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 _____	C 02/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00424448, IN00424996, and IN00427102. Complaint IN00424448 - No deficiencies related to the allegations are cited. Complaint IN00424996 - No deficiencies related to the allegations are cited. Complaint IN00427102 - No deficiencies related to the allegations are cited. Survey date: February 1, and 2, 2024. Facility number: 000228 Provider number: 155335 AIM number: 100266650 Census Bed Type: SNF/NF: 85 Residential: 28 Total: 113 Census Payor Type: Medicare: 8 Medicaid: 60 Other: 45 Total: 113 Ossian Health Care and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00424448, IN00424996, and IN00427102. Quality review completed February 2, 2024	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.