

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

PRINTED: 09/06/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2023
NAME OF PROVIDER OR SUPPLIER OSSIAN HEALTH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the investigation of Complaint Number IN00412273 that exited on 07/10/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Complaint IN00412273 - Corrected</p> <p>This visit was in conjunction with the PSR for the Life Safety Code Recertification and Emergency Preparedness Survey conducted on 07/10/23.</p> <p>Survey Date: 08/28/23</p> <p>Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650</p> <p>At this Complaint PSR survey, Ossian Health Care and Rehabilitation Center was found 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors, and all resident sleeping rooms. The facility has a capacity of 100 certified beds. At the time of the survey the census was 86.</p> <p>All areas where the residents have customary</p>	{K 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.

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{K 000}	Continued From page 1 access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/05/23	{K 000}		