

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 11/18/2013
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NAME OF PROVIDER OR SUPPLIER RENSELAER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSELAER, IN 47978
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included Investigation of Complaints IN00130688, IN00131189, and IN00139107.</p> <p>Complaint IN00130688 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00131189 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00139107 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 12,13,14,15 & 18, 2013</p> <p>Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840</p> <p>Survey Team: Heather Hite, RN - TC Heather Tuttle, RN Jennifer Redlin, RN Caitlyn Doyle, RN (11/14, 11/15 & 11/18/2013) Janelyn Kulik, RN (11/13/2013)</p>	F000000	Rensselaer Care Center respectfully submits this plan of correction and request paper compliance. 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.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Census Bed Type: SNF/NF:88 Total: 88</p> <p>Census Payor Type: Medicare: 18 Medicaid: 59 Other: 11 Total: 88</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 25, 2013, by Janelyn Kulik, RN.</p>				

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F000247 SS=A	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview the facility failed to ensure every resident was notified when there was a change in roommate for 1 of 1 residents reviewed for Admission, Transfer, and Discharge of the 1 resident who met the criteria for Admission, Transfer, and Discharge. (Resident #94)</p> <p>Findings include:</p> <p>On 11/12/13 at 3:15 p.m., Resident #94 was interviewed. At that time, the resident indicated she was given a new roommate a couple months ago. She further indicated staff did not tell her or notify her in advance she was getting a new roommate until she came back from lunch one day and there was her new roommate.</p> <p>The record for Resident #94 was reviewed on 11/15/13 at 1:14 p.m. The resident was admitted to the facility on 7/2/13. The resident's diagnoses included, but were not limited to high blood pressure, colon cancer, insomnia, and depression.</p>	F000247	247Family, resident and physician were made aware of resident 94's new room mate. Upon review the SSD reported that she had a verval conversation but failed to document on the notification. SSD recieved education on 12.4.13 related to F tag 247 and resident need to know of new roommatesSSD will do a 30 day look back of all roommate moves since 11.18.13 to identify any potential roommate notification errors. All errors will be immediately addressed. Form was put in place to verify all residents recieving a new roommate are notified. The ED will initial all roommate change forms after both residents have signed.All roommate moves will be reviewed in PI for 3 months until 95% compliance is achieved.	12/12/2013			

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	<p>Review of the 7/9/13 Admission Minimum Data Set (MDS) assessment indicated the resident was alert and oriented with memory problems.</p> <p>Review of Social Service Progress Notes dated 8/30/13, indicated "Resident got a new roommate this week. She states they are getting along very well, no concerns voiced...."</p> <p>Interview with the Social Service Director (SSD) on 11/15/13 at 10:45 a.m., indicated the resident received a new roommate on 8/26/13. The new roommate was a direct admit to Resident #94's room. Further interview with the SSD, indicated new residents were usually admitted to the skilled unit in which they were all private rooms, so there was no need to notify a resident of a new roommate. She further indicated this case was unusual in which Resident #94's new roommate was a direct admit to the West Unit. The SSD further indicated there was no documentation indicating she told Resident #94 she was getting a new roommate.</p> <p>3.1-3(v)(2)</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to monitoring blood pressures and apical pulse before administration of high blood pressure medications and doing a gradual dose reduction for an antidepressant medication for 2 of 5 residents reviewed for unnecessary medications. (Resident's #94 and #9)</p> <p>Findings include:</p>	F000329	<p>329Sited – Resident 94's blood pressures and apical pulses have been stable, without any negative outcomes. The resident physician has decreased the blood pressure and apical pulse to weekly. Resident # 9 had their physician notified of the Lexapro GDR and it has been decreased. Resident did not suffer any ill effects from the Lexapro. All Others – A 100% audit was conducted in regards to residents receiving blood pressure monitoring and apical pulse with no other findings noted. A letter</p>	12/12/2013	

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	<p>1. The record for Resident #94 was reviewed on 11/15/13 at 1:14 p.m. The resident was admitted to the facility on 7/2/13. The resident's diagnoses included, but not limited to high blood pressure and atrial fibrillation.</p> <p>Review of Physician Orders dated 7/2/13, indicated Metoprolol (a blood pressure medication) 25 milligrams (mg) one tab hold if Systolic Blood Pressure (SBP) less than 90 or Apical Pulse (AP) less than 60. Review of the 9/2013 Physician's recap indicated the above order.</p> <p>Review of the Medication Administration Record (MAR) for the month of 9/2013 indicated there was no evidence of blood pressures or apical pulses documented before administration of the Metoprolol medication for the entire month 9/1-9/30/13.</p> <p>Interview with LPN #1 on 11/15/13 at 1:55 p.m., indicated the blood pressures and apical pulses should have been completed and documented on MAR prior to administration.</p> <p>2. The clinical record for Resident #9</p>		<p>was sent out to all primary care physicians who practice with in the facility consisting of information which is required in addressing a GDR. In-service – All licensed nurses to complete mandatory in-services by 12.12.13 related to the medication administration record, blood pressures and apical pulses. Clinical leadership met with the pharmacist on 12.2.13. Pharmacy will address each medication class with a separate GDR to the physician.PI – DON or designee will audit blood pressures and apical pulses being completed 5 X per week for 4 weeks, 1 X per week for 4 weeks and then monthly X 3 months until 95% compliance is achieved. DON/Designee will receive a copy of each GDR on a monthly basis for review. GDR's not addressed fully by the physician with a patient specific rational will be readdressed with the physician. Any unusual findings will be reviewed in the monthly PI meeting.</p>				

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	<p>was reviewed on 11/14/13 at 8:30 a.m.</p> <p>The resident's diagnoses included, but were not limited to, stroke, depression, dementia without behavior disturbance.</p> <p>The Physician's Recapitulation Orders, dated 11/2013 indicated medication orders for Lexapro 20 milligrams (mg) 1 tablet orally once a day - increased depression (started 1/27/11) and Seroquel 25 mg 1/2 tab (12.5 mg) orally every day at 4 p.m. (started 9/11/13).</p> <p>MARs (Medication Administration Records) for 9/2013, 10/2013 & 11/2013 indicate medications given as ordered.</p> <p>Pharmacy Consultation Report dated 8/30/13 - GDR (Gradual Dose Reduction) request indicated resident "has received Seroquel 25 mg everyday (qd) at 4 p.m. since a decrease 2/13 for dementia with psychosis. She is also taking Escitalopram (Lexapro) 20 mg qd. Behavior logs for August, July & June have 0 behaviors noted. Recommendation: Please consider gradual dose reduction, perhaps decreasing Seroquel 25 mg to 1/2 tab (12.5 mg) qd @ 4 p.m.."</p>			

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	<p>Recommendation for GDR accepted by MD and implemented for Seroquel. Did not address Lexapro.</p> <p>Pharmacy consultation report dated 11/29/2012 - GDR (Gradual Dose Reduction) request indicated resident "has received Seroquel 50 mg qd at 4 p.m. since a failed decrease 6/12 for dementia with psychosis. She started Quetiapine in 2/12 and has only had 1 dose reduction attempt so far. She is also taking Bupropion SR 150 mg QD and Lexapro 20 mg qd for depression for over a year. Recommendation: Please consider a gradual dose reduction, perhaps decreasing Seroquel to 25 mg QD at 4 p.m. and continuing Bupropion and Lexapro." Physician's response: Decline GDR recommendation - "Working."</p> <p>Interview with the Pharmacist on 11/18/13 at 9:40 a.m., DoN (Director of Nursing), SSD (Social Service Director) and Administrator also present. The Pharmacist indicated Welbutrin (antidepressant) was discontinued in April 2013 and Seroquel (antipsychotic) dose was reduced in September, 2013. She further indicated no change has been attempted in Lexapro (antidepressant) dose since started in 2011. The Pharmacist indicated</p>				

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	<p>there was no documentation from the Physician other than "Working" on the declined GDR (Gradual Dose Reduction) form for Seroquel recommendation in 11/2012 which also listed current medications of Welbutrin and Lexapro at the time.</p> <p>3.1-48(a)(2)</p>			

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Nurse Staffing sign posted for the public to view had the facility's name on it. This had the potential to effect 88 of the 88 residents who</p>	F000356	356 Sited - The nurse staffing sign was amended to reflect the facility name during survey on 11.15.13. All Others – There are no other staffing signs to addressInservice – The scheduler and weekend managers were	12/12/2013

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	<p>were residing in the facility.</p> <p>Findings include:</p> <p>On 11/12/13 at 10:03 a.m., the Nurse Staffing sign was posted on the wall with the current date, however the facility name was not posted on the sign.</p> <p>On 11/13/13 at 10:34 a.m., and at 2:03 p.m., the Nurse Staffing sign was posted on the wall with the current date, however the facility name was not posted on the sign.</p> <p>On 11/14/13 at 9:56 a.m., and 1:33 p.m., the Nurse Staffing was posted on the wall with the current date, however the facility name was not posted on the sign.</p> <p>On 11/15/13 at 1:11 p.m., and on 11/18/13 at 10:35 a.m., the Nurse Staffing was posted on the wall with the current date, however the facility name was not posted on the sign.</p> <p>Interview with the Administrator on 11/18/13 at 10:38 a.m., indicated the facility name was not on the Nurse Staffing sign posted on the wall for the public to view</p> <p>3.1-13(a)</p>		<p>educated by the DON/Designee, prior to date of compliance, on the need to ensure the staffing sign says Rensselaer Care Center on it. PI – The sign will be monitored weekly for 4 weeks to ensure that it has Rensselaer Care Center posted on it. If 100% compliance is achieved then the sign will be monitored quarterly for 2 quarters. Any unusual findings will be reviewed in the monthly PI meeting.</p>				

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F000371 SS=E	<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 and interview, the facility failed to ensure food was stored under sanitary conditions related to dusty and dirty oven hoods, dust build up on the steamer and oven, and accumulation of grease on the oven and tilt skillet for 1 of 1 kitchen observed. (The Main Kitchen)</p> <p>Findings Include:</p> <p>1. During the Brief Kitchen Sanitation Tour with the Dietary Food Manager on 11/12/13 at 9:20 a.m. indicated the following:</p> <p>A. There was a heavy accumulation of grease and dirt noted between the slats on both oven hoods. There was also a large amount of rust noted on the inside of the oven hood above the steamer and on the wall.</p> <p>B. There was a heavy accumulation of grease build up on the outside of the tilt skillet.</p>	F000371	<p>371Sighted – The slats on the oven hoods were replaced with new stainless steel grease baffles on 11.15.13. The oven hood was repainted with rust resistant paint on 12.3.13The tilt skillet was cleaned to reduce grease build up on 11.15.13The top of the steamer and convection oven was cleaned on 11.15.13The vent storage cabinet next to the steam table was cleaned on 11.15.13All others – Kitchen audit was conducted by the ED on 12.3.13 related to sanitation, with all affected areas immediately addressed. Inservice – Kitchen staff was inserviced related sanitation by 12.5.13 by the ED and DMPI – Affected areas will be audited 5 X per week for 4 week, 1 X per week for 4 weeks and then 1 X per month for 3 month until 95% compliance is achieved. Any unusual findings will be addressed in the monthly PI meeting.</p>	12/12/2013	

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	<p>C. The tops of both the steamers and convection ovens were dirty and dusty.</p> <p>D. There was a large amount of grease build up on the back splash of the stove and on the grates.</p> <p>2. During the Full Kitchen Sanitation Tour on 11/18/13 at 10:32 a.m., with the Dietary Food Manager indicated the following:</p> <p>A. There was dirt and dust noted on the vent of the storage cabinet located next to the steam table.</p> <p>Interview with the Dietary Food Manager on 11/18/13 at 10:50 a.m., indicated all the above was in need of cleaning.</p> <p>3.1-21(i)(3)</p>				

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure each resident who required a yearly review from the Pre-Admission Screening Level Two assessment received one in a timely manner for 1 of 10 residents reviewed for Pre-Admission Screening of the 1 resident who met the criteria for Pre-Admission Screening. (Resident #51)</p> <p>Findings include:</p> <p>The record for Resident #51 was reviewed on 11/15/13 at 10:22 a.m. The resident's diagnoses included, but were not limited to, Marfan Syndrome, psychosis, dementia, and Mental Retardation.</p> <p>Review of the Minimum Data Set</p>	F000406	<p>406Sighted – BDDDS OBRA specialist was phoned on 11.15.13 regarding the late assessment for resident 51. She indicated that the assessments were running behind and would assess ASAP. The assessment was completed on 11.26.13All others – All BDDDS assessments dates were reviewed with SSD and BDDDS representative on 11.26.13Inservice – SSD was inserviced related to communication and documentation with BDDDS office by the Executive Director. PI – Audit schedule for BDDDS assessments was created and will be reviewed by SSD 1 X per week for 4 weeks, 1 X per month for 3 months and quarterly until 95% compliance is achieved. SSD will notify BDDDS of upcoming assessments and document the outcome of notification. Any unusual findings will be reviewed in the monthly PI</p>	12/12/2013	

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 11/18/2013	
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	<p>(MDS) Significant Change assessment dated 8/19/13 indicated the resident was not alert and oriented and the Pre-Admission screening indicated the resident had a mental retardation disability.</p> <p>Review of the Pre-Admission screening for the resident indicated the last annual review was completed on 10/3/12. The annual review indicated the next case review would be in 2013.</p> <p>Interview with Social Service Director (SSD) on 11/18/13 at 9:33 a.m., indicated she had contacted the Family Social Service Administration (FSSA) and they indicated they were behind with the yearly reviews. She further indicated after speaking with FSSA, the yearly review had been set up for 12/18/13 . The SSD further indicated she had not called FSSA until 11/15/13 to see if the annual review had been set up or completed. She further indicated she had no system of keeping track of when the annual reviews were to be completed and calling FSSA ahead of time to set up the appointments.</p> <p>3.1-23(a)(2)</p>		meeting.				

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F000465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was clean related to an accumulation of dirt and grease along the baseboard under the dish machine, food stained and marred kitchen walls, and grease and dirt along the baseboard behind the steamer and ovens for 1 of 1 kitchen observed. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Sanitation Tour with the Dietary Food Manager (DFM) on 11/12/13, at 9:20 a.m., the following was observed:</p> <p>A. There was a heavy accumulation of grease and dirt noted against the baseboard under the dish machine. The white PVC pipes under the dish machine were also noted with food spillage and/or dirt.</p> <p>B. The white wall behind the stove, convection ovens, tilt skillet, and steamer was dirty with food stains and/or black scuffs.</p>	F000465	<p>465Sighted – The base boards and PVC pipes were cleaned on 11.15.13The white wall behind the stove was cleaned and repainted on 12.4.13The floor and base board behind the convection oven and steamer was cleaned on 12.4.13The accordion gas pipes were cleaned on 11.15.13The white PVC pipes under the food prep sink were cleaned on 11.15.13The return ceiling vents were painted on 12.4.13All others – Kitchen sanitation audit was conducted on 12.3.13 with all identified areas immediately addressedInservice – Kitchen staff was inserviced related to sanitation on 12.5.13 by the ED and DMPI – Affected areas will be audited 5 X per week for 4 week, 1 X per week for 4 weeks and then 1 X per month for 3 month until 95% compliance is achieved. Any unusual findings will be reviewed in the monthly PI committee.</p>	12/12/2013	

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	<p>C. The floor and against the baseboard behind the convection oven and steamer was dirty with grease build up.</p> <p>2. During the Full Kitchen Sanitation Tour on 11/18/13, at 10:32 a.m., with the Dietary Food Manager the following was observed:</p> <p>A. The accordion gas pipes located behind the oven and stove were dusty and dirty.</p> <p>B. The white PVC pipes under the food prep sink and the three compartment sink were also dirty and food stained.</p> <p>C. The white wall behind and on the side of the three compartment sink was marred.</p> <p>D. The two return ceiling vents in the dish room were rusty.</p> <p>Interview with the Dietary Food Manager on 11/18/13 at 10:50 a.m., indicated all the above was in need of cleaning.</p> <p>3.1-19(f)</p>						