

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
F 0000  Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: January 4, 5, 6, 7, and 8, 2016</p> <p>Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840</p> <p>Census Bed Type: SNF/NF: 90 Total: 90</p> <p>Census Payor Type: Medicare: 17 Medicaid: 53 Other: 20 Total: 90</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on January 12, 2015.</p>	F 0000	<p>This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Immediate This facility respectfully request paper compliance.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
F 0323 SS=E Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure residents were free from hazards related to an unlocked door on the 300 hall which allowed access to the hot water heater. This had the potential to affect the 4 independently ambulatory residents who resided on the 300 hall. (300 hall)</p> <p>Finding includes:</p> <p>During the initial tour of the facility on 1/4/16 at 6:17 p.m., the door to the water heater closet on the 300 hall was observed to be unlocked and easily opened.</p> <p>A follow up observation with the ADON was completed on 1/4/16 at 6:47 p.m. At that time, the 300 hall water heater closet door remained unlocked and easily opened.</p> <p>Interview with the ADON at the time of the observation indicated the door should be locked so the water heater was not</p>	F 0323	<p>Immediate – South Hall Closet water heater door was immediately locked on 1.4.16 All others- Review of all other water heater doors was checked 1.4.16 Systemic – The Water Heater door had a storage room self-lock handle put in place on 1.5.16. Maintenance Director reviewed F tag 323 Monitored – All water heater doors will be reviewed by ED/Designee 2 X per week for 4 weeks, 2 X per month for 3 months, then quarterly until 100% compliance is achieved. All findings will be reviewed in PI</p>	01/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
F 0371 SS=F Bldg. 00	<p>accessible to residents.</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper sanitation related to low wash temperatures on the chemical dishwasher and improper sanitization of the food thermometer. The facility also failed to ensure proper food storage in the freezer. This had the potential to affect 90 of 90 resident who resided in the facility. (Kitchen)</p> <p>Findings include:</p> <p>1. On initial tour on 1/4/16 at 6:17 p.m., the following was observed:</p>	F 0371	<p>Immediate – Dishes were rewashed in accordance with policy and procedure on 1.4.16 Food in freezer was labeled and stored in accordance to policy and procedure on 1.4.16 Thermometer was cleaned and sanitized per policy and procedure on 1.6.16 All other - All other dishes were rewashed in accordance to policy by 1.6.16 Review of all food storage was conducted and found to be in compliance on 1.6.16 All thermometers were cleaned in accordance to policy on 1.6.16 Systemic – All kitchen staff were educated by the ED/Designee on</p>	01/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSELAER, IN 47978
---	---

(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
	<p>a. The Dietary Aide #1 washed dishes with the wash cycle temperature read 100 degrees Fahrenheit and the rinse cycle was 130 degrees Fahrenheit.</p> <p>Interview with the Dietary Aide #1 at 6:17 p.m. on 1/4/16, indicated the dishes were washed and ready to be used. She further indicated, she did not know what the wash and rinse temperatures should have been.</p> <p>Interview with Cook #1 on 1/4/16 at 6:20 p.m., indicated the Dietary Aide #1 should have ran the dishwasher until the temperature reached between 140-160 degrees Fahrenheit.</p> <p>The "Dish Machine Temperature Log for Jan. (January) 2016," lacked an indication of Breakfast and Lunch of "wash, rinse, strip and initial/action taken if needed" for 1/1, 1/2, 1/3, and 1/4/16. Dinner on 1/2/16 also lacked an indication of a "wash, rinse, strip and initial/action taken if needed".</p> <p>b. The freezer had opened frozen beef patties, carrots and French bread that were unlabeled, undated and exposed to the air.</p>		<p>F tag 371 by 1.22.16</p> <p>Monitoring – Dish machine log and temp will be reviewed 5 X per week by ED/Designee X 4 weeks, 1 X per month X 3 months then quarterly until 95% compliance is achieved.</p> <p>Food storage and labeling will be reviewed by ED/Designee 2 X per week for 4 weeks, 2 X per month for 3 months and then quarterly until 95% is achieved</p> <p>Thermometer sanitation will be observed by ED/Designee 2 X per week for 4 weeks, 2 X per month for 3 months and then quarterly until 95% compliance is achieved.</p> <p>All findings will be reviewed in PI</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>An interview at that time with Cook #1, indicated all of those food bags should have been labeled with the date and closed.</p> <p>The policy titled "Chemical-Sanitizing Dish Machine," was provided by the Director of Dietary Services on 1/5/16 at 9:57 a.m. and indicated was current. The policy indicated, "Policy: Chemical-sanitizing dish machines clean and sanitize items at much lower temperatures but not lower the 120 degrees Fahrenheit..."</p> <p>The policy titled, "Frozen Storage," was provided by the Director of Dietary Services on 1/5/16 at 9:57 a.m. and indicated was current. The policy indicated, "...will follow Frozen Storage guidelines to ensure food safety for residents...."</p> <p>2. During the observation of the food temperatures with Cook #2 on 1/6/16 at 10:58 a.m., the following occurred:</p> <p>Cook #2 picked up the food thermometer from the steam table, placed the thermometer into the ground meat then wiped the thermometer on a cloth on the steam table, then placed the thermometer into the pureed vegetable, then wiped the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSELAER, IN 47978
---	---

(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
	<p>thermometer on the same cloth on the steam table, next placed the thermometer into the pureed beef stroganoff, (without wiping thermometer on the cloth) then placed the thermometer into the beef cubes, wiped the same thermometer on the same cloth, then placed the same thermometer into the zucchini, wiped the thermometer on the same cloth, then placed the same thermometer into the fortified potatoes, wiped the thermometer on the same cloth, then placed the same thermometer into the beef stroganoff, then wiped the thermometer on the same cloth, then placed the same thermometer into a pan of noodles, then wiped the thermometer on the same cloth, and then finally, placed the same thermometer into another pan of stroganoff.</p> <p>Interview with the Director of Dietary Services (DDS) on 1/6/16 at 11:02 a.m., indicated that was the normal procedure was to just run the thermometer under running water. She further indicated an alcohol wipe was not needed to use on the thermometer in between temperatures.</p> <p>Interview with DDS on 1/6/15 at 11:56 a.m., indicated the cloth used to wipe the food thermometer was from the sanitization bucket.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/08/2016
NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978		
(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	
F 0465 SS=E Bldg. 00	<p>The policy titled, "Chapter 1: Food Safety and Infection Control," was provided by the DDS on 1/6/16 at 11:45 a.m. and indicated it was current. The policy indicated, " How to Sanitize a Food Thermometer: Use alcohol swabs to carefully sanitize the thermometer, or use the three-compartment sink method to wash, rinse, and sanitize the thermometer...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred and gouged walls and doors, cracked floor tile, ripped shower curtain, dented heat registers, on 4 of 4 units throughout the facility. (Rehab, Special Care, 300, 400)</p> <p>Findings include:</p> <p>An Environmental Tour was completed on 1/8/16 at 2:20 p.m. with the Maintenance Supervisor, the Director of</p>	F 0465	<p>Immediate – All repairs were completed by 1.16.15. Repairs were done by Maintenance and a sub-contractor who specializes in tile work. All others – ED Reviewed all rooms and halls to identify environmental issues on 1.14.16 Systemic – maintenance department were educated by Executive Director in regards to F-tag 465 on 1.14.16 Monitoring – ED/Designee will monitor facility 1 X per week X 4 weeks, 1 X per month for 3 months and then quarterly until 95% compliance is achieved. All findings will be reviewed in PI.</p>	01/29/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>Environmental Services, and the Administrator.</p> <p>1. Rehab:</p> <p>a. Room 3: The inner bottom of the bathroom door and door frame were marred. One resident resided in this room.</p> <p>b. Room 9: The inner bottom of the bathroom door was marred. One resident resided in this room.</p> <p>c. Room 17: The inner bottom of the bathroom door was marred. Two residents resided in this room.</p> <p>d. Room 19: The wall by bed 1 was gouged. One resident resided in this room.</p> <p>e. Room 21: The inner bottom of the bathroom door was gouged, the non-skid strips were peeling on the bathroom floor and the toilet tank lid was too small.</p> <p>2. Special Care:</p> <p>a. The hallway ceiling outside Room 217 was stained. Twenty three residents resided on this unit.</p> <p>b. Room 205: The floor tile in front of the closet was cracked. One resident resided in this room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>c. Room 210: The corner of the heat register under the window was dented in, leaving a sharp edge. One resident resided in this room.</p> <p>3. 300 Hall</p> <p>a. The floor tile in the shower room was cracked and the outer door was marred. Twenty six residents resided on this hall.</p> <p>b. Room 300: The inner bathroom door was marred. Two residents resided in this room.</p> <p>c. Room 304: The inner bathroom door was marred. Two residents reside in this room.</p> <p>d. Room 305: The inner bathroom door was marred. Two residents resided in this room.</p> <p>e. Room 316: The outer room door was marred, the wall by the closet was gouged, there was a hole in the closet door, and there was a hole in the bathroom wall above the call light control. One resident resided in this room.</p> <p>4. 400 Hall</p> <p>a. The floor tile in the shower room was cracked, one shower curtain was ripped,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978
--	--

(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
	<p>and the outer door was marred. Twenty five residents resided on this hall.</p> <p>b. Room 402: There was a gouge in the wall below the window. Two residents resided in this room.</p> <p>c. Room 403: The inner and outer bathroom door was gouged and marred. Two residents resided in this room.</p> <p>d. Room 406: The heater register cover was bent outward, slightly exposing the heating element. One resident resided in this room.</p> <p>e. Room 409: The inner bathroom door and doorjamb were marred and the closet door closest to the bathroom was marred and had a hole. Two residents resided in this room.</p> <p>f. Room 411: The bathroom doorjamb and the bathroom wall were gouged. Two residents resided in this room.</p> <p>At the time of the tour, the Maintenance Supervisor agreed all areas were in need of repair or replacement.</p> <p>3.1-19(f)</p>			

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

PRINTED: 01/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/08/2016
NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978		
(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	