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	02/07/2025

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 IN00452567 and IN00452961. Complaint IN00452567 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00452961 - Federal/state deficiencies related to the allegations are cited at F684. Survey dates: February 3, 4, 5, 6, and 7, 2025 Facility number: 000185 Provider number: 155287 AIM number: 100290840 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 11 Medicaid: 57 Other: 13 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/12/25.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure residents	F 0554	This plan of correction is prepared and executed because the	03/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sabra Coons	RN/DON	02/28/2025

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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	had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 52) Finding includes: During a random observation on 2/4/25 at 9:42 a.m., Resident 52 was observed sitting in his room. There was a clear medication cup sitting on the table next to him with multiple pills inside. The resident indicated he was going to take them and the nurse had left them in his room this morning. Resident 52's record was reviewed on 2/5/25 at 11:08 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, age-related cognitive decline, and type 2 diabetes mellitus. The Quarterly Minimum Data Set assessment, dated 10/16/24, indicated the resident was moderately impaired for daily decision making. He received insulin injections, antibiotic, diuretic, antiplatelet, and hypoglycemic medications during the 7 day look-back period. A Care Plan, dated 4/16/24, indicated the resident had a diagnosis of cognitive/communication deficit and had a moderately impaired cognitive status. He was able to make simple choices and decisions while requiring cues and reminders from staff at times. Interventions included, but were not limited to, cue, reorient, and supervise as needed. The February 2025 Physician Order Summary indicated Resident 52 received the following medications for the AM medication pass: glimepiride 4 milligram (mg) 2 tablets, acetaminophen 325 mg 2 tablets, allopurinol 100		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 it 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. F544 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident 52: Head to toe assessment completed with no adverse reactions noted. 2. Resident 52: On 2/4/25 All morning medications were administered by licensed nurse 3. Licensed nurse involved immediately educated by Nursing management *How other residents having the*	

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	mg tablet, amlodipine besylate 10 mg tablet, aspirin 81 mg tablet, bisoprolol fumarate 5 mg tablet, cholecalciferol 10 microgram (mcg) tablet, ferrous sulfate 325 mg tablet, lactobacillus capsule, metformin 500 mg 2 tablets, potassium chloride 10 milliequivalents 2 tablets, spironolactone 25 mg tablet, and torsemide 10 mg tablet. There were no self-administration assessments or physician's orders for the self-administration of any medications for Resident 52. During an interview on 2/4/25 at 10:13 a.m., the Director of Nursing (DON) indicated Resident 52 did not self-administer any medications to her knowledge. During a follow-up interview on 2/4/25 at 11:14 a.m., the DON indicated there was no self-administration of medication assessment or orders to self-administer for Resident 52. A policy titled, "Self Administration of Medications" indicated "...2. Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition...4. Facility should regularly observe the resident self-administering medications to determine if the resident's functional and cognitive skills allow for the safe and appropriate continuation of resident self-administration...5. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer..." 3.1-11(a)		*potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. All residents who receive medications have the potential to be affected 2. House audit completed and two residents in the facility have correct documentation to self administer medications. Other residents must have medication administered to them by licensed nurse. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Licensed nurses to be educated on medication administration by nursing management. Education to be completed by 3-5-25. This education will include self administration policy and assessment. 2. No licensed nursing will work past of compliance with out this education being completed. Licensed nurses to be educated on Medication self administration policy and assessment. Education to be completed by 3-5-25 *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. DON/Designee will audit 10	

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			random residents daily at different medication pass times to ensure there are no medications left at bedside x 2 month, then 10 random residents 3 times weekly at different medication pass times x2 month, the 10 random residents weekly x 1 month to complete the duration of 6 months to ensure that no resident has medications left at the bedside. 2. 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: 3-7-25. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to successfully complete and export the Minimum Data Set (MDS) assessment in a timely manner for 1 of 22 residents whose MDS assessments were reviewed. (Resident 182) Finding includes: Record review for Resident 182 was completed on 2/7/25 at 12:13 p.m. Diagnoses included, but were	F 0640	Life Care Center Rensselaer Provider ID Number: 100290840 Date Survey Completed 02/7/2025 **F 640 Encoding and Transmitted Resident Assessments**	03/07/2025

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	not limited to, Alzheimer's. The resident was admitted to the facility on 1/10/25. The Admission MDS assessment, dated 1/14/25, indicated it was in process and not yet submitted. During an interview on 2/7/25 at 2:15 p.m., the MDS Coordinator indicated the Admission MDS had not been signed off as completed for it to be submitted. The Admission MDS assessment should have been completed and submitted within 14 days.		*What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1.Resident 182 Admission assessment with ARD 1/14/25 has been completed and transmitted into the CMS database 2/7/25. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1.All residents have the potential to be affected, therefore, all active residents requiring an Admission assessment was audited to ensure it was encoded and transmitted into the data base. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.Training provided to MDSCs on 3/3/25 regarding rules for MDS encoding and transmitting per the RAI instructions 1.DON or designee will review all active residents requiring an Admission assessment to ensure timely encoding and transmission of assessments.	

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1.DON or designee will review active residents requiring an Admission assessment to ensure encoded and transmitted timely weekly x 1 month; then 5 assessments every two weeks x 3 months, then 5 assessments monthly x 2 month to ensure compliance. 2.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: 3/7/2025	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to anti-anxiety medications for 1 of 22 MDS assessments reviewed. (Resident 23) Finding includes: Resident 23's record was reviewed on 2/5/25 at	F 0641	Rensselaer Care Center Provider ID Number: 155287 Date Survey Completed 02/7/2025 **F 641 Accuracy of Assessments** *What Corrective Action will be accomplished for those residents*	03/07/2025

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	1:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and hypertension. The Quarterly MDS assessment, dated 1/13/25, indicated the resident had received anti-anxiety medications in the past seven days. The Physician's Order Summary, dated 1/2025, lacked any orders for anti-anxiety medications. The Medication Administration Record (MAR), dated 1/2025, indicated the resident had not received any anti-anxiety medications. During an interview on 2/6/25 at 3:51 p.m., the MDS Coordinator indicated the anti-anxiety medication had been marked by mistake. She would modify the assessment. 3.1-31(i)		*found to have been affected by this deficient practice:* 1.Resident #23 Quarterly assessment with ARD 1/13/2025 was modified, transmitted and accepted into the CMS repository 2/14/25 reflecting accurate coding for antianxiety medication. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1.All residents have the potential to be affected, therefore, the most recent required OBRA assessment for all active residents was reviewed for accurate coding of Antianxiety medications. Affected assessments were modified as needed. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.Training provided to MDSCs on 3/3/2025 for accurate coding of antianxiety medications in section "N0415B per RAI instructions 1.DON or designee will review all required OBRA assessments for accurate coding of antianxiety medication in N0415B prior to MDS submission.	

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1.DON or designee will review for accuracy all required OBRA assessments coded with antianxiety medication for supporting documentation in N0415B prior to MDS submission weekly x 1 month; then 5 assessments every two weeks x 3 months, then 5 assessments monthly x 2 month to ensure compliance. 2.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: 3/7/2025	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities Based on observation, record review and interview, the facility failed to ensure a resident's ADL (activities of daily living) functions were maintained related to walking the resident daily as care planned for 1 of 1 resident reviewed for rehabilitation and/or restorative care. (Resident 70)	F 0676	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	03/07/2025

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	Finding includes: On 2/4/25 at 9:28 a.m., Resident 70 was observed in his room with a family member. He was seated in a wheelchair, there was a rollator walker in his room. His daughter indicated the staff were not helping him walk with his walker like they used to. He needed staff assistance to walk with the walker. The resident's record was reviewed on 2/4/25 at 1:20 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, cerebral ischemia and acute kidney failure. The Annual Minimum Data Set assessment, dated 11/14/24, indicated the resident had mild cognitive impairment and needed partial to moderate assistance for bed mobility and transfers. A Functional Goal Care Plan, dated 8/14/24, indicated the resident had limited physical mobility related to a stroke. Intervention was the walking program, to walk the resident using his rollator walker twice daily following with his wheelchair 6-7 days a week, offer safety cues and rest periods as needed. The POC (point of care) tasks for the past 30 days indicated the resident was walked with staff on 1/11/24, 1/22/24, 1/23/24, 1/26/24 and 2/5/24. The remaining dates were marked as activity did not occur. During an interview on 2/5/25 at 12:50 p.m., the Occupational Therapist indicated the resident had received physical therapy January thru April 2024. Therapy would make recommendations to nursing staff on discharge, but she did not know who was		maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it 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. F676 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident 70 was screened by therapy and no decline in ability to ambulate was noted. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. Residents who have been discharged from therapy with a recommendation for ongoing ambulation program (walk to dine) have the ability to be affected. 2. Residents who remain in the facility and were discharged from	

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	responsible to carry out those recommendations. During an interview on 2/5/25 at 1:20 p.m., the Director of Nursing indicated therapy recommendations were in the POC tasks for CNAs to complete and they had no specific restorative nursing program. There was no additional documentation the resident was being walked twice daily. 3.1-38(a)(1)		therapy in the past 6 months were audited and any corrections needed were made. All care plans updated as needed. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Therapy will ensure that all recommendations come to DON/Designee 2. CNA's will be educated on documentation in the ADL charting for ambulation program.(walk to dine) They will be expected to complete documentation thoroughly and accurately on ambulation program (walk to dine). Education will be completed by 3-5-25. No aides will work past date of compliance with out this education being completed. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. DON/Designee will audit all residents with ambulation program (walk to dine) 5 times a week x 60 days, then 3 times a week x 60 days then weekly x 60 days to ensure that resident is being ambulated and documentation is completed. Any resident with noted decline will be referred back to therapy. 2. The results of these reviews will	

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			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: 3/7/25. 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 Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and services related to a medication not resumed at the correct frequency for 1 of 1 residents reviewed for death (Resident B), lack of a treatment order for a dressing in place, and compression stockings not worn as ordered for 2 of 3 residents reviewed for non-pressure skin issues. (Residents D and C) Findings include: 1. The closed record for Resident B was reviewed on 2/7/25 at 11:43 a.m. Diagnoses included, but were not limited to, paraplegia incomplete, unspecified convulsions, tachycardia and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 11/25/24, indicated the resident was cognitively intact, required partial to moderate assistance for bed mobility and transfers	F 0684	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 it 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	03/07/2025

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	and took an anticoagulant medication. A Physician's Order, dated 12/5/24, indicated to give Eliquis (an anticoagulant medication) 5 milligrams (mg) twice daily until 12/12/24 for chronic pulmonary embolism. The resident was having a suprapubic catheter (urine drainage that is surgically inserted through the skin) inserted and kidney stones removed on 12/16/24. The Eliquis was placed on hold prior to the procedure on 12/12/24. A Health Status Note, dated 12/16/24, indicated the resident had returned from the hospital following the procedures. The resident was to resume Eliquis on 12/18/24. The hospital inpatient discharge instructions, dated 12/16/24, indicated to resume the Eliquis on 12/18/24, medication was unchanged. An Order Note, dated 12/16/24 and entered by LPN 2, indicated to give Eliquis 5 mg one time daily related to tachycardia. A Health Status Note, dated 12/16/24, indicated the resident was being seen by the Nurse Practitioner(NP) for a post-op visit after having a suprapubic catheter and stent placement for kidney stones. The resident's medications included Eliquis 5 mg one time daily. During an interview on 2/7/25 at 2:25 p.m., LPN 2 indicated she was unsure where the order to resume Eliquis at one time daily had come from, she remembered there had been some confusion about the order. She indicated she needed to talk to the Director of Nursing. No additional information was provided.		review. F684 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident B is deceased 2. Resident D: An order was obtained for a dressing to the skin tear on her left forearm. 3 Resident C: Head to toe assessment was completed with no other areas of open skin noted. An order was obtained for resident to have a bandaid on area to right lower leg. Care plans updated. Ted hose applied per order. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. All resident who have a procedure, or hospitalized have the potential to be affected. Audits were completed on all readmitted from hospital residents for the past 3 months to ensure accuracy of medications. No other deficiency noted. 2. All residents who have a break in skin have the ability to be affected. Residents with current skin tears/break in skin or ulcers were audited to ensure treatments were in place. No other deficiency	

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	During an interview on 2/7/25 at 2:40 p.m., the NP indicated she did not change the resident's medications, she had copied them from his medication list. 2. On 2/6/25 at 10:22 a.m. Resident D was observed seated in her wheelchair in the unit dining room. There was a white bandage in place to her left forearm. On 2/6/25 at 2:06 p.m. Resident D was observed seated in her wheelchair in the unit dining room. There was a white bandage in place to her left forearm. Resident D's record was reviewed on 2/6/25 at 9:48 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, osteoporosis, and emphysema. The Quarterly MDS assessment, dated 10/25/24, indicated the resident was cognitively impaired and dependent on staff for assistance with ADLs (activities of daily living). A Progress Note, dated 1/29/25 at 5:31 p.m., indicated the resident had a new skin tear to the left forearm. The Nurse Practitioner was notified, and an order was received to cleanse the area with sterile water and apply steri strips. A Physician's Order, dated 1/29/25, indicated to monitor the left forearm skin tear for redness and drainage two times a day. There were no orders for any bandage to the area. During an interview on 2/6/25 at 3:49 p.m., the DON indicated there were no orders for a dressing to the left forearm. The resident had a skin tear at the end of January and had steri strips in place to the left forearm. 3. During an observation and		noted. 3. All residents who have an order for Ted hose have the ability to be affected. All residents with orders for ted hose were audited and no other deficiency noted. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Licensed nurses will be educated on verifying medication and orders for residents upon return from outpatient procedure and/or upon return from hospital. Medication orders will be verified with MD/NP. Education will be completed by 3-5-25 2. Licensed nurses will be educated on obtaining order from MD/NP for any dressing or bandage needed for any resident. Education will be completed on 3-5-25 3. Licensed nurses will be educated on accurate documentation in regard to ted hose placement/refusals. Education will be completed by 3-5-25. 4. No licensed nursing will work past date of compliance with out this education being completed. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1.DON/Designee will audit all residents charts who return from	

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	interview on 2/4/25 at 10:05 a.m., Resident C was seated in his motorized wheelchair. His bilateral lower extremities were both swollen, red in color, and had scattered discolorations. He had a small adhesive bandage located on his right lower leg. Resident C indicated that he was having skin issues with both lower legs and would be going to see a dermatologist soon. He did not have on any compression stockings at the time. On 2/6/25 at 2:23 p.m., Resident C was observed in his wheelchair in the hallway. Both lower legs were covered with compression stockings. On 2/7/25 at 9:43 a.m., 10:12 a.m., and 10:36 a.m., Resident C was observed in a wheelchair. His bilateral lower extremities were red in color and swollen. He had no compression stockings on. Resident C's record was reviewed on 2/5/25 at 1:32 p.m. Diagnoses included, but were not limited to, chronic kidney disease, seborrheic dermatitis (inflammatory skin condition), and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact for daily decision making. He had applications of nonsurgical dressings, and applications of ointments/medications other than to feet and received antibiotic and diuretic medications. A Care Plan, dated 2/5/25, indicated the resident had stasis dermatitis to the bilateral lower extremities. Interventions included, but were not limited to, encourage resident to elevate legs as tolerated and administer treatments as ordered. A Care Plan, dated 9/19/24, indicated the resident had congestive heart failure (CHF) and may		outpatient procedure/return from hospital to ensure accuracy of medication orders. This will be ongoing for best practice. 2. 24 hour reports will be audited 5 times a week for any new skin areas and ensure that dressing orders are in place for any and all new areas. This will be ongoing for best practice. 3. Residents who have Ted hose will be audited 5 times weekly x 60 days then 3 times weekly x 60 days then weekly x 60 days to ensure that documentation and application of Ted hose is accurate. 4. 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: 3-7-25. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	experience weight fluctuations related to diuretic medications. He had bilateral lower extremity edema. Interventions included, but were not limited to, administer diuretic medications per orders, encourage him to elevate his legs while sitting, and observe and report any signs or symptoms of CHF such as dependent edema of legs/feet, increased heart rate, or disorientation. The February 2025 Physician Order Summary indicated the resident was to wear compression stockings during the day as tolerated by the resident, and remove compression stockings at bedtime. The February 2025 Treatment Administration Record indicated the compression stockings were marked as administered in the morning on 2/4/25 and 2/7/25. The Weekly Skin Integrity Data Collection, dated 1/7/25, 1/14/25, 1/22/25, and 1/29/25, indicated the resident had chronic edema to the bilateral lower extremities. The Weekly Skin Integrity Data Collection, dated 2/5/25, indicated the resident had stasis dermatitis to bilateral lower extremities with seborrheic keratosis (seen by dermatology). There were no orders or assessment for the area on the right lower leg covered with the adhesive bandage. During an interview on 2/7/25 at 10:30 a.m., the Director of Nursing indicated the resident sometimes rolled down and removed the compression stockings himself and was very independent with his own care. The nurses were supposed to document if the compression			

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	stockings were on or off and the CNAs were responsible for putting the compression stockings on with care. The nurses should have documented correctly. During an interview on 2/7/25 at 10:35 a.m., the Assistant Director of Nursing indicated the resident probably had scratched his leg and asked for a bandage. He would remove bandages on his own once an area stopped bleeding. A policy titled, "Basic Skin Management," indicated "...3. It is the responsibility of the CNAs and therapy department to notify nursing if a change of the resident's skin is identified. Notification may be entered into PCC via eInteract and will alert nurse on the PCC Dashboard. 4. If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document an assessment/observation, obtain treatment orders, and notify MD and responsible party. 5. Orders are required for skin and wound care. There are wound care protocol orders in PCC under Orders- TX Template..." This citation relates to Complaints IN00452567 and IN00452961. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review and interview, the facility failed to ensure a resident's range of motion (ROM) was maintained related to not following therapy recommendations for routine ROM exercises for 1 of 2 residents reviewed for limited ROM and/ or positioning. (Resident 21)	F 0688	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	03/07/2025

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	Finding includes: On 2/3/25 at 3:37 p.m., Resident 21 was observed seated in her recliner, her legs were elevated with the foot rest. She indicated her legs were paralyzed and flaccid and that she used to get range of motion exercises done by the staff, but not recently. The resident's record was reviewed on 2/5/25 at 10:05 a.m. Diagnoses included, but were not limited to, paraplegia, diabetes mellitus and spinal stenosis. The Quarterly Minimum Data Set assessment, dated 12/18/24, indicated the resident was cognitively intact, required substantial to maximum assist for bed mobility and was dependent for transfers and toileting. She had not received restorative nursing services. A Physical Therapy Discharge Summary, dated 2/12/24, indicated restorative range of motion program. Interventions were to complete each range of motion is a slow rhythm motion, encourage resident to assist with the ROM, encourage resident to relax, face the resident to observe for signs of discomfort and never force extremity ranging. During an interview on 2/5/25 at 12:50 p.m., the Occupational Therapist indicated the resident had received physical and occupational therapy January thru March 2024. Therapy would make recommendations to nursing staff on discharge from therapy, but she did not know who was responsible to carry out those recommendations. During an interview on 2/5/25 at 1:20 p.m., the		maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it 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. F688 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident was screened by therapy and noted to have no decline in ROM/Mobility 2. Program was added to ADL task for completion by CNA's. Care plan updated. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. All residents discharged from therapy with a maintenance program have the ability to be affected. 2. Residents who remain in the facility and were discharged from	

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	Director of Nursing indicated therapy recommendations were in the POC (point of care) tasks for CNAs to complete and they had no specific restorative nursing program. She indicated she went back to February 2024 and was unable to find where therapy recommendations for ROM had been implemented. 3.1-42(a)(2)		therapy in the past 6 months were audited and any corrections needed were made. All care plans updated as needed. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Therapy educated by DON, to give all program recommendations to DON/Designee. Licensed therapist will not work past date of compliance until they have completed this education. 2. DON/Designee will initiate program in the ADL task bar for completion and update. Care plans will be updated. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. IDT team will review all therapy recommendations in clinical meeting 5 times a week. IDT will audit all new programs to ensure they have been initiated. This will be an ongoing process for best practice. 2. 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%.	

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			Compliance date: 3-7-25 The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to monitor nutritional intake for meals for a resident with a history of weight loss for 1 of 3 residents reviewed for nutrition. (Resident 15) Finding includes: The record for Resident 15 was reviewed on 2/5/25 at 9:54 a.m. Diagnoses included, but were not limited to, multiple sclerosis, protein-calorie malnutrition, and adult failure to thrive. The Quarterly Minimum Data Set, dated 11/21/24, indicated the resident was cognitively intact for daily decision making. She required setup help only for eating and weighed 84 pounds. The current Care Plan indicated the resident was at risk for weight fluctuations due to her current health status, variable meal intakes and refusals of nutritional supplements. Her weight loss was significant and unavoidable. Interventions included, but were not limited to, administer medications to help stimulate the resident's appetite, supplements to be offered, and serve diet as ordered. A current Physician Order Summary indicated the resident received a regular diet and whole milk and a soft cookie in the afternoon after lunch.	F 0692	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 it 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. F692 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident 15 was weighed on	03/07/2025

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	The resident's most recent weight on 2/4/25 was 78 pounds. On 1/3/25, the resident weighed 79 pounds. On 8/9/24, the resident weighed 88 pounds. A Nutrition/Dietary Note, dated 1/13/25, indicated the resident received a regular diet and was consuming 1-100% of meals over the past week. The resident was at risk for malnutrition. She had a long list of foods/beverages/fortified foods/nutritional supplements that she refused to consume. She had variable meal intakes and 9% weight loss over the last 180 days. The CNA Task ADL (Activities of Daily Living) - Eating had a frequency of documentation for three times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. (mealtimes). The meal consumption log indicated there was no documentation for the breakfast meal on 1/8, 1/10, 1/17, 1/19, 1/21, 1/24, and 1/29/25. The meal consumption log indicated there was no documentation for the lunch meal on 1/19, 1/21, 1/31, and 2/1/25. The meal consumption log indicated there was no documentation for the dinner meal on 1/8, 1/11, 1/19, 1/26, 1/27, and 1/31/25. During an interview on 2/6/25 at 3:59 p.m., the Director of Nursing indicated she had no further information regarding the missing documentation of the meal intakes. The resident may have refused those meals, as she often refused to eat. They had been working with her on finding foods that she would eat to help her gain weight. 3.1-46(a)		2-6-25. No wt loss was noted from previous wt. Resident was interviewed by DON on 2-6-25 and verified that she had been offered 3 meals daily. She continues to be on weekly weights and continues to be followed by dietitian. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. All residents have to ability to be affected. 2. House audit completed on meal consumption documentation. All areas of concern addressed. Care plans updated as needed. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.DON/Designee to provide education to CNA's in regard to accurate documentation on meal consumption. Education will be completed by 3-5-25. No aides will work past date of compliance without this education being completed. . *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. DON/Designee will audit food consumption records of 10 random	

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			residents 5x a week x 60 days then 3 times a week x 60 days then weekly x 60 days. 2. 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: 3-7-25. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure residents received the necessary respiratory care and treatments related to medications not initiated for a resident with COVID-19 for 1 of 2 residents reviewed for respiratory infections (Resident 70) and incorrect oxygen flow rates for 2 of 2 residents reviewed for oxygen. (Residents 10 and 65) Findings include: 1. On 2/4/25 at 9:28 a.m., Resident 70 was observed in his room. There were signs on his door that indicated he was on contact and droplet isolation precautions. There was a personal protective equipment bin outside the door with gowns, gloves, masks and faceshields. A family	F 0695	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 it 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	03/07/2025

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	member present indicated he had COVID-19. The resident's record was reviewed on 2/4/25 at 1:20 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, cerebral ischemia and acute kidney failure. The Annual Minimum Data Set assessment, dated 11/14/24, indicated the resident had mild cognitive impairment and needed partial to moderate assistance for bed mobility and transfers. A Health Status Note, dated 1/31/25, indicated new orders were received for Vitamin C, Zinc, Mucinex, Duonebs (breathing treatment) as needed and oxygen as needed for positive COVID-19 diagnoses. The Physician's Orders lacked orders for Vitamin C, Zinc, Mucinex, Duonebs or oxygen. The January and February 2025 Medication Administration Record lacked documentation the medications had been initiated or administered. During an interview on 2/4/25 at 2:47 p.m., the Director of Nursing indicted the orders for the medications had not been entered. She indicated it would be corrected. 2. On 2/4/25 at 10:07 a.m., Resident 10 was observed sitting in a wheelchair in her room. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 2.5 liters. On 2/5/25 at 10:11 a.m., Resident 10 was observed lying in bed. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 2.5 liters. Record review for Resident 10 was completed on 2/5/25 at 12:12 a.m. Diagnoses included, but were		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. F 695 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident 70: Orders for Duo Nebs, Mucinex, Vitamin C and Zinc were immediately added to resident order list. Resident assessed and no respiratory distress or negative outcome noted. 2.Resident 10 Her oxygen liter flow was corrected immediately upon notification. Resident assessed and no respiratory distress or negative outcome noted . 3 Resident 65. His oxygen liter flow was corrected immediately upon notification. Resident assessed and no respiratory distress or negative outcome noted. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* 1. All residents on Oxygen have the potential to be affected. 2.. House audit of residents on oxygen completed with no other	

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	not limited to, chronic obstructive pulmonary disease, heart failure, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident had a memory problem. The resident required a partial moderate assistance with transfers and received oxygen therapy. A Care Plan, dated 10/16/23 and revised 10/19/23, indicated the resident had oxygen therapy related to ineffective gas exchange and shortness of breath due to diagnosis of chronic obstructive pulmonary disease. An intervention included for oxygen via nasal cannula at 2 liters continuously. The February 2025 Physician's Order Summary (POS) indicated an order for oxygen at 2 liters continuously per nasal cannula. During an interview on 2/5/25 at 10:15 a.m., LPN 1 indicated the resident was supposed to be on 2 liters of oxygen and she would adjust the flow rate. 3. On 2/4/25 at 2:02 p.m., Resident 65 was observed lying in bed. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 1 liter. On 2/5/25 at 10:20 a.m., Resident 65 was observed in her room. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 1 liter. Record review for Resident 65 was completed on 2/5/25 at 10:22 a.m. Diagnoses included, but were not limited to, stroke, chronic obstructive pulmonary disease, anxiety, hypertension, and		deficiency noted 3. Audit of all residents that currently reside in facility who have had any out patient procedure or hospitalization in the past 90 days to ensure accuracy of medications. No other deficiency noted. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. All nursing staff including Licensed Nurses and CNA's as well as guardian angels will be educated on Oxygen liter flow rate, where to find current liter flow rate for residents and how to accurately read concentrator. Nurses instructed to correct liter flow as needed. All other staff educated to report any discrepancies to nurse. Education to be completed by 3-5-25. Licensed nurses, CNA's as well as guardian angels will not work past date of compliance without this education being completed. *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. DON/Designee will audit flow rate of residents on Oxygen 5 times a week x 60 days then 3 times a week x 60 days then weekly x 60 days. 2. The results of these reviews will be discussed at the monthly	

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RENSSELAER CARE CENTER	1309 E GRACE ST RENSSELAER, IN 47978

(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
	hemiplegia. The Quarterly MDS assessment, dated 1/20/25, indicated the resident was cognitively intact. The resident required a partial moderate assistance with transfers and received oxygen therapy. A Care Plan, dated 11/30/23 and revised 9/16/24, indicated the resident had oxygen therapy related to ineffective gas exchange secondary to asthma. An intervention included oxygen at 3 liters via nasal cannula when napping and at night. The February 2025 POS indicated an order for oxygen at 3 liters per nasal cannula when napping and at night. During an interview on 2/5/25 at 10:22 a.m., RN 1 indicated the resident's oxygen should be at 3 liters and she would correct the flow rate on the concentrator. 3.1-47(a)(6)		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: 3-7-25. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	