STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155287	A. BUILDING 00 B. WING	02/23/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00422083, IN00427056 and IN00427905. Complaint IN00422083 - No deficiencies related to the allegations are cited. Complaint IN00427056 - Federal/state deficiencies related to the allegations are cited at F656 and F744. Complaint IN00427905 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 22 and 23, 2024. Facility number: 000185 Provider number: 155287 AIM number: 100290840 Census Bed Type: SNF/NF: 76 Total: Census Payor Type: Medicare: 8 Medicaid: 57 Other: 11 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/29/24.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Rensselaer Care Center agrees with the allegations and citations listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Costello	Executive Director	03/14/2024

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

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F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer			

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	would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for			

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	ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility failed to ensure a resident and/or their responsible party were notified in writing related to a bed hold notice for 1 of 1 residents reviewed for hospitalization. (Resident 71). Finding includes: Resident 71's record was reviewed on 2/24/24 at 1:15 p.m. Diagnosis included, but were not limited to, protein calorie malnutrition, major depressive disorder and psychotic disorder with delusions. condition. The State Optional Minimum Data Set (MDS) assessment, dated 1/30/24, indicated the resident was cognitively impaired. A Progress Note, dated 10/10/23, indicated the resident was referred to the neuro psychiatric hospital for evaluation and treatment due to aggressive behavior. The resident was readmitted to the facility on 10/17/23. There was a lack of documentation that any bed hold policy had been completed or provided in writing to the resident or his responsible party. During an interview with the Director of Nursing, on 2/23/24 at 2:00 p.m., she indicated she does not have the bed hold forms for the residents transfer to the neuro psychiatric hospital.	F 0622	**F 622** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 71was issued a bed hold notice for discharge from 10/10/2023. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Discharges for the last 30 days were audited and any residents who did not receive a bed hold notice were sent bed hold notice via mail. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The DON/designee to educate nursing staff and SSD/designee in regard to bed hold policy and completing bed hold notice with all discharges. Education to be completed by 3/14/24.	03/18/2024

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	3.1-12(a)(6)(A)		***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit all resident discharges x 6 months to ensure bed hold notices have been completed on all discharges. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to develop and implement a care plan for a resident with a history of wandering into other resident's room, for 1 of 21	F 0656	**F 656** ***What corrective action(s) will be accomplished for those residents found to have been***	03/18/2024

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	resident care plans reviewed. (Resident C) Finding includes: On 2/22/24 at 2:25 a.m., Resident C was observed walking down the hallway towards Resident's B room. Resident C was no longer viewed in the hallway and had wandered into Resident B's room. Record review for Resident C was completed on 2/20/24 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, and hypertension. The Admission Minimum Data Set assessment, dated 1/12/24, indicated the resident was cognitively impaired. The resident had delusions, physical and verbal behaviors towards others, intrudes on the privacy of others, and significantly disrupted care or living environment. The resident was independent with mobility. A Care Plan, dated 2/2/24, indicated the resident does not allow others personal space. She intrudes on the space of others. Interventions included to encourage as much participation/interaction by the resident as possible during care activities, praise the resident when behavior was appropriate, and provide consistency in care to promote with ADLs. The Care Plan did not have any indication the resident would wander into other resident's room or provide any interventions on what staff were to do if the resident did. During an interview on 2/23/24 at 11:12 a.m., CNA 1 indicated Resident C was always wandering into peoples' rooms and she was known to wander into Resident B's room a few times prior. When she would wander into another resident's room, staff		***affected by the deficient practice?*** Resident C care plan was updated to reflect current behavior of wandering into others rooms. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Residents with wandering behaviors or potential for wandering behaviors were identified. Care plans for those residents were reviewed and updated as needed. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON/Designee to educate all staff who are involved with care planning, from all departments, on care plan writing including problem, goal and accurate interventions. Education will be completed by 3/14/24. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** IDT will review the 24/72 hour report 5 days a week to monitor for any behaviors, this will include any new admissions. Care plan	

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	would just direct her out of there. During an interview on 2/23/24 at 11:28 a.m., the Director of Nursing indicated there was no care plan in place for the resident wandering into other residents' rooms. This citation relates to Complaint IN00427056. 3.1-35(a)		will be updated in the clinical meeting to reflect behavior. Practice will be ongoing for best practice. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure ADL (activities of daily living) care was provided to a dependent resident, related to showering as scheduled, for 1 of 3 residents reviewed for ADL care. (Resident 22) Finding includes: During an interview on 2/19/24 at 10:18 a.m., Resident 22 indicated she was not receiving twice weekly showers. Resident 22's record was reviewed on 2/21/24 at	F 0677	**F 677** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 22 was offered a shower on 2/23/24 and refused. She received her shower on 2/26/24 per her schedule. ***How other residents having the potential to be affected by the***	03/18/2024

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	9:11 a.m. Diagnoses included, but were not limited to, paraplegia (leg paralysis), and rheumatoid arthritis. The Admission Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was cognitively intact for daily decision making. She had an impairment in functional range of motion to both lower extremities and was dependent on staff for ADL care, including bathing. A Care Plan, dated 1/20/23, indicated the resident needed ADL assistance including, but not limited to, bed mobility, bathing, and personal hygiene. The Task ADL - Bathing indicated the resident was to receive a bed bath every Sunday and Thursday. There were no bed baths documented on 12/7/23, 1/7/24, 1/21/24, 2/1/24, 2/15/24, and 2/18/24 for the months of December 2023 to February 2024. There was no documentation of bed baths offered on days other than Sunday and Thursday. During an interview on 2/22/24 at 2:16 p.m., the Director of Nursing indicated the resident should have received twice weekly bed baths. 3.1-38(a)(2)(A)		***same deficient practice will be identified and what corrective action(s) will be taken?*** All residents have the potential to be affected. A house audit was completed on 2/28/24 and 2/29/24 with 2 issues identified and were immediately addressed. Both residents were offered and received showers upon being identified. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON/designee to educate nursing staff on ADL care including showers by date of compliance. Shower assignments to be completed by the charge nurse. Charge nurse to ensure showers have been completed or refusals documented by the end of the shift. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit shower schedule 5 times a week x 60 days, then 3 times a week x 60 days then weekly for the duration of 6 months to ensure that showers are being given and/or refusals are documented per schedule.	

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			The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services, related to not holding a medication as ordered, for 1 of 1 residents reviewed for constipation, lack of Physician notification of a lab result, for 1 of 7 residents reviewed for accidents, and not assessing or monitoring skin discolorations, for 1 of 1 residents reviewed for non pressure skin conditions. (Residents 13, 67 and 27) Findings include:	F 0684	**F684** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #13: Physician was updated and orders clarified. No negative outcomes. Resident #67: Physician was updated with the Vitamin D level with no new orders. No negative	03/18/2024

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	1. On 2/19/24 at 10:47 a.m., Resident 13 was observed lying in her bed. She indicated she had been having some issues with constipation, and had recently been sent to the hospital for treatment of constipation. The resident's record was reviewed on 2/21/24 at 9:00 a.m. Diagnoses included, but were not limited to, iron deficiency, congestive heart failure and Diabetes Mellitus. The Admission Minimum Data Set (MDS) assessment, dated 1/0/24, indicated the resident had moderate cognitive deficits and required extensive assistance of 2 staff for bed mobility, transfers and toileting. Current Physician's Order indicated the resident received Ferrous Sulfate (iron) 325 milligrams (mg) three times daily. A Care Management Note, dated 2/8/24 at 5:09 p.m., indicated the resident was having some constipation. Physician orders were received to hold iron for one week and start Miralax daily. A Health Status Note, dated 2/8/24 at 8:08 p.m., indicated the resident was complaining of abdominal pain and the family requested she be sent to the hospital for evaluation. The resident was sent out at that time. A Health Status Note, dated 2/8/24 at 10:10 p.m., indicated the resident had returned from the hospital where she had been treated for constipation. The February 2024 Medication Administration Record indicated the resident was administered		outcomes. Resident #27: Discoloration was measured and MD notified. New order received to monitor and measure weekly until resolved. No negative outcomes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents have the potential to be affected by the deficient practice. Audit completed for all medications on hold to ensure they were not given. Audit completed on all lab orders in last 30 days to ensure physician notification. Whole house skin sweep to be completed by date of compliance to ensure all areas identified have proper monitoring in place. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The DON/designee to provide education to nursing staff to include following physician orders, notification of lab results to MD timely, and on skin assessment completion both with admission/readmission and with any new finding. Assessment to include measurements, and orders to continue to monitor and	

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	Ferrous Sulfate 325 mg on the following dates and time when the medication was to be on hold: 2/9/24 evening 2/10/24 morning and evening 2/11/24 morning and midday 2/12/24 midday 2/13/24 morning The remaining doses of Ferrous Sulfate for that week were noted to have been held or refused by the resident. During an interview with the Director of Nursing (DON) on 2/21/24 at 1:45 p.m., she indicated when the resident had returned from the hospital on 2/8/24, all her previous medications had been resumed. She was unsure if the medication had ever been placed on hold as ordered. 2. Resident 67's record was reviewed on 2/21/24 at 1:10 p.m. Diagnoses included, but were not limited to, dementia, protein calorie malnutrition, history of falls and major depression. The Significant Change MDS assessment, dated 1/16/24, indicated the resident was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. An Event Note, dated 1/24/24, indicated the resident had fallen from a mechanical lift. She had a skin tear to her elbow, bruising to her left hand and back and small hematoma on the back of her head. She was sent to the emergency room for evaluation. No further injuries were noted. A Care Management Note, dated 1/25/24, indicated the Medical Director had been updated on the resident's status and new orders had been		measure until resolved by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit the 24/72 hour report and order listing report 5 times a week to ensure that orders rec'd were properly carried out. Audits will be ongoing for best practice. DON/Designee will audit labs drawn 5 times a week x 60 days, then 3 times a week x 60 days then weekly for the duration of 6 months, to ensure that MD has been notified of lab result timely. DON/Designee will audit 24/72 hour report including admissions/readmissions for any skin irregularities 5 times a week x 60 days, then 3 times a week x 60 days then weekly for the duration of 6 months, to ensure that measurement, description and continued monitoring and measuring are completed until resolved. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below	

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	received to obtain a repeat x-ray of her ribs and a Vitamin D level. A Health Status Note, dated 1/26/24, indicated the Vitamin D level had been drawn and sent to the lab. There were no results of the Vitamin D level in the resident's record or indication the results had been received in the notes. During an interview with the DON on 2/22/24 at 2:10 p.m., she indicated she was able to locate the test results in the computer. She was unable to find the original lab results or documentation the Physician had been notified of the results. 3. On 2/19/24 at 9:51 a.m., a dark purple discoloration was observed on Resident 27's left arm and right hand. On 2/23/24 at 11:45 a.m., Resident 27 was observed with a dark purple mark on the right hand and a dark purple mark on the left arm. The record for Resident 27 was reviewed on 2/19/24 at 10:00 a.m. Diagnoses included, but were not limited to, venous insufficiency, local infection of the skin and subcutaneous tissue and Diabetes Mellitus with other skin ulcer. The State Optional Minimum Data Set (MDS) assessment, dated 11/18/23, indicated the resident was cognitively intact. The Care Plan, dated 7/12/23, indicated the resident was at risk for abnormal bleeding and bruising related to the use of Coumadin (blood thinner medication) for chronic venous insufficiency.		100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	The Admission Assessment, dated 2/18/24, indicated the resident had bruising to the upper extremities. There were no measurements, description, or specific location of discolorations noted. There was no documentation of the discoloration being monitored or treated. During an interview with the Director of Nursing on 2/23/23 at 3:14 p.m., she indicated the Admission Assessment does not properly document the resident's measurements and accurate location of discoloration. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure safety measures were in place to prevent accidents, related to fall precautions not implemented for a resident with a history of falls, for 1 of 3 residents reviewed for accidents. (Resident 64) Finding includes: Resident 64 was observed asleep in bed on 2/19/24 at 11:30 a.m. She had a regular mattress	F 0689	**F 689** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #64: The bolstered mattress was immediately applied to resident's bed. ***How other residents having the***	03/18/2024

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	and the bed was in the lowest position. On 2/20/24 at 11:42 a.m., Resident 64 was observed in her bed, which was in the lowest position with a regular mattress. Resident 64's record was reviewed on 2/20/24 at 2:14 p.m. Diagnoses included, but were not limited to, fracture of the left femur with routine healing, dementia, and visual/auditory hallucinations. The Significant Change Minimum Data Set (MDS) assessment, dated 2/5/24, indicated the resident was severely cognitively impaired for daily decision making. She had an impairment to one lower extremity and used a wheelchair. A Care Plan, revised on 2/9/24, indicated the resident was at risk for falls related to cognitive impairment related to dementia, poor safety awareness and balance, and history of a fall with fracture. Interventions included, but were not limited to, concave mattress to bed, body pillow in bed for comfort and positioning, and frequent rounds while in bed. During an interview on 2/21/24 at 2:13 p.m., the Assistant Director of Nursing indicated the resident had gone to the hospital after a fall, and upon return, they had moved her room closer to the nurses' station. The concave mattress did not get moved during the transition. 3.1-45(a)(2)		***potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Audit completed on all residents that had falls in the past 60 days to ensure safety measures are in place. No other deficient practice was identified. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** The DON/designee to complete education with nursing staff/housekeeping related to ensuring all safety measures are transferred with resident when any room move is completed by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit residents with falls 5 times a week x 60 days, then 3 times a week x 60 days then weekly to complete the duration of 6 months to ensure that fall interventions are in place. Furthermore, any resident who has a room move will be audited to ensure all current interventions are moved with resident. The results of these reviews will be discussed at the monthly facility	

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			Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure staff monitored output from a foley catheter every shift per the care plan, for 1 of 1 residents reviewed for catheters. (Resident 22) Finding includes: Resident 22's record was reviewed on 2/21/24 at 9:11 a.m. Diagnoses included, but were not limited to, paraplegia (leg paralysis), neuromuscular dysfunction of bladder, and rheumatoid arthritis. The Admission Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was cognitively intact for daily decision making. She had an impairment in functional range of motion to both lower extremities and was dependent on staff for activities of daily living, and had an indwelling catheter. A Care Plan, dated 1/20/23, indicated the resident had an indwelling catheter. Interventions included, but were not limited to, catheter care every shift, observed and document for pain/discomfort due to catheter, and urinary output every shift. There was no documentation in the record related to the urinary output every shift per the resident's	F 0690	**F 690** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 22: care plan immediately updated to remove monitoring of output. No negative outcome. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** A house audit was completed and all residents with an indwelling Foley catheter were identified. The care plans of those residents were reviewed and corrected to reflect no monitoring of output. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** All staff who are involved with care	03/18/2024

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	care plan for the indwelling catheter. Interview on 2/23/24 at 10:47 a.m., the Director of Nursing indicated they do not document outputs for everyone with a catheter. It was an oversight when the care plans were generated, and it should have not been added. 3.1-41(a)(2)		planning from all departments to receive education on care plan writing including problem, goal and accurate interventions by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit all new admissions who have a Foley catheter, as well as any current resident who may receive an order for indwelling Cath, to ensure care plan is completed and correct. This practice will be ongoing for best practice. Care plans of all residents will be reviewed quarterly and as needed by the IDT to ensure accuracy of care plan. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0744 SS=D	483.40(b)(3) Treatment/Service for Dementia			

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Bldg. 00	§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure continuous effective interventions were implemented to prevent known triggers for residents with dementia who were observed with physical behaviors and wandering behaviors, for 2 of 3 residents reviewed for dementia care. (Residents B and C) Findings include: 1. On 2/22/24 at 2:25 a.m., Resident C was observed walking down the hallway towards Resident's B room. Resident C was no longer viewed in the hallway and Resident B was heard yelling "get out of here". LPN 1 was observed coming out of a room across the hall and went into Resident B's room. A minute later, Resident C was observed leaving Resident B's room. She walked down the hallway and sat down in a chair by the nurses' station. A few minutes later, Resident B was observed walking down the hallway. She stopped in front of Resident C and yelled at her "give me back my glasses". Resident B was then observed grabbing the glasses off of Resident C's face, smacking her on the right side of her face, and then proceeding to grab her on the top of her head and pull downward. At that time, the residents were separated by staff. LPN 1 then came back out of the room she was in previously across from Resident B's room, and was told what had just happened. Record review for Resident B was completed on	F 0744	**F 744** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** A door sensor alarm was placed on residents B's room on 2/23/24 to alert staff of anyone entering the room, or the resident exiting the room. Resident B has since been moved off of the Dementia unit to a private room in the general population to help reduce any wandering into her room by other residents. Resident C remains on the unit and continues to be followed by Psych services. No further altercations have occurred with this resident. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** A house audit was completed to identify any resident who wanders into others rooms and/or has the potential to wander. Care plans were updated accordingly. Dementia unit criteria was reviewed by IDT and Regional	03/18/2024

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	2/21/24 at 2:34 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder with delusions. The Quarterly Minimum Data Set (MDS) assessment, dated 2/12/24, indicated the resident was moderately cognitively impaired. The resident had inattention behaviors that fluctuated, hallucinations, and behaviors of physical and verbal directed towards others. The resident was independent with her mobility. A Progress Note, dated 2/4/24, indicated on 2/3/24 at 10:10 p.m., a CNA was alerted because resident B was yelling, "Get Out". The CNA entered Resident B's room and witnessed Resident B bent over and striking Resident C on her lower back. Resident C was laying belly down and army crawling to get out of the room. The CNA immediately separated the residents and the resident was put on 1 on 1 supervision. A Care Plan, dated 1/26/24 and revised 2/6/24, indicated the resident had been known to have increased agitation when others entered her personal space, and was possessive of her personal space. Interventions included to observe and redirect others away from her doorway/ room, redirect her away from others as needed, stop sign/banner on resident's doorway to deter intrusive wanderers. A Care Plan, dated 1/26/24, indicated Resident B had a resident to resident altercation related to pulling another resident to the ground. Interventions included, when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation.		team. All residents were re-evaluated for continuing to meet criteria. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON/Designee to provide education to dementia care nursing staff to include immediate sharing of altercations with staff so that continued safety may be provided for all residents by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** IDT will review the 24/72 hour report for any change and/or increase in behaviors in residents on the dementia unit. IDT will complete the secured unit continued placement evaluation on any resident with new and/or increased behaviors to ensure they are placed in the correct unit. Room changes will be completed as needed. SSD/Designee will follow up with staff to ensure they are aware of any altercations and proper protocol is being followed and care plans will be updated accordingly. The results of these reviews will be discussed at the monthly facility	

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	A Care Plan, dated 1/26/24, indicated Resident B was in a resident to resident altercation where she was noted to slap another resident. An intervention included to guide resident away from stressors, and to observe resident for stressors. A Care Plan, dated 2/5/24 and revised 2/6/24, indicated to guide resident away from stressors. Interventions included to observe resident for stressors, guide the resident away from things that agitate her such as when someone enters her personal space. Observe, evaluate and redirect others away from resident as needed. Observe and listen for signs and symptoms of agitation such as tone and volume of voice, furrowed brow, gestures and intervene immediately. Use a calm but firm approach and redirect others away from the resident. There was no indication when LPN 1 left Resident B's room, that she went and alerted staff what just happened so they were aware to keep an eye on the both of the residents. 2. Record review for Resident C was completed on 2/20/24 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, and hypertension. The Admission MDS, dated 1/12/24, indicated the resident was cognitively impaired. The resident had delusions, physical and verbal behaviors towards others, intrudes on the privacy of others and significantly disrupted care or living environment. The resident was independent with mobility. A Care Plan, dated 2/2/24, indicated the resident does not allow others personal space. She		Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	intrudes on the space of others. Interventions included to encourage as much participation/ interaction by the resident as possible during care activities, praise the resident when behavior was appropriate, and provide consistency in care to promote with ADLs. A Care Plan, dated 2/5/24 and revised 2/13/24, indicated the resident had a psychosocial well-being problem related to recent altercation. An intervention included when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. During an interview on 2/23/24 at 9:35 a.m., the Administrator indicated Resident C had walked into Resident B's room and picked up her glasses. Resident B was yelling at Resident C to get out and give her her glasses. LPN 1 ran into Resident B's room and Resident C was wearing her own glasses and holding Resident B's glasses in her hand. The nurse was able to get the glasses back from Resident C and then noticed one of the lenses was missing from the glasses. The nurse told Resident B they would get her glasses fixed and then she left the room and went back into another resident's room, where she had been providing care previously. The nurse then came out of the room after the altercation in the hallway with the 2 residents and helped separate them. A CNA had found Resident B's broken glass lens in Resident C's pocket. During an interview on 2/23/24 at 11:12 a.m., CNA 1 indicated he and LPN 1 were providing care for a resident across the hall from Resident B's room. They heard Resident B yell "get out of here". LPN 1 then left the room. When she returned, she indicated to him that Resident C had gone into Resident B's room and took her glasses from her.			

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	LPN 1 had to get Resident B's glasses back from Resident C, and then Resident C left Resident B's room. LPN 1 told him they needed to hurry with providing care so they could go back out and monitor both Resident B and Resident C. The CNA indicated it was approximately 6 minute from the time the nurse came back into the room until the altercation happened in the hallway between the 2 residents. He indicated Resident C was always wandering into peoples' room and she was known to wander into Resident B's room a few times prior. During an interview on 2/23/24 at 11:28 a.m., the Director of Nursing indicated the nurse should have let staff know after the initial incident between Resident B and Resident C happened, so the staff could make sure to keep an eye on them and keep them apart, since they had a history of an altercation in the past. This citation relates to Complaint IN00427056. 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were stored properly and with appropriate labeling, for 1 of 4 medication carts observed. (South Cart 1) Finding includes: On 2/23/24 at 10:16 a.m., South Cart 1 was observed with the Assistant Director of Nursing (ADON) and the following was observed: - There was a bottle of Cranberry oral 450 milligram (mg) tablets with no labels. - There were 8 unidentified pills found in the bottom of the drawers of the cart. - There were crushed medications found in the bottom of the drawers of the cart. - An insulin glargine 100 unit/milliliter pen was labeled with patient information, but no open date. - An insulin lispro 100 unit/milliliter pen was labeled with patient information, but no open date.	F 0761	**F 761** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** The south med cart was immediately cleaned and any and all meds with no labels, insulins not dated, or loose pills noted were removed from the cart. No negative outcomes ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents have the potential to be affected. All other medication carts were audited and no other deficiencies were noted. ***What measures will be put into place or what systemic changes will be made to ensure that the***	03/18/2024

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	- There was a bottle of antacids 500 mg tablets with no labels. The ADON indicated the medication cart needed to be cleaned out, the insulin pens were in use and should always have an open date written on the label, and the medication bottles should have the appropriate labels on them. A policy titled, "5.3 Storage and Expiration Dating of Medications, Biologicals," and noted as current indicated, "...2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened. 5.1 Facility staff may record the calculated expiration date based on date opened on the primary medication container...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn makeshift, incomplete, damaged, or missing labels or cautionary instructions." 3.1-25(j)		***deficient practice does not recur?*** The DON/Designee to provide education to all Licensed nursing staff and QMA's on Storage and expiration dating of medications by date of compliance. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/Designee will audit 2 med carts 5 times a week x 60 days, then 2 med carts 3 times a week x 60 days, then 2 med carts weekly for the duration of 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen, related to boxes of food stored on the freezer floor and clean dishes stored upright on a shelf, for 1 of 1 kitchens observed. (Main Kitchen). This had the potential to affect all 76 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 2/19/24 at 9:38 a.m., with Cook 1 the following was observed: a. The walk in freezer had boxes stacked up on the floor. The area was stacked with multiple boxes and not much room to get around them. b. There were multiple bowls, plates, and small plates stored upright on a shelf.	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · No residents were affected by the deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · 76 residents have the potential to be affected. · The Dietary Director received education on 2/26/2024 related to the proper food storage and maintained a clean, safe and	03/18/2024

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	During an interview on 2/19/24 at 9:55 a.m., Cook 1 indicated the truck had delivered the boxes stored on the freezer floor on 2/15/24. She was on vacation and just returned. She was in the process of trying to put everything away, but someone should have already put everything away. She was unaware the dished needed to be stored inverted versus upright to prevent dust & debris from collecting. 3.1-21(i)(3)		sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. · Dietary Director to educate all dietary staff related to the proper food storage and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth by date of compliance. · The Dietary Director received education on 2/26/2024 related to storing clean dishes inverted to minimize the collection of dust and debris. · Dietary Director to educate all dietary staff related to storing clean dishes inverted to minimize the collection of dust and debris by date of compliance. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Dietary Director/designee will conduct random checks to ensure proper food storage and is maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. · Dietary Director/designee will conduct random checks to ensure that all dishes are stored inverted to minimize the collection	

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			of dust and debris. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** · Dietary Director/designee will conduct daily checks 5 times a week x 2 months, then 3 times a week x 2 months, then weekly for the duration of 6 months to ensure we are in compliance with storing food and ensuring dishes are inverted according to state, federal, and local guidelines · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to not using hand hygiene in between glove changes during wound care, and touching resident items with gloved hands for 2 of 4 residents observed for pressure ulcers. (Residents 16 and 22) Findings include: 1. On 2/22/24 at 11:53 a.m., Resident 16 was lying in bed. The Assistant Director of Nursing (ADON) was getting ready to complete wound care. The ADON indicated the resident was on enhanced barrier precautions related to a history of MRSA (Methicillin-resistant Staphylococcus aureas) infection. The ADON was wearing a	F 0880	**F880** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #16 wounds were assessed with no s/s of infection noted. No negative outcomes. Resident #22 wounds were assessed with no s/s of infection noted. No negative outcomes. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Audit completed for all residents	03/18/2024

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	mask, she put on a gown, washed her hands and then applied a pair of gloves. The resident had a wound to his sacrum. The ADON removed the packing out of the wound. She then changed her gloves and cleansed the wound. She changed her gloves and then repacked the wound. With the same gloved hands, she opened the resident's bedside dresser to get out a wet wipe to wipe the resident's bottom because he was starting to have a bowel movement. She wiped the resident's bottom and then changed gloves. She then applied a paste to the resident's bottom surrounding the wound. The ADON did not complete any hand hygiene each time she removed her gloves and applied new gloves. Record review for Resident 16 was completed on 2/22/24 at 11:04 a.m. Diagnoses included, but were not limited to, Alzheimer's, dementia, traumatic brain injury, seizure disorder, and stage 4 pressure ulcer. The Quarterly Minimum Data Set (MDS) assessment, dated 12/20/23, indicated the resident was severely cognitively impaired. The resident required assistance with all his activities of daily living. The resident had a stage 4 pressure ulcer on admission. A Care Plan, dated 1/3/24 and revised 2/7/24, indicated the resident was on enhanced barrier precautions related to wound and history of MRSA. Staff were to wear proper ppe (personal protective equipment) while providing care. The February 2024 Physician's Order Summary indicated orders for: - Cleanse sacral wound with wound cleanser. Skin		with wounds/dressing changes. All residents with wounds/dressing changes were assessed and no s/s infection noted to wounds. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Infection Prevention Nurse completed wound treatment education and competencies on licensed nursing staff, to included education on hand hygiene with every glove change. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** IP/Designee will audit 4 dressing changes 3 times a week x 3 months, then 4 dressing changes weekly x 3 months to ensure proper hand hygiene is completed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring	

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	prep to wound periphery. Lightly pack the wound with collagen and then alginate. Leave the area open to air and apply barrier cream to surrounding wound edges; every shift - Isolation: Enhanced Barrier Precautions Diagnosis: Wound, history of MRSA; every shift related to pressure ulcer of sacral region, stage 4. During and interview on 2/2/24 at 12:08 p.m., the ADON indicated she would normally use hand sanitizer each time she removed her gloves and before putting on a new pair during wound care, but she did not have any. She also should not have opened the resident's drawer to get the wet wipes with her gloved hands. 2. On 2/22/24 at 9:37 a.m., the Assistant Director of Nursing (ADON) performed a wound care treatment for Resident 22. The ADON prepared her supplies wearing clean gloves. She removed the gloves, and put on new gloves. She removed the resident's old dressing from her sacral wound, which was dated 2/22/24. She removed her gloves and donned new gloves. She removed a second dressing from the right hip. She removed her gloves, donned clean gloves, and applied a new foam dressing to the right hip wound. She removed her gloves, donned clean gloves, washed the sacral wound with wound wash and patted it dry with sterile gauze. She removed her gloves, donned clean gloves, and applied alginate to the wound. She then covered it with gauze to fill the wound and applied an absorbent dressing over it and taped it down. The ADON did not perform hand hygiene between any glove changes. The ADON indicated she should have performed hand hygiene between glove changes. During an interview on 2/22/24 at 2:16 p.m., the Director of Nursing indicated the ADON should		compliance in this Plan of Correction.	

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	have performed hand hygiene in between donning new gloves. A policy titled, "Hand Hygiene," and noted as current, indicated "Procedure...2. Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident; b. After contact with blood, body fluids, or visibly contaminated surfaces; c. After contact with objects and surfaces in the resident's environment...e. Before performing a procedure such as a an aseptic task (e.g. insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care)..." 3.1-18(b)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring appropriate use of antibiotic therapy and reduce antibiotic resistance by only initiating therapy based on the McGeer Criteria for true infections, for 1 of 1 residents reviewed for respiratory care. (Resident 2) Finding includes:	F 0881	**F 881** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #2: MD was updated regarding the resident not meeting McGeer criteria for use of Antibiotic. MD gave order to	03/18/2024

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	Resident 2's record was reviewed on 2/22/24 at 9:50 a.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. A Health Status Note, dated 2/15/24, indicated the resident was complaining of a non-productive cough and shortness of breath. His oxygen saturation was within normal limits and he was noted to have some rhonchi (abnormal lung sounds) to the upper lobes. The Physician ordered a chest X-ray, Robitussin and Tessalon pearls (cough medication). The chest X-ray result, dated 2/16/24, was negative for infiltrates. A Physician's Order, dated 2/16/24, indicated to start amoxicillin-pot clavulanate (an antibiotic) 875/125 milligrams every 12 hours for 10 days for infection. During an interview with the Infection Preventionist on 2/22/24 at 1:50 p.m., she provided the antibiotic tracking and indicated the resident did not meet McGeer Criteria for a respiratory infection. During an interview with the Director of Nursing, on 2/22/24 at 2:10 p.m., she indicated she had spoken to the Physician on 2/18/24 with the results of a second x-ray. The second x-ray was unremarkable for infiltrates, but the Physician indicated to continue the antibiotic. There was no indication given why the antibiotic was continued.		continue antibiotic. Conversation was documented. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** Audit completed to identify all residents on antibiotic therapy and no further deficiencies noted. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON provided IP with education on Antibiotic Stewardship program. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/designee will audit new antibiotic orders to ensure that McGeer's criteria is met. If not met, DON/Designee will audit to ensure that MD was updated and documentation is present for continuing antibiotic therapy. Audit will be completed 5x a week x 60 days, then 3 times a week x 60 days, then weekly for the duration of 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3	

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			months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 3/18/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	