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	10/17/2022

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/17/22 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 85 at the time of this survey. Quality Review completed on 10/21/22	E 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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction.	
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: 10/17/22 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	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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tomi	Cobb	11/02/2022

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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	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. Buildings one and two were 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 and 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 85 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 10/21/22		survey results of the facility, we respectfully request a paper desk review of the plan of correction.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the Laundry each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either	K 0355	K0355 Failed to inspect fire extinguisher in laundry room. This plan of correction is prepared and executed because it is	10/18/2022

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	manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the laundry room. Findings include: Based on observation during a tour of the facility with the Administrator and the Regional Maintenance Director on 10/17/22 at 12:15 p.m., the monthly inspection tag on the ABC fire		required by the provisions of State and Federal law and not because Ossian Health and Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction. Facility will create a checklist of locations of fire extinguishers in facility to ensure no extinguishers will be missed in monthly inspections. This deficient practice had the potential to affect the laundry room staff. Administrator will audit maintenance director's monthly inspections x 6 months.	

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	extinguisher located in the laundry lacked documentation of monthly inspections. Based on interview at the time of observation, the Administrator confirmed the extinguisher located in the laundry was missing the monthly visual inspections. The finding was reviewed with the Administrator and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 45 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on observation during a tour of the facility with the Administrator and the Regional Maintenance Director on 10/17/22 at 12:25 p.m. and 12:33 p.m., the corridor doors to resident rooms 219 and 116 did not latch into the frame when tested. Based on interview at the time of observation, the Administrator agreed the corridor doors to rooms 219 and 116 would not latch into the door frame. The finding was reviewed with the Administrator and the Regional Maintenance Director during the exit conference.	K 0363	K0363 Resident door did not latch closed-219 and 116 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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction. Facility will repair door latches to resident rooms 219 and 116. This deficiency has the potential to	10/21/2022

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	3.1-19(b)		affect 4 residents. Maintenance director will audit all 45 resident door frames monthly x6 months to ensure door latches are able to keep door closed.	
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: 10/17/22 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. Buildings three and four were 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 and surveyed with Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility has a	K 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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction.	

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	capacity of 100 and had a census of 85 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 10/21/22			
K 0131 SS=E Bldg. 04	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 2 occupancy separation fire barrier doors met the requirements of LSC 18.1.3.3(2) which states other occupancy are separated from areas of health care occupancies	K 0131	K0131 AL/SNF door did not latch into frame. This plan of correction is prepared and executed because it is	11/02/2022

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	by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. This deficient practice could affect 15 residents on the rehabilitation hall. Findings include: Based on observation during a tour of the facility with the Administrator and the Regional Maintenance Director on 10/17/22 at 12:20 p.m., the right door leaf of the fire barrier that separates health care from assisted living did not latch into the frame. Based on interview at the time of observation, the Regional Maintenance Director stated the fire door leaf did not latch into the frame due to there was no latch catch on the door frame. The finding was reviewed with the Administrator and the Regional Maintenance Director during the exit conference. 3.1-19(b)		required by the provisions of State and Federal law and not because Ossian Health and Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction. Facility has installed door latching hardware to ensure door is latched into frame. 15 residents on the rehabilitation hall could be affected by this deficiency. Maintenance will check/audit latch on fire doors monthly for 6 months.	
K 0324 SS=E Bldg. 04	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			

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	*cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include: Based on observation with the Administrator and the Regional Maintenance Director on 10/17/22 at	K 0324	K0324 Failed to show shut off location to stove in therapy gym. 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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction. Facility located shut off for therapy stove in the mechanical room located on 400 hallway of Assisted Living side. Therapy staff members along with facility department heads were educated on the location of shut off and that stove will need to be in the “off” position unless being used and supervised by staff therapy	10/18/2022

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	12:14 p.m., there was a cooktop in the therapy gym that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the Administrator and the Regional Maintenance Director stated it was unknown how to deactivate the cooktop from power. The finding was reviewed with the Administrator and the Regional Maintenance Director during the exit conference. 3.1-19(b)		member. A sign was also placed directly above stove with shut off information. This deficiency could have affected 5 residents in the therapy gym. Maintenance will audit all stoved in facility 1x week for 4 weeks and then monthly for 5 months.	
K 0920 SS=E Bldg. 04	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.			

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	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations with the Administrator and the Regional Maintenance Director on 10/17/22 at 12:15 p.m., a power strip was in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Administrator agreed a power strip was in use in a resident care area, did not meet 1363A or 60601-1, and removed the power strip. The finding was reviewed with the Administrator and the Regional Maintenance Director during the exit conference. 3.1-19(b)	K 0920	K0920 Power strip in therapy gym was not the required UL rating for patient care areas. 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 Rehab agrees with the allegations and citations listed. Ossian Health and Rehab 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 a consideration of the survey results of the facility, we respectfully request a paper desk review of the plan of correction. The facility will hold quarterly in servicing on appropriate power strips in patient care areas. Audits (angel rounds) will be conducted by departments heads weekly and audits and reporting will be added to housekeepers' checklists to ensure no further non-medical grade rated power strips are used in resident care areas. This deficient practice could have affected 5 residents that were in therapy gym. Managers and housekeeping staff will audit resident rooms weekly for 6	10/24/2022

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			months to ensure non-medical grade power strips are not used in resident care area.	