

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2014
--	---	--	---

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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/21/14</p> <p>Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rensselaer Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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>The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and in spaces open to the corridors. Resident rooms are equipped</p>	K010000	<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. 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 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/21/2014	
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			
K010018 SS=E	<p>with battery powered smoke detectors. The facility has the capacity for 157 and had a census of 94 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Two detached sheds for general storage were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/21/2014
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>Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 13 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 26 residents on the core unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/21/14 at 1:20 p.m., the door separating resident room 205 from the exit corridor failed to latch when tested three times with the maintenance director. The maintenance director commented at the time of observation, the latch needed to be "adjusted" before it could latch into the door frame.</p> <p>3.1-19(b)</p>	K010018	<p>K 018Room 205 was immediately adjusted to latch into the door frameMaintenance Director and assistant educated on regulations. All doors shall be inspected to insure functionality and code complianceAll corridor fire/smoke doors shall be inspected weekly for 1 month and quarterly thereafter per preventative maintenance program to ensure functionality and code compliance Maintenance director to monitor and review preventative maintenance logs quarterly at safety committee meetings</p>	02/07/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2014	
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			
K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure a ceiling smoke partition in 1 of 13 smoke compartments was sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and and 6 or more residents in the core lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/21/14 at 1:00 p.m., one unsealed ceiling conduit penetration was found in the core mechanical transfer switch room. The maintenance director said at the time of observation, recent electrical work was done and he hadn't known the penetration was unsealed.</p> <p>3.1-19(b)</p>	K010025	<p>K 025Conduit penetration was immediately sealed using materials designed specifically for this purpose. Maintenance Director and assistant educated on regulations. All smoke barrier walls were inspected by 1.30.14 to ensure complianceAll smoke/fire barrier walls will be inspected quarterly for one year and annually there afterPreventative maintenance logs will be reviewed by the safety committee quarterly to ensure continued compliance for one year following the noted issue.</p>	02/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/21/2014	
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			
K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure doors serving hazardous areas such as rooms larger than 50 square feet storing combustible materials in 2 of 13 smoke compartments self closed and latched to prevent the passage of smoke. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 20 or residents on the core and 400 unit.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 01/21/14 at 2:00 p.m., the seven by twelve foot</p>	K010029	<p>K 029Both room doors were immediately fitted with self-closing devices. Maintenance Director and assistant educated on regulations. All storage room doors were inspected by 1.30.14 to ensure proper closing and latchingAll storage rooms will be inspected weekly for 1 month and quarterly thereafter. Preventative Maintenance logs will be reviewed by the safety committee quarterly to ensure continued compliance for one year following the noted issue.</p>	02/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/21/2014
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	
K010072 SS=E	<p>room near 401 was used for storing 34 cardboard supply laden cartons and plastic bags filled with clothing. The access door from the corridor had no self closer. The maintenance director said at the time of observation, the room was a former office which was being used for storage.</p> <p>b. Based on observation with the maintenance director on 01/21/14 at 2:40 p.m., the eight by ten foot room near the core nurses' station was lined with shelves for the clean linen stored there. The access door from the corridor had no self closer. The maintenance director said at the time of observation, the room which also housed telephone equipment was recently changed to accommodate clean linen storage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 4 of 9 exterior</p>	K010072	K 72All exit areas were immediately shoveled and	02/07/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2014
--	---	--	---

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>exit discharges were maintained to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect residents, staff and 20 or more residents on the special care unit, skilled unit and core smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/21/14 between 12:35 p.m. and 3:00 p.m., emergency exit discharges were covered with areas of ice and snow for the exits from the special care unit near room 213, from the skilled unit near room 014 and room 20, and from the core between the exit discharge and the gate. The maintenance director acknowledged at the time of observations, the surfaces should have been cleared.</p> <p>3.1-19(b)</p>		<p>cleared of remaining ice during survey processThe maaintenance director and assistant were educated on the K 72 All exit doors will be reviewed weekly or during snow storms, to ensure optimal adhearance to regulation.Safety Committee will review all logs related to snow removal.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155287	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2014
--	---	--	---

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
K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 6 or more residents in the adjacent core lounge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 01/21/14 at 1:30 p.m., a power strip extension cord was used to supply power to a microwave in the employee break room. The maintenance director acknowledged at the time of observation, the power strip should not have been used.</p> <p>3.1-19(b)</p>	K010147	<p>147Microwave was removed during the survey processMaintenance Director and assistant educated on regulations. Facility was inspected to ensure safe use of power stripsFacility will be inspected weekly for one month and quarterly thereafter to ensure safety and compliance. Safety committee will review any findings from inspection.</p>	02/07/2014