ons, records review, and	K 0	761	This plan of correction is prepared	ared	06/20/2025
	interviews, the facil	ity failed to ensure the annual			and executed because it is		
	_	ng of 1 of 1 oxygen room fire			required by the provisions of s	tate	
	_	ed in accordance of LSC			and federal law and not becau		
		inicating openings in dividing			Ossian Health and Rehabilitat		
	-	d by 19.1.1.4.1 shall be protected			Center agrees with the allegat		
		osing fire door assemblies.			and citations listed. Ossian He and Rehabilitation Center	aitti	
		3.) LSC 8.3.3.1 Openings			maintains that the alleged		
		ire protection rating by Table			deficiencies do not individually	/ or	
	8.3.4.2 shall be prot	ected by approved, listed,			collectively jeopardize the hea	lth	
		semblies and fire window			and safety of our residents, no	r	
		r accompanying hardware,			are they of such character to I		
	_	s, closing devices, anchorage,			our capability to render adequ	ate	
		nce with the requirements of for Fire Doors and Other			care. As consideration of the		
	·	s, except as otherwise			survey results the facility respectfully request paper rev	iew	
		de. NFPA 80 5.2.1 states fire			of the plan of correction.	~ VV	
	-	all be inspected and tested not			Maintenance director relabele	d all	
less than annually, and a written record of the				doors with fire rating and crea			
	inspection shall be s	signed and kept for inspection			map of all locations of fire doo		
	by the AHJ. NFPA	80, 5.2.4.1 states fire door			Maintenance director also		

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

Event ID:

08RD21 Facility ID: 000228

If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	COMP	(X3) DATE SURVEY COMPLETED 06/03/2025	
NAME OI	F PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COI	)	
OSSIAI	N HEALTH CARE AN	ID REHABILITATION CENTER		AVIS RD AN, IN 46777		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPENCION (CONTROL OF THE APPENCION (CONTROL OF THE ACTION SHOWN CONTROL OF THE ACTION S	ULD BE PROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION visually inspected from both	TAG	inspected all fire doors a	nd	DATE
		overall condition of door		documented for our upda		
		0, 5.2.4.2 states as a minimum,		annual inspections. IDT		
	the following items			fire door audits 2x a year		
	(1) No open holes of	or breaks exist in surfaces of		to ensure all doors are la		
	either the door or fr			inspected properly. Date	of	
	, , o	light frames, and glazing beads		compliance June 20, 202	25.	
		rely fastened in place, if so				
	equipped.	1: 1 1 1				
		e, hinges, hardware, and				
		reshold are secured, aligned, er with no visible signs of				
	damage.	er with no visible signs of				
	(4) No parts are mis	ssing or broken.				
		s do not exceed clearances				
	listed in 4.8.4 and 6					
	(6) The self-closing	g device is operational; that is,				
	the active door com	pletely closes when operated				
	from the full open p	position.				
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	is installed, the inactive leaf				
	closes before the ac					
		are operates and secures the				
	door when it is in the	-				
	1 1	vare items that interfere or				
	frame.	are not installed on the door or				
		fications to the door assembly				
	' '	ed that void the label.				
	_	edge seals, where required, are				
		their presence and integrity.				
	This deficient pract	ice could affect 25 residents in				
	one smoke compart	tment.				
	Findings include:					
		ons with the Maintenance				
		dministrator on 06/03/25 at				
		gen transfilling room door was				
		e fire door. Based on records				
1	review at I I (I/4 n n	a the documentation of the	1	•		1

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

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155335			JILDING	nstruction 01	(X3) DATE COMPL <b>06/03</b> /	ETED	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, 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)	TE	(X5) COMPLETION DATE
	cross-corridor fire d One were inspected room fire door was on an interview at 1 Director stated the c door was not inspec	viewed with the Administrator e Director during the exit					
K 0000							
Bldg. 02			K 0	000			
	Provider Number: 1 AIM Number: 1002 At this Life Safety C Care and Rehabilita compliance with Re Medicare/Medicaid Life Safety from Fin	55335 66650 Code survey, Ossian Health tion Center was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101,					
	buildings. (Bldg 1)	ity is made up of four original facility, (Bldg 2) dining ) Kitchen addition, and (Bldg lition.					

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

Event ID:

08RD21

Facility ID: 000228

If continuation sheet Page 7 of 13

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 06/03/2025		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, 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)	ιΤΕ	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 02	(000) construction a facility has a fire ala detection in the correction. The facilit 19, Existing Health 16.2. The facility hence of 83 at the tensus of 83 at the te	residents have customary ered. All areas providing re sprinklered, except two tenance storage.  Inpleted on 06/09/25  Maintenance and Testing riew and interview, the facility required testing for 1 of 1 dry IFPA 25 section 13.4.4.2.2.2 and whenever the system is a valve shall be trip tested with ally open and the ree, if provided, in service. To pipe systems shall be tested for air leakage, using one of testhods: at 40 psi (3.2 bar) shall be	K 0.	353	This plan of correction is prep and executed because it is required by the provisions of s and federal law and not because it is required by the provisions of s and federal law and not because it is required by the provisions of s and federal law and Rehabilitation Center agrees with the allegat and citations listed. Ossian He and Rehabilitation Center maintains that the alleged deficiencies do not individually collectively jeopardize the hea and safety of our residents, no are they of such character to lour capability to render adequicare. As consideration of the survey results the facility respectfully request paper rev of the plan of correction.  #2 Facility repaired small hole the ceiling of riser room using	state use tion tions ealth  y or alth or imit eate	06/20/2025

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

Event ID:

08RD21

Facility ID: 000228

If continuation sheet Page 8 of 13

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY  COMPLETED  06/03/2025	
	PROVIDER OR SUPPLIER HEALTH CARE AN	D REHABILITATION CENTER	215 DA	ADDRESS, CITY, STATE, ZIP COD AVIS RD N, IN 46777	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	addressed. This defi residents, staff, and Findings include: Based on records re Director and Admir a.m., the dry sprink! test for Buildings O sprinkler inspection air leak test was cor an interview at 11:0 Director stated the a	existence of the second	TAG	caulk to ensure ceiling construction is maintained. T deficiency happened in the p and is already corrected.  Maintenance personnel were educated on using fire caulk any openings or penetrations our smoke barriers. HFA and maintenance director will surfire barriers monthly for 6 mo and review in QAPI to ensure compliance. Date of compliar June 20, 2025.	ast on s in vey nths
K 0000	3.1-19(b)				
Bldg. 03					
_	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 06/03  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety 0 Care and Rehabilita compliance with Re Medicare/Medicaid Life Safety from Fin	00228 55335	K 0000		

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

Event ID:

08RD21

Facility ID: 000228

If continuation sheet

Page 9 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING  03			(X3) DATE SURVEY COMPLETED		
12.21211		155335	B. WII			06/03/	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD 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	TE	COMPLETION
TAG	REGULATORY OR Life Safety Code (L	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	This one-story facil buildings. (Bldg 1) and lounge, (Bldg 3	ity is made up of four original facility, (Bldg 2) dining ) Kitchen addition, and (Bldg					
K 0761	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						
SS=F Bldg. 03	Based on observation interviews, the facilians inspection and testing separation fire barrich Assisted Living were LSC 18.1.1.4.1.1 Considered and the consideration of the facility of the facility approved self-closure (See also Section 8. required to have a facility of the facility of	ons, records review, and ity failed to ensure the annual and of 4 of 5 fire doors in the er between Building Three and re completed in accordance of communicating openings in s required by 18.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies.  3.) LSC 8.3.3.1 Openings in protection rating by Table rected by approved, listed, semblies and fire window accompanying hardware,	K 07	761	This plan of correction is prepared executed because it is required by the provisions of sand federal law and not because of the content of t	tate use ion ions ealth  or or lth or	06/20/2025

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

Event ID:

08RD21 Facility ID: 000228

If continuation sheet Page 10 of 13

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 06/03/2025		
	OF PROVIDER OR SUPPLIEI	R ID REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, IN 46777		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	including all frame and sills in accorda NFPA 80, Standard Opening Protective specified in this Codoor assemblies shall be sides than annually, inspection shall be by the AHJ. NFPA assemblies shall be sides to assess the cassembly. NFPA 80 the following items (1) No open holes of either the door or fi (2) Glazing, vision are intact and secur equipped. (3) The door, frame noncombustible thrand in working ord damage. (4) No parts are min (5) Door clearances listed in 4.8.4 and (6) The self-closing the active door comfrom the full open part (7) If a coordinator closes before the active door when it is in the (9) Auxiliary hardwards prohibit operation as frame. (10) No field modification of the self-closing and inspected to verify	s, closing devices, anchorage, nee with the requirements of a for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both overall condition of door 0, 5.2.4.2 states as a minimum, shall be verified: or breaks exist in surfaces of the same light frames, and glazing beads ely fastened in place, if so the special states of the same states of		IAU	care. As consideration of the survey results the facility respectfully request paper reviof the plan of correction.  Maintenance director relabeled doors with fire rating and creat map of all locations of fire door Maintenance director also inspected all fire doors and documented for our updated annual inspections. IDT will refire door audits 2x a year in Quito ensure all doors are labeled inspected properly. Date of compliance June 20, 2025.	d all ted a rs. view API	DATE

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

Event ID:

08RD21 Facility ID: 000228

If continuation sheet Page 11 of 13

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

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155335		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY COMPLETED 06/03/2025	
	PROVIDER OR SUPPLIE	R ND REHABILITATION CENTER		215 DA	ADDRESS, CITY, STATE, ZIP COD VIS RD N, IN 46777	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
TAG	REGULATORY OF Building Three.	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Director and the Ad 12:21 p.m., the five barrier between Bu Living were rated a was one set of cross inspected, but there the wall to facility Based on records redocumentation of to only listed the cross for Building Three were not listed as interview at 12:11 stated the other for Building Three we.	ons with the Maintenance diministrator on 06/03/25 at a fire doors in the separation fire ilding Three and Assisted as 45-minute fire doors. There is execution fire doors that were as were four other fire doors in the rooms that were not inspected. Eview at 11:04 p.m., the the annual fire door inspections is execution for door assembly that the other four fire doors in spected. Based on an inp.m., the Maintenance Director or fire doors in the fire wall of the not inspected.					
	conference at 2:00	p.m.					
	3.1-19(b)						
K 0000							
Bldg. 04	Licensure Survey v	00228 155335	K 000	00			

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

Event ID:

08RD21

Facility ID: 000228

If continuation sheet

Page 12 of 13

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

PRINTED: 06/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155335	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMP	(X3) DATE SURVEY COMPLETED 06/03/2025	
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	(EACH CORRECTIVE ACTION SE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 08RD21 Facility ID: 000228 If continuation sheet Page 13 of 13