

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155335	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 07/10/2023
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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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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 07/10/23</p> <p>Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650</p> <p>At this Emergency Preparedness survey, Ossian Health Care and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 100 and had a census of 83 at the time of this survey.</p> <p>Quality Review completed on 07/13/23</p>	E 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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.	
E 0004 SS=F Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tomi	Cobb	07/27/2023

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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	<p>must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient</p>	E 0004	E004-F Review and update EP plan annually This plan of correction is prepared and executed because it is	07/28/2023

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E 0013 SS=F Bldg. --	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 10:40 a.m., the EEP had a date of 01/01/22 on the cover page, no other date could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the RDPM stated the EEP has not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the RDPM during the exit conference.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b),</p>		<p>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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>Emergency Preparedness Binder policy and procedure approval sheet and all EP policies and procedures will be reviewed and will be updated annually by Maintenance Director or HFA. The deficient practice could have the potential to affect all occupants of facility. Maintenance director and HFA were educated on the regulation for updating EP binder, policies, and procedures. Regional director of operations will audit EP Binder quarterly for 6 months. Date of compliance will be July 28, 2023.</p>	

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	<p>§441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must</p>			

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	<p>address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 10:40 a.m., the EEP had an annual review date of 01/01/22, no other date could be found to show the EPP's Policies and Procedures were reviewed and updated within the last year.</p>	E 0013	E013-F Development of EP policies and procedures 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit	07/28/2023

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E 0029 SS=F Bldg. --	<p>Based on an interview during records review, the RDPM agreed the EPP's Policies and Procedures had not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the RDPM during the exit conference.</p> <p>3.1.19(b)</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC</p>		<p>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> <p>Emergency Preparedness Binder policy and procedure approval sheet and all EP policies and procedures will be reviewed and will be updated annually by Maintenance Director or HFA. The deficient practice could have the potential to affect all occupants of facility. Maintenance director and HFA were educated on the regulation for updating EP binder, policies, and procedures. Regional director of operations will audit EP Binder quarterly for 6 months. Date of compliance will be July 28, 2023.</p>		

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E 0036 SS=F Bldg. --	<p>facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 10:40 a.m., the EPP had an annual review date of 01/01/22 and no other date could be found to show the EPP's Communication Plan was reviewed and updated within the last year. Based on interview during records review, the RDPM agreed the EPP's Communication Plan had not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d),</p>	E 0029	<p>E029-F Development of communication plan 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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. · Communication plan was updated, and quick reference binders made for staff. This deficient practice could have the potential to affect all occupants. HFA or designee will educate staff members at All staff meetings monthly x 6months. Date of Compliance will be July 28, 2023.</p>	07/28/2023	

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	<p>§485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the</p>			

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	<p>emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 10:40 a.m., the EEP had a review date of 01/01/22 on the cover page, no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records</p>	E 0036	<p>E036-F Training and testing</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate</p>	07/28/2023
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E 0039 SS=C Bldg. --	<p>review, the RDPM state the EPP's Training and Testing Plan has not been reviewed or updated within the last year.</p> <p>This finding was reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based</p>		<p>care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction.</p> <p>The hazard and vulnerability assessment tool was updated immediately. This deficient practice had the potential to affect all occupants. The maintenance director will update the hazard and vulnerability assessment annually and place in EP binder. Date of compliance will be July 28, 2023.</p>	

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	<p>functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p>			

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	<p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p>			

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	<p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not</p>			

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	<p>limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p>			

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	<p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p>			
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	<p>(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d): (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group</p>			

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	<p>discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p style="padding-left: 20px;">(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p style="padding-left: 20px;">(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p style="padding-left: 20px;">(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p style="padding-left: 20px;">(B) A mock disaster drill; or</p> <p style="padding-left: 20px;">(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,</p>			

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	<p>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency</p>			
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	<p>scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the</p>	E 0039	<p>E039-C EP testing requirements</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>· Facility will have emergency preparedness exercise with after action report x2 annually. The alleged deficient practice could have the potential to affect all occupants. Facility held active shooter table top exercise on July 25, 2023. Date of compliance will be July 28th 2023.</p>	07/28/2023

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K 0000 Bldg. 01	<p>LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 10:50 a.m., documentation for the actual natural emergency conducted on 04/05/23 was incomplete. The emergency event documentation did not show if the facility's response was analyzed to ensure the EPP policies were effective. Based on interview at the time of records review, the RDPM agreed no documentation for analyzing the LTC facility's response was completed.</p> <p>This finding was reviewed with the RDPM at the exit conference</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>This visit was conducted in conjunction with the Life Safety Code Complaint Investigation of Complaint IN00412273</p> <p>Survey Date: 07/10/2023</p> <p>Facility Number: 000228 Provider Number: 155335 AIM Number: 100266650</p> <p>At this Life Safety Code survey, Ossian Health</p>	K 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate care. As a consideration of the survey results the facility	

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K 0100 SS=E Bldg. 01	<p>Care and Rehabilitation Center was found not 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 V111 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 100 and had a census of 83 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 07/13/23</p> <p>NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 smoke barrier doors in the 300 hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect 5 staff and 25 residents in the 300 hall.</p>	K 0100	<p>respectfully requests a paper review of the plan of correction.</p> <p>K100-E General requirements- Smoke door failed latch test 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</p>	07/28/2023

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K 0211 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Regional Director of Property Management (RDPM) on 07/10/23 at 2:55 p.m., the set of smoke barrier doors to the 300 hall was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the RDPM agreed the smoke doors were equipped with latching devices, but the doors did not properly latch when tested.</p> <p>The finding was reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all staff in the service hall</p>	K 0211	<p>Center agrees with the allegations and citations listed. Ossian Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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"> Fire door was repaired immediately to latch into frame. <p>The deficient practice could have affected 5 staff members and 25 residents on the 300 hall. Maintenance director will check fire doors weekly x2 months and monthly x4 months. Date of compliance July 28, 2023.</p> <p>K211-E Means of egress-Clean linen cart and service hall table</p> <p>This plan of correction is prepared and executed because it is required by the provisions of State</p>	07/28/2023

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	<p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Regional Director of Property Management (RDPM) 07/10/23 at 2:30 p.m., the corridor contained a clean linen cart that was unattended. During the tour at 3:00 p.m. in the service hall there a 2 foot by 4 foot table in the corridor with covid supplies on it. Based on an interview at the time of observations, the RDPM agreed there was a linen cart and table in the corridor.</p> <p>The findings were reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:</p> <p>(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm).</p> <p>(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.</p> <p>(c)The wheeled equipment is limited to the following:</p> <p>i. Equipment in use and carts in use</p> <p>ii. Medical emergency equipment not in use</p> <p>iii. Patient lift and transport equipment</p> <p>This deficient practice affects any residents in the area of room 306.</p>		<p>and Federal law and not because Ossian Health and Rehabilitation Center agrees with the allegations and citations listed. Ossian Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>· COVID testing table in service hallway was removed immediately, PPE cart was replaced with cart with working wheels and Linen cart was removed from west hall immediately. The deficiency could have affected all staff members in the service hall and residents around the 306 room area. Maintenance director or designee will audit PPE carts to ensure all wheels are in working order, weekly x2 months and monthly for 4 months. West hall staff members were educated on proper linen placement and handling procedures. HFA, DON or designee will audit hallways for linen carts 1x week for 2 months and monthly for 4 months. IDT will review this in allstaff meetings monthly for 6 months. Date of compliance July 28, 2023.</p>	
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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 07/10/2023
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K 0291 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on an observation during a tour of the facility with the RDPM 07/10/2 at 3:00 p.m., in the corridor by resident room 306, a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to be moved out of the halls during an emergency. Based on an interview at the time of observations, the RDPM agreed the PPE cart was not equipped with wheels.</p> <p>The findings were reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1</p> <p>Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 5 of 5 battery backup lights. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility.</p>	K 0291	K291-C Emergency Lighting- Form need itemized 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit	07/28/2023
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K 0293 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 12:53 p.m., the "Emergency Lighting Battery Test" form indicated the battery operated lights were tested monthly and annual but the form was not itemized to show that each emergency light in the facility was tested. Based on an interview at the time of record review, the RDPM indicated there are five battery powered lights in the facility, and agreed they did not document the test results for each individual light.</p> <p>This finding was reviewed with the RDPM at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 2 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO</p>	K 0293	<p>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> <p>Battery operated lights will be itemized and added to TELS system to ensure inspection. The alleged deficient practice could affect all residents in facility. Maintenance director or designee will audit monthly. Date of Compliance July 28, 2023.</p> <p>K293-E Exit Signage-SNF activity room and employee breakroom 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</p>	07/28/2023

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K 0324 SS=E Bldg. 01	<p>in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 20 residents in the Activity room and staff in the employee break room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Regional Director of Property Management (RDPM) on 07/10/23 at 3:15 and 3:25 p.m., in the Activity room the door to the outside courtyard was marked as an exit door and in the employee break room the door leading to the same courtyard did not have a sign to identify if it was an exit.. Based on interview at the time of the observations, the RDPM agreed the courtyard is not an exit to the public way and acknowledged the courtyard doors did not have a "NO EXIT" sign posted in either location.</p> <p>3.1-19(b)</p> <p>NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p>		<p>and citations listed. Ossian Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>· Activity room back door and employee break room door are not a true exit and exit sign will be replace with a "This is not an exit" sign. The alleged deficient practice could affect staff that use the break room and any occupants using the activity room. Date of compliance July 28, 2023.</p>	

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	<p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 50 residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Regional Director of Property Management (RDPM) on 07/10/23 at 3:25 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; use the fire extinguisher on it. The employee failed to indicate activating the UL 300 hood extinguishing system and then using the K Class fire extinguisher if needed for a hood grease fire. The RDPM and Dietary Manager acknowledged the Cooks response and stated all kitchen staff will be informed on proper response to a grease fire under the hood.</p> <p>This finding was reviewed with the RDPM at the exit conference.</p>	K 0324	<p>K324-E Cooking facilities 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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"> Kitchen staff will be educated on the ANSL system and fire procedures for their department. All occupants of facility could be affected by the alleged deficient practice. Monthly in-services will be performed by CDM for 6 months to ensure kitchen staff knowledge of fire procedures. Date of compliance July 28, 2023. 	07/28/2023

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K 0341 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.</p> <p>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm control panel with the Regional Director of Property Management (RDPM) on 07/10/23 at 2:50 p.m., the time on the display of the fire alarm control panel indicated the time to be 20:28:23 when checked at 2:50 p.m. and the date was indicated as 05/28/23 Based on interview at the time of observation, the RDPM agreed the fire alarm control panel had the wrong date and time.</p>	K 0341	<p>K341-C Fire alarm system- Wrong date and time 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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>	07/28/2023	

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K 0345 SS=F Bldg. 01	<p>The finding was reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Regional Director of Property Management (RDPM) on 07/10/23 at 11:30 a.m. there was documentation on the annual</p>	K 0345	<p>Fire alarm panel date and time was updated to correct date and time. Date and time of fire panel information will be added to fire drill report sheet. Maintenance director or designee will audit time and date of fire panel weekly x2 months and then monthly for 4 months. Date of compliance July 28, 2023.</p> <p>K345-F Fire alarm system-testing and maintenance</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate</p>	07/28/2023

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K 0363 SS=E Bldg. 01	<p>fire alarm system inspection on 3/15/23 of batteries needing replacement and smoke detector failed sensitivity testing in the dining room. Based on interview at the time of observation, the RDPM confirmed the issues still need to be corrected and stated the repairs will be completed but have not happened yet.. The fire alarm system is operational.</p> <p>This finding was reviewed with the RDPM during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Corridor - Doors Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping</p>		<p>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"> Fire alarm panel batteries were replaced immediately, and Task will be added into TELS system to audit panel for battery life. Smoke detector in main dining room was replaced with a new one and is now in working order. This alleged deficient practice could affect all occupants of facility. Maintenance director or designee will audit batteries visually monthly. Date of compliance July 28, 2023. 	

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	<p>the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors resist the passage of smoke and capable of resisting fire for 20 minutes. This deficient practice could affect 30 residents in two smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during tour of the facility with the Regional Director of Property Management (RDPM) on 07/10/23 at 2:30 p.m., the corridor door to the training room had a pencil size hole through the door. This condition would not limit the spread of smoke from one side of the fire barrier to the other. Based on interview at the time of observation, the RDPM agreed the door lock was replaced and the new lock did not cover one of the holes in the door.</p>	K 0363	<p>K363-E Corridor-doors-Pencil size hole in shower room door</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character to limit our capability to render adequate care. As a consideration of the survey results the facility</p>	07/28/2023
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K 0711 SS=E Bldg. 01	<p>This finding was reviewed with the RDPM at the exit confernece.</p> <p>3.1-19(b)</p> <p>NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire</p>	K 0711	<p>respectfully requests a paper review of the plan of correction.</p> <p>North hall shower room door hole was repaired. This alleged deficiency could have the potential to affect 30 residents. All doors will be checked weekly for 2 months and checked monthly for 4 months by Maintenance Director or designee. Date of compliance will be July 28, 2023.</p> <p>K711-E Evacuation and relocation plan- MC smoke doors 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 maintains that the alleged</p>	07/28/2023	

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K 0712 SS=F Bldg. 01	<p>(6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants of the Dementia unit.</p> <p>Findings include:</p> <p>Based on record review with the Regional Director of Property Management (RDPM) on 07/10/23 at 11:25 a.m., the provided "Fire Emergency Procedures" lacked information on partial or horizontal evacuation from one smoke compartment beyond a smoke or fire barrier to the next smoke compartment. Based on interview during records review, the RDPM agreed the Fire Emergency Procedures that was provided for review did not include complete instruction for Evacuation of the smoke compartment from the Dementia Unit. The Dementia Unit entrance door was inside the smoke compartment double doors. When staff (QMA) in the Dementia unit was questioned about the location of the smoke door location for evacuation of the Dementia unit she stated they would relocate beyond the Dementia unit door. The actual smoke door to the next compartment is the double doors past the Dementia unit entrance door.</p> <p>This finding was reviewed with the RDPM at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire</p>		<p>deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>· Education will be provided to staff about the location of the smoke barrier doors and their purpose for evacuations. Fire procedures were updated in each EP binder. Education will be provided quarterly to staff members in facility allstaff meetings. Date of compliance July 28, 2023.</p>		

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	<p>alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 11:56 a.m., the fire drill forms for third shift drill on 03/16/23 indicated transmission of signal was not tested for that month. Based on interview at the time of record review, the RDPM agreed they did not transmit the signal the next day after the 03/16/23 fire drill.</p> <p>The fire drills on 09/27/22, 10/24/22 and 01/10/23 did not include a staff roster.</p> <p>These findings were reviewed with the RDPM at the exit conference.</p> <p>3.1-19(b)</p>	K 0712	<p>K712-F Fire drills</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>· Corrective action cannot be taken as the alleged deficiency occurred in the past, but facility will perform a fire drill on each shift this month. Fire drills will be conducted regularly, one drill will be performed per shift per quarter. Documentation verifying that fire alarm signal was received by monitoring company and will be</p>	07/28/2023

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K 0761 SS=F Bldg. 01	3.1-51(c) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so	K 0761	recorded on fire drill sheet. The deficient practice could have affected all occupants of facility. HFA or designee will audit monthly x6 months. Date of compliance July 28, 2023. K761-F Maintenance, inspection and testing-doors, Annual fire door inspection 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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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 alleged deficiency happened in the past and corrective action cannot take place. The deficient practice could have affected all occupants of the facility. Annual fire door inspections was performed on 7/24/23 and will happen bimonthly x 6months by maintenance	07/28/2023	

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	<p>equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on record review with the Regional Director of Property Management (RDPM) on 07/10/23 documentation of an annual inspection for the fire door assemblies within the last year was not available for review. Based on interview at the time of records review and observation, the RDPM stated he was unaware that the annual fire door inspection was not completed. There was documentation of the most recent annual fire door inspection completed on 03/15/22.</p> <p>This finding was reviewed with the RDPM at the exit conference.</p>		director or designee. Date of compliance July 28, 2023.	

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K 0918 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p>			
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	<p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of 12 months and weekly inspection for 7 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Regional Director of Property Management (RDPM) on 07/10/23 at 12:56 p.m., no documentation was available for the months of February and March 2023 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log showed the weekly inspections were not conducted between January 11 and April 4, 2023. Based on an interview at the time of record review, the RDPM agreed the above mentioned generator inspections were not conducted.</p> <p>The findings were reviewed with the RDPM during the exit conference.</p>	K 0918	<p>K918-F Electrical systems-Generator testing and documentation.</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 maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of our residents, nor are they of such character 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> <p>The alleged deficiency happened in the past and corrective action cannot take place. Generator inspections and work will happen monthly by maintenance director or designee. Date of compliance July 28, 2023.</p>	07/28/2023

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

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	3.1-19(b)				