STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00254981 and IN00256503. Complaint IN00254981 Substantiated no findings related to the allegations are cited. Complaint IN00256503 Unsubstantiated due to lack of evidence. Survey dates: March 22, 23, 26, 27, 28, and 29, 2018 Facility number: 000228 Provider number: 155335 AIM number: 100266650 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 8 Medicaid: 49 Other: 24 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 3, 2018.	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to ensure a care plan was revised for 1 out of 7 residents reviewed for care plan revisions. (Resident B) Findings included: A review of Resident B's clinical record on 3/28/18 at 10:30 a.m., indicated a BIMS (Brief Interview of Mental Status) 15, meaning cognitively intact. Diagnoses included, but were not limited to: pneumonia and depression.	F 0657	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 the residents, nor are they of such character so as	04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	Resident B's Behavior Sheet, dated 2/13/2018 at 16:57 (4:57 p.m.) indicated "... the resident had stated he would be better of {sic} dead..." and "...Will have psych see him next visit..." A Progress Note, dated 2/14/2018 at 16:56 (4:56 p.m.) indicated on 2/13/2018, Resident B stated to the Speech Therapist "...I'd be better of{sic} dead..." The SSD (Social Service Director) talked with the resident and he indicated he had no plans to harm himself. A Physician Progress Note, dated 2/14/2018 at 14:00 (2 p.m.) indicated "...Acute visit for statements of wanting to die..." Resident B had voiced concerns of not bouncing back, wishing he would die and be better off dead. Resident B had denied any plan to hurt himself. A review of Resident B's Care Plans for depression indicated no potential for negative statements of wanting to die. During an interview on 3/29/18 at 2:49 p.m., the SSD indicated the comment made by the resident about wanting to die was more of a depression statement and they would not have implemented anything on the Care Plan unless he had an actual plan. The Speech Therapist had reported it to her and that was why there was a documented progress note. During an interview on 3/29/18 at 3:12 p.m., the RNC (Regional Nurse Consultant) indicated they did not address the statement of wanting to die on the depression Care Plan because he meant no indication of actual harm. A form from CMS's (Centers for Medicare &		to limit our capability to render adequate care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction. Resident B's care plan has been updated. All residents have the potential to be affected by the alleged deficiency. Social Service Director will be in serviced on proper Care planning. DON/Licensed Designee will monitor behaviro sheets to ensure proper care planning if needed. This will be done every 2 weeks for 8 weeks then monthly for 4 months. This will then be monitored through QAPI until 100% compliance is achieved. Date of compliance: 4/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2017, "CAA Process and Care Planning", provided by the RNC on 3/29/2018 at 5:19 p.m., indicated "...Review and revise the current care plan, as needed..." and "...The overall care plan should be oriented towards: 5. Managing risk factors to the extent possible or indicating the limits of such interventions..." 3.1-35(c)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents were provided adequate supervision and/or had fall interventions in place for 2 of 6 residents reviewed with falls. (Resident 30, and Resident 41) Findings include: 1. On 3/28/18 at 10:00 a.m., the clinical record of Resident 30 was reviewed. Diagnoses included, but were not limited to, the following: generalized muscle weakness, cognitive communication deficit, unspecified dementia, repeated falls, anxiety disorder, restlessness, agitation and unspecified hallucinations.	F 0689	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 the residents, nor are they of such character so as to limit our capability to render adequate care. As a consideration of the survey results	04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	The significant change MDS (Minimum Data Set) assessment, dated 1/23/18, indicated the following: severely impaired cognition; transfer assistance (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position, excludes to/from bath/toilet) required extensive assistance (resident involved in activity, staff provide weight-bearing support) with 2 person physical assist; balance during transitions and walking related to moving from seated to standing position, walking, surface-to-surface transfer (transfer between bed and chair or wheelchair) indicated resident was not steady, and only able to stabilize with human assistance; had mobility devices (walker, wheelchair), and number of falls since admission with no injury was 2 or more; falls with injury (except major) - skin tears, abrasions, lacerations was 1. An admission Fall risk evaluation, completed on 11/28/17, indicated the resident had a fall risk score of 12. This score signified moderate fall risk. A plan of care with the focus of "I am at risk for falls related to personal history of falls, impaired balance, incontinence, vision impairment, extremely short attention span, hallucinations and Dx (diagnosis) dementia. I have been witnessed by staff to slide myself to the edge of my wheelchair, then lower myself to the floor" had an initial date of 11/28/17 and revision date of 2/16/18. The plan of care included the following interventions: "An anti-roll back device will be used to lock my wheelchair (wc) because I sometimes forget to lock the brakes (2/27/18)...I may choose to kneel crawl on the floor in search of my kitties (12/4/17)..."		the facility respectfully requests a paper review of the plan of correction. Resident #30 and #41 had anti-roll backs applied to their wheel chairs and #30 had bed and chair alarms re-applied. Alleged deficiency regarding supervision cannot be corrected as it occurred in the past. All residents have the potential to be affected by the alleged deficiencies. DON/licensed designee will conduct a weekly fall meeting to review all falls in the last week and implement appropriate interventions. All falls will be reviewed for 4 weeks to ensure interventions are in place and working properly. Staff on the Memory Care Unit will be in serviced that residents cannot be left unattended in the lounge area at any time. The Administrator will review meeting minutes monthly with the DON to ensure effectiveness. This will occur monthly for 6 months then followed through QAPI until 100% compliance is achieved. HFA/designee will do rounds daily to ensure someone is available on the Memory Care Unit lunge area to supervise the residents. This will be reviewed by the HFA/desingnee weekly for 2 months then monthly for 4 months then reviewed in QAPI monthly until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	A plan of care with the focus of "I need assistance with my ADLs (activities of daily living)...dementia", dated 12/6/17 included the following interventions: "...I am able to walk short distances, however, I need a wheelchair for long distances (12/6/17)...I need extensive assistance of (1-2) staff for walking (12/6/17)...I need extensive assistance of (1-2) staff for transfers (12-6-17)..." A Fall IDT note dated 12/27/17 at 4:24 p.m. indicated "...(Resident 31 name) had 2 falls on 12/26/17...was seen by CNA to be attempting to ambulate without assist and lost her balance and landed on her bottom...dementia is severe and she has virtually no short term memory. Does not benefit from reminders..." A Fall IDT note dated 1/10/18 at 2:41 p.m., indicated the following: "...resident was witnessed by CNA (certified nursing assistant) to stand up from her wheelchair and fall to the floor...small head laceration noted...Root cause of fall: Resident has BIMS (Brief Interview for Mental Status) of 01 (severe cognitive impairment), is unable to recall past a few seconds, and has no safety awareness..." A quarterly fall risk evaluation, competed on 1/22/18, indicated the resident had a fall risk score of 17 (high fall risk). The fall risk evaluation included, but was not limited to, the following: resident had intermittent confusion, 2 or more falls in 1 month, chair bound (and/or assist with elimination) and balance problem while standing. A progress note, dated 1/31/18 at 7:59 p.m. indicated "Resident attempted to stand up from wheelchair and lost her balance and fell to floor..." A progress note dated 2/7/18 at 10:16 a.m.,		Date of compliance: 4/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	indicated the following: "...resident stood from wheelchair and lost her balance, falling to the floor landing on her right side..." A Fall IDT note dated 2/22/18 at 5:53 p.m., indicated the following: "...two concurrent falls, first on 2/20/18...and second on 2/21/18 at 12;30 p.m., when resident was attempting to self transfer and missed chair landing on the floor..." A Fall IDT note dated 3/9/18 at 9:54 a.m., indicated the following: "...Resident was sitting in recliner in memory unit sitting room on 3/8/18, when she attempted to get out of the recliner and she fell to the floor, hitting her head...bump noted on right side on forehead...Root cause of fall: Resident has no safety awareness and very low cognition. She is not aware of the risk she takes when trying to self transfer due to same..." A progress note, dated 3/11/18 at 1:05 p.m., indicated the following: "...resident was found on floor in activity area, it appeared resident was attempting to self ambulate from chair to chair and fell to ground..." On 3/27/18 at 11:23 a.m., Resident 30 was observed in her wheelchair at table with Resident 41. Resident 30 was observed to be reaching for Resident 41's drinking glass and Resident 41 would move the glass out of reach of Resident 30. Resident 30 was then observed to stand, with a forward leaning posture at her waist, and began to attempt to walk towards Resident 41, hanging onto the back of Resident 41's chair. Resident 30 then sat back down in her wheelchair. CNA 6 was observed to have her back to the Resident 30 and no other staff was observed in the dining room at this time. At this time, CNA 13 and CNA 15 were observed to assist a resident who had gotten ill,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	back to her room. At 11:26 a.m., Resident 30 was observed to stand again from her wheelchair. The right side of Resident 30's wheelchair was parallel to the wall but was moving backwards as Resident 30 was observed to stand. The left side of Resident 30's wheelchair was observed to have the brake locked. At this time, CNA 6, who had her back to Resident and 30 was not observing Resident 30, was made aware the right side of her wheelchair was moving as Resident 30 stood. CNA 6 was interviewed and indicated she had locked both wheelchair brakes but Resident 30 "possibly (name of resident) had unlocked the one." The resident was assisted back to her wc by CNA 6, the right brake locked and was given her lunch tray. On 3/27/18 at 11:30 a.m., Resident 30 was again observed to again stand at the table and lean back towards the locked wc with her legs. At 11:38 a.m., Resident 30 was observed to again try to stand from her wheelchair but CNA 6 was now sitting beside the resident. On 3/27/18 at 3:50 p.m. the DON (Director of Nursing) provided a current copy of the "kardex report" for Resident 30. She indicated the kardex was what staff referred to regarding resident care. The kardex indicated the following: "...I am able to walk short distances, however, I need a wheelchair for long distances. I need physical assist to propel my wheelchair...I need extensive assistance of 1-2 for transfers and walking; safety: An anti-roll back device will be used to lock my wheelchair because I sometimes forget to lock the brakes..." On 3/27/18 at 4:03 p.m. the DON was requested to observed the resident in her wc in the locked dementia unit. The resident was observed to be standing in front of her wc. The DON indicated the resident did not have any antiroll back devices			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	(device attached to the wheelchair to prevent it from rolling backwards) on her wc at this time. The DON indicated she had put an order in the computer system today at 2:30 - 3:00 p.m. for anti roll back device to be applied to the resident's wheelchair. On 3/28/18 at 11:00 a.m. Resident 30 was observed at a dining room table, sitting in a standard dining room chair. The Activity Assistant 8 was observed to be standing beside the resident. Resident 30 was observed to repeatedly stand up out of the standard dining room and chair. Activity Assistant 8 repeatedly verbally directed the resident to sit down. The resident repeatedly stood up and sat down, despite instruction by Activity Assistant 8 to remain seated. LPN 14 was observed in the hall of the unit passing medications and was observed to occasionally come into the dining room to deliver medications. Activity Assistant 8 remained at Resident 30's side, instructing her to sit down repeatedly. On 3/28/18 at 11:04 a.m. LPN 14 was interviewed. She indicated CNA 15 was at lunch now and would be back in a minute. She indicated CNA 13 was also on the unit but was assisting other resident's at this time. On 3/28/18 at 11:06 a.m., Activity Assistant 8 continued to stand by Resident 30, reminding her to sit down and she continued to stand and sit out of the dining room chair. On 3/28/18 at 12:00 p.m., Activity Assistant 8 was observed to leave the dementia unit. At 12:01 p.m., CNA 15 and CNA 13 indicated a resident in the dining room needed to be put to bed immediately. Both CNA 13 and 15 were observed to assist a resident in a wheelchair out of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	dining room. At this time, there were no staff in the dining room. A family member was sitting at a table with their resident at this time and was the only other person in the dining room area, with residents other than the Indiana State Department of Health (ISDH) surveyor. At 12:01 p.m., Resident 30 began to stand up and sit down out of her standard dining room chair. The ISDH Surveyor stood behind the resident's chair so the dining room chair would not slid out from underneath the resident. The resident continued to stand up and sit down intermittently. At 12:03 p.m., CNA 13 and CNA 15 returned to the dining room and assisted Resident 30. On 3/29/18 at 8:45 a.m., the DON and Regional Nurse Consultant (RNC) were interviewed. They were made aware Resident 30 was observed to be given 1:1 observation and instruction by Activity Assistant 8 on 3/27/18 during the noon meal. They were also made aware Resident 30 had been left unattended, standing and sitting in a standard dining room chair on 3/28/18 from 12:01 p.m. to 12:03 p.m., with only a family member in attendance in the dining room and no additional facility staff. The RNC and DON indicated since 11/30/17, the resident had "been found on the floor" 19 times. They indicated not all the resident's "falls" were witnessed so they "claim them all as falls," even though she had been observed at times to intentionally go to the floor. They indicated the goal for this resident in regards to falls was to allow her to stand without getting hurt, not necessarily to keep her off the floor. The RNC indicated for the resident not to be on the floor was an unrealistic goal, as she has been observed to get on the floor and look for her kitties and this was care planned as such. The RNC indicated they always try to keep Resident 30 in the lounge area during the day so they can			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	keep an eye on her. The RNC indicated for Resident 30 not to fall was an unrealistic expectation. The RNC indicated being on the floor looking for her kitties was not unfamiliar to Resident 30. The DON indicated on 2/26/17, when the resident fell, she had put a requested in the computer system for anti roll back devices to be put on the resident's wc. She indicated when maintenance went to put the anti roll back devices on the wheelchair, the resident had anti tippers (device attached to wheelchair to prevent it from tipping over backwards) on the wc and the maintenance man mistook the anti tippers for the anti roll back devices, so he counted the request completed. The DON indicated the anti roll back devices were not put on the wc until 3/28/19. The DON indicated resident had not had any injuries from her falls. On 3/29/18 at 10:14 a.m. the RNC was interviewed. She indicated if the resident falls out of bed on her mat and doesn't get hurt, their care plan has worked. An anonymous family interview, indicated there were times in the dementia unit, when there was not adequate staff to supervise the residents in the dining room. The anonymous family member indicated there were times when the 1 or 2 staff would need to assist a resident and this would leave no one in the dining room to supervised those residents who were in the dining room. 2. On 3/27/18 at 2:30 p.m., the clinical record of Resident 41 was reviewed. Diagnoses included, but were not limited to, the following: delirium due to physiological condition, unspecified dementia and unspecified macular degeneration. The quarterly MDS assessment, dated 2/6/18			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	indicated the following: resident is severely cognitively impaired; bed mobility and transfer required extensive assistance with 2 person physical assist required; walking in room and corridor did not occur; locomotion on and off unit (self sufficiency in wheelchair) required 1 person physical assistance; balance: moving seated to standing and surface to surface transfer was not steady, only able to stabilize with human assistance. A plan of care, with a revision date of 8/8/17, addressed the problem of "I have impaired vision related to macular degeneration I am only able to see shapes and colors this can distress me at time (sic) but if you explain to me I have macular degeneration I will understand..." A plan of care, with a revision date of 8/11/17, addressed the problem of "I have the potential for falls related to: hx (history) falls, impaired balance, psychotropic med (medication) use, incontinence, vision and hearing deficit, dementia...Goal: I will comply with safety measures...Interventions: anti-roll backs on wheelchair (8/14/12)...wheelchair and bed alarms per family insistence (12/13/17)..." A progress note, dated 1/12/18 at 8:41 p.m., indicated 5:00 p.m. "...resident in bathroom...notified by resident roommate that she needed help...sitting on bathroom floor.." A Fall IDT (interdisciplinary team) note, dated 1/15/18 at 1:19 p.m., indicated the following: "...Resident found on floor in bathroom..." A Quarterly Fall Risk Evaluation, dated 2/5/18, indicated the resident had a fall risk score of 25, which indicated the resident was a "high fall risk." The assessment indicated the resident was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	disoriented all spheres, all of the time; 1-2 falls in past 3 months; chair bound - and/or assist with elimination; poor vision and required use of assistive devices (i.e. cane, walker, furniture). A progress note, dated 3/8/18 at 2:30 a.m., indicated the following: "..writer responded to call of "help me" coming from resident's room....observed to be sitting on her buttocks on the floor next to her bed, the locked wheelchair also next to her...Immediate intervention:...back to bed. Bed alarm on..." A Fall IDT related to the 3/8/18 2:30 a.m. fall, dated 3/9/18 at 9:54 a.m. indicated the following: "...Resident found sitting on floor beside bed at 0230 (2:30 a.m.) this a.m. Resident has dementia with a BIMS (Brief Interview for Mental Status) of 2. She has no safety awareness. She is unable to retain directive past a minute or two..." A progress note, dated 3/25/18 at 11:11 a.m., indicated the following: "...Resident found on floor in front of recliner with leg rest still elevated and alarm sounding. Bruising noted immediately to left cheek and face..." A Fall IDT note dated 3/26/18 at 2:33 p.m., indicated the following: "Resident found on floor in front of her recliner, alarm was sounding, resident exhibited immediate bruising to left side of face. LPN assessed resident...bruising to left side of face...Intervention and care place updated: dycem to seat of recliner..." A "Device Evaluation" form, dated 3/26/18 indicated the following: "...Device considered: chair alarm and bed alarm per family's insistence...Conclusion: Based on above evaluation, the device is used as a(n)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	"reminder/safety device..." On 03/27/18 at 8:38 AM Resident 41 was observed on the dementia unit, in a recliner in the TV/lounge/activity area. She was observed to have a black/purple/reddish bruised observed to her left eye, which began extending downward towards her left jaw. No alarm was observed on the resident and/or the recliner. On 3/27/18 at 10:05 a.m., CNA 15 was observed to put the foot of the recliner down for the resident and assisted the resident to sit upright in the recliner. On 3/27/18 at 10:35 a.m., Resident 41 remained in the recliner in an upright position. No staff were observed to be in the TV/lounge/activity area. CNA 15 was observed to be assisting other residents ambulating to the dining room tables to the adjacent dining room area. CNA 6 was observed in the dining room area. At 10:36 a.m., CNA 6 was observed to have pushed a resident to the other side of the area, the dining area, and left this resident out of direct vision. On 3/27/18 at 10:42 a.m., a nurse was behind the desk at the nurses station, working on the computer, which was on the opposite side of the room for the resident in the recliner. CNA 6 was observed pouring coffee for residents in the dining area was out of reach of Resident 41. On 3/27/18 at 10:52 a.m., LPN 18 was observed to leave the nurses station and the area where Resident 41 was sitting in her recliner. CNA 6 remained in the adjacent dining area and had her back to Resident 41. No staff was observed to be directly observing the resident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	On 3/27/18 at 10:59 a.m., CNA 13 and CNA 6 assisted Resident 41 up from the recliner. No alarm was observed and/or heard to sound from the recliner. No alarm was observed in the resident's wheelchair prior to her being placed in it. CNA 13 and CNA 6 were not observed to place and/or activate any type of alarm on the resident's wheelchair. On 3/27/18 at 11:55 a.m., CNA 15 was observed to take the resident back to her room in the wheelchair. CNA 15 was interviewed. She indicated she was waiting on assistance to transfer the resident from her wc to the toilet as the resident "had a fall the other day and she is weak." At 11:56 a.m., CNA 13 was observed to also assist the resident to the toilet. No alarm was observed on the resident and/or the wheelchair. No alarm sounded as the resident stood. At 11:58 a.m., the resident was assist back to the wc. At 11:59 a.m., CNA 15 and CNA 13 were observed to assist the resident to her bed. No alarm was observed to be in the bed and/or placed on the resident's bed at this time. No alarm was observed to have sounded. CNA 13 was observed to have left the room. CNA 15 was interviewed and indicated she had completed care for the resident. At 12:00 p.m., CNA 15 was interviewed. She indicated the resident was in bed and currently didn't have a bed alarm on. At this time, CNA 15 looked around the resident's room and found a wheelchair pressure alarm pad and a bed pressure alarm pad in a chair. CNA 16 indicated "Oh, someone made her bed this morning and forgot to put it back on her bed" as CNA 16 held the pad alarms. CNA 16 indicated Resident 30 used to have a pull tab alarm on when she was in her wheelchair. CNA 15 was observed to place a pressure alarm pad on the resident in bed at this time and also placed a pressure alarm pad in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	resident's wc. No anti-roll back device was observed to this resident's wheelchair at this time. On 3/27/18 at 3:45 p.m., the DON provided a current copy of the resident's "Kardex Report" which indicated the following: "...Safety: alarm bed (sic) and chair alarm per sons' request...anti roll backs on wheelchair..." On 3/28/18 at 4:55 p.m., the Regional Nurse Consultant provided a current copy of the facility policy and procedure for "Fall Investigation and Risk Evaluation" dated 9/2017. The policy include the following: "It is the policy of this facility to provide an environment that is free from accident hazards...and provide supervision and assisted devices to prevent avoidable accidents...All residents will have a care plan developed that includes...individualized interventions to decrease their risk of falls..."accident" refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident..."avoidable accident" means that an accident occurred because the facility failed to: identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement,et measures to reduce the hazards/risks as much as possible and/or implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan...to eliminate the risk, if possible, and, if not, reduce the risk of an accident...monitor the effectiveness of the interventions and modify the care plan as necessary..."unavoidable accident' means that an accident occurred despite sufficient ad comprehensive facility systems designed and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	implemented to: identify environmental hazards and individual resident risk of an accident, including the need for supervision...implement interventions, including adequate supervision, consistent with the resident's needs, goals, care plan...monitor the effectiveness of the interventions and modify the interventions as necessary..."Assistive Device" refers to any item...fixtures such as hand rails...that is used by or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety..."Fall" refers to unintentionally coming to rest on the ground, floor or other lower level...a fall without injury is still a fall..."supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident...adequate supervision may vary from resident to resident and from time to time for the same resident...after a fall...initiate a post fall investigation; update the care plan with new intervention in the fall care; the Interdisciplinary Team will review the fall and determine the root cause to the extent possible; Update the care plan with new intervention(s) as indicated..." On 3/29/18 8:35 a.m., the DON and Regional Director of Quality Assurance were interviewed. They indicated since the resident's plan of care indicated she was to have had an alarm in both her wheelchair and bed, she should have had these alarms in place. The DON and Jan were also made aware the resident was not observed to have antirollback devices on her wc and the plan of care indicated these were to be in place. They indicated in the last 6 months, the resident had falls on 3/25/18, 3/8/18, 1/12/18, 10/24/17 and 10/8/17. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were properly labeled and discarded when expired for 3 of 3 medication carts observed. This practice affected 8 residents whose medications were administered by the facility. (Resident 181, Resident 71, Resident 66, Resident 17, Resident 52, Resident 13, Resident 233 and Resident 69) Findings include:	F 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	04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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. O 3/28/18 at 12:18 p.m., the 300/North Hall medication cart was observed with Nurse 16. The following was observed: Resident 181's OTC (Over-the-Counter) Fluticasone Nasal Spray (a corticosteroid, used to treat symptoms of sneezing, stuffy, runny, itchy nose) was opened, the medication spray bottle was labeled with Resident 181's name and the physician's name, but was lacking an opened date. An interview with Nurse 16 indicated Resident 181's Fluticasone Nasal Spray was brought from home and was already opened and an open date was put on the nasal spray. Resident 71 had 2 opened bottles of Fluticasone Nasal Spray in the medication cart with Rx (prescription) labels on the Nasal Spray Bottles. One bottle of the Fluticasone Nasal Spray was lacking an opened date the other opened Fluticasone Nasal Spray bottle had an opened date of 3/14/18 written on the lable. The Rx label indicated the Fluticasone Nasal Spray had a Rx fill date of 1/20/18. Resident 71 also had an open bottle on Saline Nasal Spray. The Saline Nasal Spray was also lacking an opened date. An interview with Nurse 16 at the time, indicated Resident 71 had been in the hospital and had returned to the facility with the opened Fluticasone Nasal Spray which was dated 3/14/18 and the opened Saline Nasal Spray. Nurse 16 indicated the nasal sprays should have been labeled with an open date. 2. On 03/29/18 at 3:35 p.m., the 100/West Hall medication cart was observed with Nurse 17. The following was observed: Resident 66's Latanoprost Soln (Solution) 0.005% (Eye Drop used to treat glaucoma) with a Rx fill date of 3/8/18 was opened, but was lacking an open date.		and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction. Medications outdated were removed at the time of finding and over the counter med bottles labeled with the doctors names. All residents had the potential to be affected by the alleged deficiency. Nurses and QMAs to be in serviced on the ploicy for proper med storage and labeling. DON/licensed designee will monitor medication carts and medication room to ensure all medications are labeled and stored per policy. This will occur 3 times per week for 4 weeks then weekly for 8 weeks then monthly for 3 months. this will then be monitored through QAPI until 100% compliance is achieved. Date of compliance: 4/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	Resident 17's Lubrifresh Oin P.M. (a Lubricating Eye Ointment) with a Rx fill date of 1/19/18 was opened but was lacking an open date. Resident 17's Artificial Tears Soln 0.4 % (a solution specially formulated to moisten the eyes) with a Rx fill date of 1/9/18 was opened but was lacking an opened date. Resident 52's Basaglar KwikPen (an insulin to treat diabetes mellitus) with labeled with an open date of 3/1/18. An interview at the time with Nurse 17 indicated the insulin expired in 28 days and indicated the insulin expired yesterday on 3/28/18. She indicated she did not know if Resident 52 was given the Basaglar insulin this morning. Nurse 17 reviewed the electronic MAR (Medication Administration Record) and indicated Resident 52's Basaglar insulin had been administered earlier today. Nurse 17 was observed to remove Resident 52's expired Basaglar Insulin KwikPen from the medication cart. The clinical record review for Resident 52 began on 3/29/18 at 4:05 p.m. Diagnoses included but were not limited to diabetes mellitus, atherosclerotic heart disease, hypertension, anemia in chronic kidney disease, dementia. Resident 52's March 2018 MAR was provided by the DON (Directory of Nursing) indicated, "...Basaglar KwikPen Solution Pen-Injector 100 unit/ml (milliliter, a measurement)...Inject 30 units subcutaneously one time a day for diabetes...Morning....a check mark with nurse's initials were present on 1/29/18..." which indicated Resident 52 was given the expired insulin.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	3. On 3/29/18 at 4:00 p.m., the 200/South Medication cart was observed with Nurse 1. The following was observed: Resident 13's OTC Fish Oil 1000 mg (milligram), 300 capsule count was lacking the Physician's Name on the bottle. Resident 233's OTC Calcium 600 mg + Vitamin D3 500 IU (international Units, a measurement) 150 tablet count was lacking the Physician's name on the bottle Resident 69's OTC Arthritis Pain Relief-Acetaminophen 650 mg, 150 count was lacking the Physician's Name on the bottle. On 3/29/18 at 5:11 p.m., the DON (Director of Nursing) was interviewed. She indicated she would expect the nurse to check the insulin's open date and not administer the insulin after the insulin was expired. The DON agreed the open date was Day 1 and Resident 52's Basaglar insulin would have expired on 3/28/19 and should not have been administered today, 3/29/18. The DON also indicated the nasal sprays should have been labeled with open date and the OTC medications should be labeled with the Resident's name and the Physician's name. On 3/29/18 at 5:39 p.m., the DON provided copy of the documentation from PDR.net (Physician's Drug Reference Internet site) which indicated, "...Long acting Human Insulins...BASAGLAR...Storage of vials: Insulin glargine vials may be stored in the refrigerator or at room temperature once opened. Once opened, vials must be used within 28 days or be discarded, even if they still contain insulin...." On 3/29/18 at 5:50 p.m., the Regional Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	Consultant was interviewed. She indicated the facility was to follow the ISDH (Indiana State Department of Health) Regulations for dating and labeling multiple use medications and labeling the OTC medications for storage. 3.1-25 (j) 3.1-25(l)(2) 3.1-25(o)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure refrigerated, frozen, and dry foods were properly labeled and dated, potentially affecting 81 of 81 residents.	F 0812	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	04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	During a tour with the CDM (Certified Dietary Manager) of the kitchen on 3/22/18 at 10:05 a.m., the following food items were observed with no date opened label: An opened bottle of Southwestern Chipolte Salad Dressing, located in the walk-in refrigerator. An opened half gallon of Skim Milk, 1/8 full, located in Refrigerator 1. An opened container of Tomato Juice, 1/2 full, located in Refrigerator 1. An opened box of frozen cookies, located in the White Freezer 1. An opened package of hot dog buns, located under the prep table, on the shelf. An opened loaf of sandwich bread, located under the prep table, on the shelf. An unopened bottle of Raspberry Vinaigrette Salad Dressing, with a "Best if used by" date of 5/22/2015, located in the walk in refrigerator. 2 one gallon zip lock bags with dinner rolls in both bags and had no labels as to what the contents or date opened was. The two bags were located under the prep table, on the shelf. During an interview with the CDM on 3/28/18 at 3:04 p.m., indicated the staff should have dated items when they were opened. During an interview with the ED (Executive Director) on 3/28/2018 at 5:15 p.m., indicated the facility had no policy for food storage and they refer to the state guidelines.		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 the residents, nor are they of such character so as to limit our capability to render adequate care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction. The items without open dates and the unopened item that was out of date were discarded at the time of the findings. All residents had the potential to be affected by alleged deficiency. Dietary staff will be in serviced on food storage. Director of Dietary/designee will monitor food storage to ensure open products are dated and not past their expiration date. This will be done by auditing food storage 3 times a week for 2 months, then 1 time a week for 4 months. This will then be monitored through QAPI monthly until 100% compliance is obtained. Date of compliance: 4/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
F 9999 Bldg. 00	During an interview with Dietary Aide 2 on 3/29/18 at 10:51 a.m., indicated when a food item is opened for the first time in the kitchen, you were to write the date opened on it and store it where it belongs. 3.1-21(i)(1) and (3) 3.1-14 Personnel q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure 10 of 10 employee records reviewed, were complete with the required documentation. (Certified Nurse Aides 3 and 6, Student Nurse Aides 5 and 7, Housekeeper 4, Activity Assistant 8, Nurses 9 and 10, Social Services 11 and Personal Care Assistant 12) Findings include:	F 9999	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 the residents, nor are they of such character so as to limit our capability to render adequate care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction. Personnel files for those employees found with missing documentation have been corrected. All employees have the potential to be affected by alleged deficiency. Human Resource Director will be in serviced on Employee File retention. All employee files will be audited to	04/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	The Personnel record review began on 3-29-2018 at 3:20 p.m. 1. The contents of 6 personnel files lacked a job description, job specific orientation and the physician signature and date on the physical exam for the following staff: CNA 3 (Certified Nurse Aide), with a hire date of 11-19-2017. Housekeeper 4, with a hire date of 7-17-2017. CNA student 5, with a hire date of 12-6-2017. CNA 6, with a hire date of 10-12-2017. Nurse 10, with a hire date of 9-25-2017. Personal Care Assistant 12, with a hire date of 2-17-2018. 2. The contents of 2 personnel files lacked a job description for the following staff: CNA student 7, with a hire date of 2-21-2018. Activity Assistant 8, with a hire date of 9-27-2017. 3. The contents of the personnel file for Nurse 9, with a hire date of 9-25-2017, lacked a physician signature and date on the physical exam. 4. The contents of the personnel file for Social Service 11, with a hire date of 1-29-2018, lacked a job description and a physician signature and date on the physical exam. An interview with Human Resources on 3-29-2018 at 4:20 p.m., indicated the new employees were given a copy of their job description at hire and signed a form which indicated the job description was received (Job Description Performance Management System Signature Sheet). Human Resources indicated she thought if the employee had signed a form which stated they had received		ensure proper documentation is acquired and correct. Administrator/designee will audit new hire employee files 1 time a week for 2 months then 1 time a month for 4 months. This then will be monitored through QAPI until 100% compliance is obtained. Date of compliance: 4/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	03/29/2018

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
	their job description, that would be good enough to place in the personnel file instead of placing a signed copy of the job description in each employee file. Human Resources indicated the nurse on the floor performed the physical exam for the new hire and when the physician came to the facility, the Employee Physical form was signed and dated by the physician. Human Resources indicated the job specific orientation checklist was given to the employee at hire to keep with them. The new employee was to have the supervising staff sign off when the task was completed. Human Resources indicated the employee was to return the job specific orientation checklist to her when completed. Human Resources was asked how she ensured each employee file had the required, completed documentation and forms. Human Resources indicated she did an audit about 6 months ago on random selected employee files and audited them for the physician signature and date on the physical exam and for the completion of the job specific orientation checklist. An interview with Human Resources on 3-29-2018 at 4:40 p.m., indicated the facility did not have a policy for the personnel file contents and she provided an undated "General Orientation List" used to ensure the new hires were given the required forms. A review of the "General Orientation List" indicated "New Employee Physical" and "Job Description" were listed on the form.			