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	08/22/2022

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. Survey dates: August 17, 18, 19, and 22, 2022. Facility number: 000228 Provider number: 155335 AIM number: 100266650 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 2 Medicaid: 45 Other: 35 Total: 82 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 23, 2022	F 0000	b>	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the MDS (minimum data set) for hospice care was completed for 1 of 5 residents reviewed (Resident 56). Findings included: A review of Resident 56's record on 8/18/2022 at	F 0641	b> - Plan of Correction: F 641 Accuracy of Assessments - **what corrective action(s) will be accomplished for those residents found to have been**	08/30/2022

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

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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	1:45 PM, indicated Dx (Diagnoses) included cerebral atherosclerosis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. A physician order dated 8/1/22, indicated to admit to hospice with primary diagnosis of atherosclerosis heart disease, and secondary diagnosis of adult failure to thrive. An MDS dated 7/4/22, was reviewed. Under section O special treatments, procedures, and programs; under other, hospice care was not selected for resident. The MDS did not show anything to indicate Resident 56 had hospice care. In an interview on 8/18/22 at 3:13 PM, the Director of Nursing and Administrator indicated they should have done an MDS with hospice. The significant change was done because of hospice, and it should have been there. A current facility policy, Care planing, dated 3/20, was provided by the Administrator on 8/19/22 at 9:47 AM. The policy indicated..." The comprehensive care plan will be completed within 7 days after completion of the comprehensive MDS...."		**affected by the deficient practice?** Resident 56's MDS completed on 8/2/22 was reviewed by the MDS coordinator. The MDS coordinator completed a modification of significant assessment on 8/18/22 to include hospice services under section O. - **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.** The deficient practice has the potential to affect residents who are currently receiving hospice services. The Director of Nursing and MDS coordinator will review the MDS assessments- section O for all residents receiving hospice services to ensure each resident's MDS are completed accurately. Any MDS with inaccuracies will be corrected by modification. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DON/Designee will audit newly completed MDS assessments for	

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			accuracy under section O special treatments, procedures, and programs are coded accurately. These audits will be conducted 5 days per week for four weeks, then three days a week for four weeks, then once a week for eight weeks, then randomly thereafter for two months. All audits will be forwarded to QA for monthly review for minimum of 6 months, until 100% compliance noted for two consecutive months, then quarterly X 2or until QAPI committee deems compliance. Plan of Correction for deficient practice will be 8/30/2022.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and			

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	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure a care plan for hospice care was completed for 1 of 5 residents reviewed (Resident 56). Findings included: A review of Resident 56's record on 8/18/2022 at 1:45 PM, indicated Dx (Diagnoses) included, cerebral atherosclerosis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. A physician order dated 8/1/22, indicated the	F 0656	b> Plan of Correction: F 656 Develop/implement comprehensive care plan - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 56's care plan was reviewed by the MDS coordinator. Resident 56's care plan was	08/30/2022

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	resident was admitted to hospice with primary diagnosis of atherosclerosis heart disease, and secondary diagnosis of adult failure to thrive. A care plan dated 8/11/22, was reviewed. There was not a care plan for hospice care that would include a focus, goal and personalized interventions or coordinate with Hospice services. In an interview on 8/18/22 at 3:13 PM the Director of Nursing and Administrator indicated there should have been a care plan for hospice. A current facility policy, Care planning, dated 3/20 was provided by the Administrator on 8/19/22 at 9:47 AM. The policy indicated..." It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services, that are to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being...." 3.1-35(a)		updated to include Hospice services being received by the resident. - **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.** The deficient practice has the potential to affect other residents who are receiving Hospice services. The Director of Nursing and MDS coordinator will review the care plan of each resident receiving Hospice services to ensure the plan of care reflects special services being received. Care plans will be updated to reflect services being received. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Don/designee will audit newly completed care plans for special services being received for accuracy and comprehensive care plan development. These audits will be conducted 5 days per week for four weeks, then three days a week for four weeks, then once a week for 8 weeks, then randomly thereafter for two months. All audits will be forwarded to QA	

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			for monthly review for minimum of 6 months until 100% compliance noted for two consecutive months, then quarterly x 2 or until QAPI committee deems compliance. Plan of Correction for deficient practice will be 8/30/2022.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 19 and 22, 2022. Facility number: 000228 Residential Census: 37 Ossian Health Care and Rehabilitation was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed August 23, 2022	R 0000	b>	