

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155335	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/20/2023
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NAME OF PROVIDER OR SUPPLIER  OSSIAN HEALTH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 215 DAVIS RD OSSIAN, IN 46777
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00417226, IN00417327, IN00417840 and a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00417226 - Federal/state deficiencies related to the allegations are cited at F880 and F885.</p> <p>Complaint IN00417327 - Federal/state deficiencies related to the allegations are cited at F885.</p> <p>Complaint IN00417840 - No deficiencies related to the allegations are cited.</p> <p>Survey date: September 20, 2023</p> <p>Facility number: 000228 Provider number: 155335 AIM number: 100266650</p> <p>Census Bed Type: SNF/NF: 83 Residential: 36 Total: 119</p> <p>Census Payor Type: Medicare: 3 Medicaid: 77 Other: 39 Total: 119</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review compelted September 22, 2023</p>	F 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 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tomi Cobb	HFA	10/03/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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F 0880 SS=E Bldg. 00	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p>			

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	<p>(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to properly contain the transmission of COVID-19 for 5 of 11 residents reviewed for infection control (Resident E, Resident G, Resident N, Resident O, and Resident Q).</p> <p>Findings include:</p>	F 0880	F880-E 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	10/06/2023

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	<p>A list of COVID-19 positive residents was provided by the Administrator on 9/20/23 at 12:54 PM. The list indicated Resident E, Resident G, Resident N, Resident O and Resident Q tested positive for COVID-19.</p> <p>During an observation on 9/20/23 at 10:22 AM, Resident E, Resident G, Resident N, Resident O and Resident Q's rooms had signage to indicate the residents were on red zone precautions (COVID positive). The signage indicated upon entrance the staff donned personal protective equipment (PPE), a gown, gloves, N95 mask and face shield prior to entering the resident's room.</p> <p>During a continuous observation on 9/20/23 at 10:22 AM, Restorative Aide 2 donned PPE outside of Resident E and Resident G's room. Restorative Aide 2 donned a gown, gloves and face shield and kept on her surgical mask. Restorative Aide 2 entered Resident E and Resident G's room without an N95 mask on.</p> <p>During a continuous observation on 9/20/23 at 10:51 AM, Activity Assistant 3 entered Resident N's room with only a surgical mask on. Activity Assistant 3 handed Resident N a newspaper and patted his back. Activity Assistant 3 then exited the room. Activity Assistant 3 then donned a gown, gloves and an additional surgical mask. Activity Assistant 3 entered Resident O and Resident Q's room. Activity Assistant 3 did not put on a face shield prior to entering Resident O and Resident Q's room. Activity Assistant 3 exited the room at 10:54 AM with a gown, gloves and surgical masks on. Activity Assistant 3 did not dispose of her PPE, but walked around in the hallway with her PPE on until reminded to doff the PPE.</p>		<p>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.</p> <ul style="list-style-type: none"> <li>· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility is conducting PPE donning and doffing in servicing to staff for our positive COVID residents rooms. IDT will be watching staff perform this procedure and educating staff while observing. The activity assistant and restorative aid will have 1 on 1 training of proper procedures of donning, doffing PPE in covid positive rooms.</li> <li>· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All COVID positive residents had the potential to be affected by the deficient practice.</li> <li>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; IP or designee will educate staff</li> </ul>	

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	<p>In an interview on 9/20/23 at 10:54 AM, Activity Assistant 3 indicated she had worked at the facility for 5 months. Activity Assistant 3 indicated she had not been educated on what to wear into or when to take off PPE from a red zone room.</p> <p>In an interview on 9/20/23 at 10:28 AM, the Director of Nursing (DON) indicated staff should wear a gown, gloves, N95 mask and a face shield into a red zone room and take them off prior to exit from the room.</p> <p>In an interview on 9/20/23 at 2:09 PM Certified Nurse Aide 5 (CNA) and the Activity Director indicated prior to entering a red zone room staff donned PPE. CNA 5 and the Activity Director indicated staff donned a gown, gloves, face shield and N95 prior to entering a red zone room and doffed the PPE right before they exited the room.</p> <p>A policy, dated 5/8/2023, titled "Core Principles of COVID IPC &amp; NH Visitation," was provided by the Administrator on 9/20/23 at 12:54 PM. The policy indicated staff should use appropriate PPE in accordance with the Center for Disease Control and Prevention (CDC) when staff assisted those who tested positive for COVID-19, experienced symptoms or had close contact with someone with COVID-19.</p> <p>The CDC COVID Data Tracker, accessed on 9/20/23, indicated the county transmission level was low.</p> <p>This Federal citation is related to Complaint IN00417226.</p> <p>3.1-18(a)</p>		<p>members on COVID policy and procedures and the use of PPE now and in our monthly ALLSTAFF meetings for continued education and training on proper practices.</p> <ul style="list-style-type: none"> <li>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and IP or designee will watch staff members don and doff PPE in COVID positive rooms 2x week for 2 weeks, 1x week for 2 weeks and will do random observations 4x month for 5 months. Results will be reviewed in QAPI until no further issues are noted.</li> <li>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.</li> </ul> <p>Date of correction is October 6, 2023.</p>	

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F 0885 SS=D Bldg. 00	<p>483.80(g)(3)(i)-(iii) Reporting-Residents,Representatives&amp;Families</p> <p>§483.80(g) COVID-19 reporting. The facility must—</p> <p>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—</p> <p>(i) Not include personally identifiable information;</p> <p>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and</p> <p>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.</p> <p>Based on interview and record review the facility failed to ensure families/representatives were notified of COVID-19 exposure for 3 of 10 residents reviewed (Resident B, Resident C, Resident J).</p> <p>Findings include:</p> <p>A list of COVID-19 positive residents was provided by the Administrator on 9/20/23 at 12:54 PM. The list indicated the roommates of Resident</p>	F 0885	<p>F885-D</p> <p>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</p>	10/06/2023

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	<p>B, Resident C and Resident J were COVID-19 positive. The document indicated Resident B's roommate tested positive on 9/18/23, Resident C's roommate tested positive on 9/10/23 and Resident J's roommate tested positive on 9/10/23.</p> <p>A record review was completed for Resident B on 9/20/23 at 2:15 PM. There was no documentation indicating Resident B's representative/family was notified of the positive roommate exposure.</p> <p>A record review was completed for Resident C on 9/20/23 at 2:16 PM. A COVID Resident testing/screening assessment indicated Resident C's family was notified on 9/12/23 of the positive roommate exposure three days after the exposure.</p> <p>A record review was completed for Resident J on 9/20/23 at 2:17 PM. A progress note, dated 9/13/23, indicated Resident J's family was notified of positive roommate exposure three days after the exposure.</p> <p>A policy, dated 5/8/2023, titled "Core Principles of COVID IPC &amp; NH Visitation," was provided by the Administrator on 9/20/23 at 12:54 PM. The policy did not indicate notification procedures of positive exposures.</p> <p>This Federal citation relates to Complaint IN00417327, and IN00417226.</p>		<p>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.</p> <ul style="list-style-type: none"> <li>· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Education was provided to nurse managers and floor nurses on notification of COVID positive residents and prolonged exposure of roommates to roommate and responsible parties of residents within 24 hours.</li> <li>· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 3/10 roommates of COVID positive residents were affected by the alleged deficient practice.</li> <li>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; IP or designee will do weekly in servicing with floor nurses and nursing managers for 4 weeks and then monthly x5 months.</li> <li>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur,</li> </ul>	

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			<p>i.e., what quality assurance program will be put into place; and DON/IP/Designee will audit COVID notifications daily until the outbreak is over to ensure all notifications are being made within 24 hours.</p> <p>· by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.</p> <p>Date of compliance is October 6, 2023.</p>	