Sabra Coons

PRINTED: 03/12/2025 FORM APPROVED OMB NO. 0938-039

02/28/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155287	B. WING		02/07/2025
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST SELAER, IN 47978	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00	Licensure Survey. T Investigation of Con IN00452961.  Complaint IN00452 related to the allegar Complaint IN00452 related to the allegar Survey dates: February Facility number: 00 Provider number: 1: AIM number: 10029 Census Bed Type: SNF/NF: 81 Total: 81  Census Payor Type: Medicare: 11 Medicaid: 57 Other: 13 Total: 81	reflect State Findings cited in 0 IAC 16.2-3.1.	F 0000		
F 0554 SS=D Bldg. 00		nin Meds-Clinically Approp			
		on, record review, and ty failed to ensure residents	F 0554	This plan of correction is prep and executed because the	ared 03/07/2025
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiency statement 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 disclodays 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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RN/DON

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155287	B. WING 02/07/2025			/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	L.			GRACE ST		
BENIGGE	LAER CARE CENT	FR			ELAER, IN 47978		
INLINGUE	LALIT CARE CENT	LIX		ILINGS	ELALIN, IN 41310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ers for medications and an		provisions of state and federal law			
		dminister their own			require it and not because		
		f 1 resident reviewed for			Rensselaer Care Center agree		
	self-administration	of medication. (Resident 52)			with the allegations and citatio		
					listed. Rensselaer Care Cente	r	
	Finding includes:				maintains that the alleged		
		0/4/05 10 10			deficiencies do not jeopardize		
	_	oservation on 2/4/25 at 9:42			health and safety of the reside		
		ras observed sitting in his room.			nor is it of such character to lir		
		nedication cup sitting on the			our capabilities to render adec	-	
	table next to him with multiple pills inside. The				care. Please accept this plan	o†	
	resident indicated he was going to take them and				correction as our credible		
	the nurse had left them in his room this morning.				allegation of compliance that t		
	D 11 4 521	1 2/5/25			alleged deficiencies have or w		
		l was reviewed on 2/5/25 at			correct by the date indicated to		
	_	es included, but were not			remain in compliance with stat		
	_	e communication deficit,	and federal regulations, the facility				
		re decline, and type 2 diabetes			has taken or will take the action		
	mellitus.				set forth in this plan of correcti		
	The Overterly Mini	marina Data Cat aggaggmant			We respectfully request a desi	K	
		mum Data Set assessment, icated the resident was			review.		
		d for daily decision making. He					
		ections, antibiotic, diuretic,			F544		
		ooglycemic medications during			What Corrective Action will be		
	the 7 day look-back				accomplished for those reside		
	are / day look-odek	. portod.			found to have been affected b		
	A Care Plan dated	4/16/24, indicated the resident			this deficient practice:	,	
	· ·	cognitive/communication			1. Resident 52: Head to toe		
	_	oderately impaired cognitive			assessment completed with no	n	
		to make simple choices and			adverse reactions noted.	-	
		uiring cues and reminders from			2. Resident 52: On 2/4/25 All		
	-	ventions included, but were not			morning medications were		
		ient, and supervise as needed.			administered by licensed nurs	e	
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				3. Licensed nurse involved		
	The February 2025	Physician Order Summary			immediately educated by Nurs	sing	
		52 received the following			management		
		AM medication pass:			9		
		-					
	glimepiride 4 milligram (mg) 2 tablets,				How other residents having th	_	1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  02/07/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1309 E GRACE ST RENSSELAER, IN 47978		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	aspirin 81 mg tablet tablet, cholecalcifer ferrous sulfate 325 capsule, metformin chloride 10 milliequ spironolactone 25 n tablet.  There were no self-physician's orders for any medications for During an interview	ag tablet, and torsemide 10 mg administration assessments or or the self-administration of		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 be affected  2. House audit completed and residents in the facility have correct documentation to self administer medications. Other esidents must have medicati administered to them by licen nurse.	e al to di two ron
	knowledge.  During a follow-up a.m., the DON indices self-administration orders to self-administration orders to self-administration orders to self-administration orders to self-administration with the should assess and direction with the should assess and directions, whether seemedications is safe	of medication assessment or uister for Resident 52.		What measures and what systemic changes will be madensure that the deficient practices on medication administration nursing management. Educated to be completed by 3-5-25. The ducation will include self administration policy and assessment.  2. No licensed nursing will we past of compliance with out the ducation being completed.	cated by ion nis
	condition4. Facili resident self-admini determine if the rescognitive skills allo continuation of resirracility should ensu	ty should regularly observe the stering medications to dent's functional and w for the safe and appropriate dent self-administration5. are that orders for list the specific medication(s)		Licensed nurses to be educated on Medication self administrated policy and assessment. Educated to be completed by 3-5-25. How the corrective action will monitored to ensure the defice practice will not recur, i.e., whe quality assurance program will put in place:  1. DON/Designee will audit 10.	tion ation be ient iat III be

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	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETE		COMPLETED 02/07/2025			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1309 E GRACE ST RENSSELAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				random residents daily at differ medication pass times to ensurthere are no medications left at bedside x 2 month, then 10 random residents 3 times were at different medication pass times were at different medication of 6 month to complete the duration of 6 month to ensure that no resident has medications left at the bedside 2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of revisible below 100%. Compliance date: 3-7-25. The Administrator at Rensselaer Content is responsible in ensur compliance in this Plan of Correction.	kly mes  nths e. s will  iews f	
F 0640 SS=A Bldg. 00	failed to successfull Minimum Data Set	iew and interview, the facility y complete and export the (MDS) assessment in a timely	F 0640	Life Care Center Rensselaer Provider ID Number: 1002908 Date Survey Completed 02/7/2	-	
	assessments were re Finding includes:	residents whose MDS viewed. (Resident 182)  desident 182 was completed on Diagnoses included, but were		F 640 Encoding and Transmitted Resident Assessments		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155287	B. WING 02/07/2025			/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹					
BENIGGE	LAER CARE CENT	-ER	1309 E GRACE ST RENSSELAER, IN 47978				
NENSSE	LAEN VARE VENT	LIX		KENSS			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		eimer's. The resident was			What Corrective Action will be	1	
	admitted to the faci	lity on 1/10/25.			accomplished for those reside	nts	
					found to have been affected b	У	
		OS assessment, dated 1/14/25,			this deficient practice:		
	indicated it was in p	process and not yet submitted.			1.Resident 182 Admission		
					assessment with ARD 1/14/25	;	
	_	on 2/7/25 at 2:15 p.m., the			has been completed and		
		ndicated the Admission MDS			transmitted into the CMS		
	_	off as completed for it to be			database 2/7/25.		
		mission MDS assessment					
		ompleted and submitted within					
	14 days.				How other residents having th	е	
					potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
					action will be taken:		
					1.All residents have the pote		
					to be affected, therefore, all a		
					residents requiring an Admiss	ion	
					assessment was audited to		
					ensure it was encoded and		
					transmitted into the data base		
					What measures and what		
					systemic changes will be mad		
					ensure that the deficient pract	ice	
					doesn't recur:		
					1.Training provided to MDS0		
					on 3/3/25 regarding rules for N		
					encoding and transmitting per	the	
					RAI instructions		
					1.DON or designee will revie	ew all	
					active residents requiring an		
					Admission assessment to ens		
					timely encoding and transmiss	sion	
					of assessments.		
			I		i		1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155287	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/07/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1309 E GRACE ST  RENSSELAER, IN 47978				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE	ON	
F 0641	483.20(g)			How the corrective action will monitored to ensure the deficing practice will not recur, i.e., who quality assurance program will put in place:  1.DON or designee will revie active residents requiring an Admission assessment to ensure encoded and transmitted time weekly x 1 month; then 5 assessments every two weeks months, then 5 assessments monthly x 2 month to ensure compliance.  2.The results of these review will be discussed at the month facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, if compliance is below 100%. Compliance date: 3/7/2025	ent at II be ew ure ly s x 3 ws ally or a		
SS=A Bldg. 00	Based on observation interview, the facility Minimum Data Set accurately complete	on, record review and ty failed to ensure the (MDS) assessment was ed related to anti-anxiety f 22 MDS assessments	F 0641	Rensselaer Care Center Provider ID Number: 155287 Date Survey Completed 02/7/	2025	25	
	Finding includes:			F 641 Accuracy of Assessme			

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Resident 23's record was reviewed on 2/5/25 at

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accomplished for those residents

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155287	B. W	ING		02/07/	2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R			GRACE ST			
RENSSE	LAER CARE CEN	ΓER		RENSSELAER, IN 47978				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		es included, but were not limited			found to have been affected b	y		
		mellitus, major depressive			this deficient practice:			
	disorder, and hyper	tension.			1.Resident #23 Quarterly			
					assessment with ARD 1/13/20	)25		
	The Quarterly MD	S assessment, dated 1/13/25,			was modified, transmitted and	l		
	indicated the reside	ent had received anti-anxiety			accepted into the CMS reposi	tory		
	medications in the	past seven days.			2/14/25 reflecting accurate co	ding		
					for antianxiety medication.			
	The Physician's Or	der Summary, dated 1/2025,						
	lacked any orders for anti-anxiety medications.							
					How other residents having th	ne		
	The Medication Administration Record (MAR),				potential to be affected by the			
	dated 1/2025, indicated the resident had not				same deficient practice will be	)		
	received any anti-a	nxiety medications.			identified and what corrective			
					action will be taken:			
	During an interview	v on 2/6/25 at 3:51 p.m., the			1.All residents have the pote	ential		
	MDS Coordinator	indicated the anti-anxiety			to be affected, therefore, the r	nost		
	medication had bee	n marked by mistake. She			recent required OBRA			
	would modify the a	assessment.			assessment for all active resid	dents		
					was reviewed for accurate cod	ding		
	3.1-31(i)				of Antianxiety medications.			
					Affected assessments were			
					modified as needed.			
					What measures and what			
					systemic changes will be mad	le to		
					ensure that the deficient pract	tice		
					doesn't recur:			
					1.Training provided to MDS	Cs		
					on 3/3/2025 for accurate codi	ng of		
					antianxiety medications in sec	ction		
					"N0415B per RAI instructions			
					·			
					1.DON or designee will review			
					required OBRA assessments			
					accurate coding of antianxiety			
					medication in N0415B prior to	)		
					MDS submission.			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			ОМ	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155287	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/07/2025	
	PROVIDER OR SUPPLIEF		1309 E	ADDRESS, CITY, STATE, ZIP COD E GRACE ST SELAER, IN 47978		
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F 0676 SS=D	483.24(a)(1)(b)(1) Activities Daily Liv	-(5)(i)-(iii) ring (ADLs)/Mntn Abilities		How the corrective action will monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put in place:  1.DON or designee will revie for accuracy all required OBR assessments coded with antianxiety medication for supporting documentation in N0415B prior to MDS submiss weekly x 1 month; then 5 assessments every two weeks months, then 5 assessments monthly x 2 month to ensure compliance.  2.The results of these review will be discussed at the month facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%.  Frequency and duration of revisible be increased as needed, in compliance is below 100%.  Compliance date: 3/7/2025	ent at II be ew A sion s x 3 vs	
Bldg. 00	interview, the facili ADL (activities of o	on, record review and ty failed to ensure a resident's daily living) functions were to walking the resident daily as	F 0676	This plan of correction is prep and executed because the provisions of state and federa require it and not because		03/07/2025

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70)

care planned for 1 of 1 resident reviewed for

rehabilitation and/or restorative care. (Resident

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Rensselaer Care Center agrees

with the allegations and citations

listed. Rensselaer Care Center

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	T OF HEALTH AND HU! R MEDICARE & MEDIC					RM APPROVED 1B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	_	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155287	A. BUILDING <u>00</u> B. WING		COMPLETED 02/07/2025		
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD			
RENSSE	ELAER CARE CENT	ER		E GRACE ST SELAER, IN 47978			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	OBE COMPLETION	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	Finding includes:			maintains that the alleged deficiencies do not jeopardiz health and safety of the resid	lents		
		.m., Resident 70 was observed		nor is it of such character to			
		amily member. He was seated		our capabilities to render ade			
		re was a rollator walker in his		care. Please accept this plan	of		
	_	indicated the staff were not		correction as our credible			
		vith his walker like they used to.		allegation of compliance that			
	He needed staff assistance to walk with the			alleged deficiencies have or			
	walker.			correct by the date indicated			
	TELL 11 4	1 2/4/25		remain in compliance with st			
		d was reviewed on 2/4/25 at		_	nd federal regulations, the facility		
		s included, but were not limited		has taken or will take the actions			
		c respiratory failure, cerebral		set forth in this plan of correct			
	ischemia and acute			We respectfully request a de review.	SK		
		um Data Set assessment, dated					
		the resident had mild cognitive					
	_	eded partial to moderate		F676			
	assistance for bed n	nobility and transfers.		What Corrective Action will b			
				accomplished for those resid			
		Care Plan, dated 8/14/24,		found to have been affected	by		
		nt had limited physical		this deficient practice:			
	I -	a stroke. Intervention was the		1. Resident 70 was screened	•		
		o walk the resident using his		therapy and no decline in ab	ility to		
		te daily following with his		ambulate was noted.			
	rest periods as need	s a week, offer safety cues and					
	lest periods as need	ed.		How other regidents having t	ho		
	The POC (point of	care) tasks for the past 30 days		How other residents having to potential to be affected by the			
	•	nt was walked with staff on		same deficient practice will b			
		/23/24, 1/26/24 and 2/5/24. The		identified and what corrective			
		re marked as activity did not		action will be taken:	•		
	occur.			Residents who have been			
				discharged from therapy with			
	During an interview	v on 2/5/25 at 12:50 p.m., the		recommendation for ongoing			

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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

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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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155287	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/07/2025			
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	During an interview Director of Nursing recommendations w to complete and the nursing program. T	out those recommendations.  y on 2/5/25 at 1:20 p.m., the		therapy in the past 6 months audited and any corrections needed were made. All care updated as needed.  What measures and what systemic changes will be made 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 ch for ambulation program. (wall dine) They will be expected to complete documentation thoroughly and accurately on ambulation program (walk to dine). Education will be completed. Education being completed.  How the corrective action will monitored to ensure the deficing practice will not recur, i.e., who quality assurance program with put in place:  1. DON/Designee will audit a residents with ambulation program (walk to dine) 5 times a week days then weekly x 60 days then seekly x 60 days then yeekly x 60 days then yeek	were plans  de to tice  arting k to  bleted past nis  be cient nat ill be ll ggram k x x 60 0			
				noted decline will be referred to therapy.  2 The results of these review				

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CENTERS FOR	MEDICARE & MEDIC.	AID SERVICES			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155287	B. WING		02/07/2025	
RENSSE	ROVIDER OR SUPPLIER	ER	STREET ADDRESS, CITY, STATE, ZIP COD 1309 E GRACE ST RENSSELAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0684 SS=D Bldg. 00	483.25 Quality of Care  Based on observation interview, the facility received the necessate to a medication not frequency for 1 of 1 (Resident B), lack of dressing in place, and worn as ordered for non-pressure skin is  Findings include:  1. The closed record on 2/7/25 at 11:43 and were not limited to, unspecified convuls diabetes mellitus.  The Quarterly Minity assessment, dated 1	on, record review and ty failed to ensure residents ary care and services related resumed at the correct residents reviewed for death of a treatment order for a and compression stockings not 2 of 3 residents reviewed for ssues. (Residents D and C)  If for Resident B was reviewed a.m. Diagnoses included, but paraplegia incomplete, ions, tachycardia and  mum Data Set (MDS) 1/25/24, indicated the resident	F 0684	be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, it compliance is below 100%. Compliance date: 3/7/25. The Administrator at Rensselaer Compliance in this Plan of Correction.  This plan of correction is prepared executed because the provisions of state and federal require it and not because Rensselaer Care Center agree with the allegations and citation listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize health and safety of the resident in it of such character to lingual our capabilities to render adectore. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or work to the fact of the fact in this plane with state and federal regulations, the fact has taken or will take the action to the fact has taken or will t	or a  views f  Care ring  ared 03/07/2025  I law es ons er  the ents mit quate of the vill be o te icility ons	
	· ·	1/25/24, indicated the resident act, required partial to		has taken or will take the action set forth in this plan of correct		

moderate assistance for bed mobility and transfers

set forth in this plan of correction.

We respectfully request a desk

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155287	B. W	NG		02/07/	/2025
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			GRACE ST		
RENSSE	LAER CARE CEN	TER			ELAER, IN 47978		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	and took an anticoa	agulant medication.			review.		
	A Physician's Orde	er, dated 12/5/24, indicated to					
	give Eliquis (an anticoagulant medication) 5				F684		
		vice daily until 12/12/24 for			What Corrective Action will be	Э	
	chronic pulmonary	-			accomplished for those reside	ents	
	-				found to have been affected b		
	The resident was ha	aving a suprapubic catheter			this deficient practice:		
	(urine drainage that	t is surgically inserted through			1. Resident B is deceased		
	the skin) inserted a	nd kidney stones removed on			2. Resident D: An order was		
	12/16/24. The Eliquis was placed on hold prior to				obtained for a dressing to the	skin	
	the procedure on 12/12/24.				tear on her left forearm.		
					3 Resident C: Head to toe		
	A Health Status No	ote, dated 12/16/24, indicated			assessment was completed v	vith	
	the resident had ret	urned from the hospital			no other areas of open skin n	oted.	
	following the proce	edures. The resident was to			An order was obtained for res	sident	
	resume Eliquis on	12/18/24.			to have a bandaid on area to right		
					lower leg. Care plans updated	d. Ted	
		ent discharge instructions,			hose applied per order.		
		licated to resume the Eliquis on					
	12/18/24, medication	on was unchanged.					
					How other residents having the		
		ted 12/16/24 and entered by			potential to be affected by the		
		give Eliquis 5 mg one time			same deficient practice will be		
	daily related to tach	nycardia.			identified and what corrective		
	A II141. Gt 4 31	4- 4-4-110/16/04 : 1: 4-1			action will be taken:		
		ote, dated 12/16/24, indicated			1. All resident who have a		
		ing seen by the Nurse			procedure, or hospitalized ha		
		or a post-op visit after having a r and stent placement for			the potential to be affected. A		
		resident's medications			were completed on all readm from hospital residents for the		
	included Eliquis 5				3 months to ensure accuracy	-	
	meraded Eliquis 3	ing one time daily.			medications. No other deficie		
	During an interview	w on 2/7/25 at 2:25 p.m., LPN 2			noted.	ПОУ	
	_	Insure where the order to			2. All residents who have a b	reak	
		one time daily had come from,			in skin have the ability to be	Jan	
	_	ere had been some confusion			affected. Residents with curre	ent	
		e indicated she needed to talk			skin tears/break in skin or ulc		
		Jursing. No additional			were audited to ensure treatn		
	information was pr				were in place. No other defici		
						,	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155287	B. W	NG		02/07	/2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
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RENSSE	LAER CARE CENT	FR			SELAER, IN 47978		
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					noted.		
	_	v on 2/7/25 at 2:40 p.m., the NP			3. All residents who have an o		
indicated she did not change the resident's				for Ted hose have the ability to			
	medications, she had copied them from his				affected. All residents with ord		
	medication list. 2. On 2/6/25 at 10:22 a.m. Resident				for ted hose were audited and	no	
	D was observed seated in her wheelchair in the				other deficiency noted.		
		There was a white bandage in			What measures and what		
	place to her left for	earm.			systemic changes will be mad		
	0:: 2/6/25 + 2.06	Decident Description			ensure that the deficient pract	ice	
	_	.m. Resident D was observed			doesn't recur:		
		chair in the unit dining room.			1. Licensed nurses will be		
	There was a white bandage in place to her left			educated on verifying medication			
	forearm.				and orders for residents upon		
	D: 1 4 DI				return from outpatient procedu		
		was reviewed on 2/6/25 at 9:48			and/or upon return from hospi		
	dementia with beha	luded, but were not limited to,			Medication orders will be verif		
	osteoporosis, and en		with MD/NP. Education will be				
	osteoporosis, and er	mpnysema.			completed by 3-5-25 2. Licensed nurses will be		
	The Quarterly MDS	S assessment, dated 10/25/24,			educated on obtaining order fr	om	
		nt was cognitively impaired			MD/NP for any dressing or	OIII	
		taff for assistance with ADLs			bandage needed for any resid	ent	
	(activities of daily l				Education will be completed o		
	(activities of daily f	iving).			3-5-25	11	
	A Progress Note de	ated 1/29/25 at 5:31 p.m.,			3. Licensed nurses will be		
		nt had a new skin tear to the			educated on accurate		
		Jurse Practitioner was notified,			documentation in regard to tec	d	
		ceived to cleanse the area with			hose placement/refusals.	-	
	sterile water and ap				Education will be completed b	V	
		1			3-5-25.	,	
	A Physician's Order	r, dated 1/29/25, indicated to			4. No licensed nursing will wo	rk	
	-	earm skin tear for redness and			past date of compliance with o		
		a day. There were no orders			this education being complete		
	for any bandage to				How the corrective action will		
					monitored to ensure the defici		
	During an interview	on 2/6/25 at 3:49 p.m., the			practice will not recur, i.e., who	at	
	_	re were no orders for a dressing			quality assurance program wil		
		The resident had a skin tear at			put in place:		
	the end of January a	and had steri strips in place to			1.DON/Designee will audit all		
		During an observation and			residents charts who return from	om	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155287	B. W	NG		02/07/	2025
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NAME OF F	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
551005					GRACE ST		
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWIDERIC BY AN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	interview on 2/4/25	at 10:05 a.m., Resident C was			outpatient procedure/return fro	m	
		zed wheelchair. His bilateral			hospital to ensure accuracy of		
	lower extremities were both swollen, red in color,				medication orders. This will be		
		iscolorations. He had a small			ongoing for best practice.		
		ocated on his right lower leg.			2. 24 hour reports will be audit	ed 5	
	_	d that he was having skin			times a week for any new skin		
		ver legs and would be going to			areas and ensure that dressing		
		soon. He did not have on any			orders are in place for any and	-	
	compression stockii				new areas. This will be ongoin		
	compression stocki	ings at the time.			best practice.	y ioi	
	On 2/6/25 at 2:23 n	.m., Resident C was observed in			3. Residents who have Ted ho		
	_				will be audited 5 times weekly		
	his wheelchair in the hallway. Both lower legs were covered with compression stockings.				· · · · · · · · · · · · · · · · · · ·		
	were covered with	compression stockings.			60 days then 3 times weekly x		
	On 2/7/25 at 0.42 a	10:12 a m and 10:26 a m			days then weekly x 60 days to ensure that documentation and		
		.m., 10:12 a.m., and 10:36 a.m., erved in a wheelchair. His			application of Ted hose is		
		emities were red in color and			accurate.	•••	
	swollen. He had no	compression stockings on.			4. The results of these reviews	WIII	
	D 11 (C) 1	. 1 2/5/25 + 1.22			be discussed at the monthly		
		was reviewed on 2/5/25 at 1:32			facility Quality Assurance		
	-	luded, but were not limited to,			Committee meeting monthly fo	or a	
		ase, seborrheic dermatitis			total of 3 months and then		
	(inflammatory skin	condition), and heart failure.			quarterly thereafter once		
					compliance is at 100%.		
		mum Data Set (MDS)			Frequency and duration of rev		
	· ·	1/22/24, indicated the resident			will be increased as needed, if		
		act for daily decision making.			compliance is below 100%.		
		s of nonsurgical dressings, and			Compliance date: 3-7-25. The		
		ments/medications other than			Administrator at Rensselaer C		
		antibiotic and diuretic			Center is responsible in ensuri	ng	
	medications.				compliance in this Plan of		
					Correction.		
	A Care Plan, dated	2/5/25, indicated the resident					
		s to the bilateral lower					
		ntions included, but were not					
	limited to, encourage	ge resident to elevate legs as					
	tolerated and admin	ister treatments as ordered.					
		9/19/24, indicated the resident					
	had congestive hear	t failure (CHF) and may					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

32LL11

Facility ID: 000185

If continuation sheet Page 14 of 24

NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE  (AS ID SUMMARY STATEMENT OF DEFICIENCIE  PRIFIX TAO  RESOLUTIONY ROUSE INDERTWING NO FORMATION  experience weight fluctuations related to distretic medications. He had bilateral lower extremity edems. Interventions included, but were not limited to, administer distretic medications per orders, encourage him to elevate his less while siting, and observe and report any signs or symptoms of CHF such as dependent edema of legs/feet, increased heart rule, or disordination.  The February 2025 Physician Order Summary indicated the resident was to wear compression stockings string 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, 1/44/25, 1/22/25, and 1/29/25, indicated the resident had stasis dermatitis to 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 kernosis (seen by dematology).  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	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  RENSSELAER CARE CENTER  O(X4) ID  PREFIX  (CACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  RENDIALTORY OR LSC IDENTIFYMEND BY FORMATION  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 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 1/29/35, 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 demantitis to bilateral lower extremities.  The Weekly Skin Integrity Data Collection, dated 2/5/25, indicated the resident had stasis demantitis to bilateral lower extremities.  The weekly Skin integrity Data Collection, dated 2/5/25, indicated the resident had stasis demantitis to bilateral lower extremities.  The weekly Skin integrity Data Collection, dated 2/5/25, indicated the resident bad stasis demantitis 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 handage.  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	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
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RENSSELAER CARE CENTER  (X4) ID  REGULATORY OR LSC DENTIFYING DEFICIENCE  GLACI DEFICIENCY MUST BE PRICEDED BY FULL  TAG  REGULATORY OR LSC DENTIFYING DEFORMATION  experience weight fluctuations related to distrete medications. He had bilateral lower extremity edema. Interventions included, but were not limited to, administer distretic 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 were marked as administered in the morning on 2/4/25 and 27/125.  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 bad stasis demantitis 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 27/125 at 10:30 a.m., the Director of Nursing indicated the resident sometimes rolled down and removed the				<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
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Director of Nursing indicated the resident sometimes rolled down and removed the		<b>.</b>	0/7/05 / 10.20					
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		_						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

32LL11

Facility ID: 000185

If continuation sheet Page 15 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/07/2025	
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST SELAER, IN 47978	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
TAG	stockings were on or responsible for putt on with care. The no documented correct	ly.	TAG	DEFICIENCY	DATE
	Assistant Director of resident probably has	or on 2/7/25 at 10:35 a.m., the of Nursing indicated the ad scratched his leg and asked yould remove bandages on his opped bleeding.			
	indicated "3. It is and therapy departn change of the reside Notification may be and will alert nurse any new skin altera the responsibility of document an assess treatment orders, an party. 5. Orders are	sic Skin Management," the responsibility of the CNAs ment to notify nursing if a ent's skin is identified. e entered into PCC via eInteract on the PCC Dashboard. 4. If tion/wound is identified, it is f the nurse to perform and ment/observation, obtain and notify MD and responsible required for skin and wound and care protocol orders in PCC Template"			
	This citation relates and IN00452961.	to Complaints IN00452567			
	3.1-37(a)				
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent	Decrease in ROM/Mobility			
-	interview, the facili range of motion (RO not following theral routine ROM exerc	on, record review and ty failed to ensure a resident's OM) was maintained related to by recommendations for ises for 1 of 2 residents d ROM and/ or positioning.	F 0688	This plan of correction is prepared and executed because the provisions of state and federa require it and not because Rensselaer Care Center agreewith the allegations and citation listed. Rensselaer Care Center.	es ons

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

Page 16 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  02/07/2025	
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP COD E GRACE ST SELAER, IN 47978	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	Finding includes:  On 2/3/25 at 3:37 p seated in her recline the foot rest. She in paralyzed and flace range of motion exe not recently.  The resident's record 10:05 a.m. Diagnos limited to, parapleg stenosis.  The Quarterly Minited to parapleg stenosis.  The Quarterly Minited to parapleg stenosis.  The Polymer Minited to parapleg stenosis.  The Polymer Minited to parapleg stenosis.  The Quarterly Minited to parapleg stenosis.  A Physical Therapy 2/12/24, indicated received restorative and program. Intervention range of motion is a encourage resident encourage resident observe for signs of extremity ranging.  During an interview Occupational Thera received physical and January thru March recommendations to from therapy, but she for the state of the	c.m., Resident 21 was observed er, her legs were elevated with dicated her legs were id and that she used to get ercises done by the staff, but diabetes mellitus and spinal mum Data Set assessment, icated the resident was equired substantial to bed mobility and was fers and toileting. She had not nursing services.  Discharge Summary, dated estorative range of motion ons were to complete each a slow rhythm motion, to assist with the ROM, to relax, face the resident to discomfort and never force  of on 2/5/25 at 12:50 p.m., the pist indicated the resident had not occupational therapy 2024. Therapy would make on nursing staff on discharge need id not know who was		maintains that the alleged deficiencies do not jeopardiz health and safety of the resignor is it of such character to our capabilities to render adcare. Please accept this plan correction as our credible allegation of compliance that alleged deficiencies have or correct by the date indicated remain in compliance with stand federal regulations, the has taken or will take the act set forth in this plan of correction.  F688  What Corrective Action will to accomplished for those resignand to have been affected this deficient practice:  1. Resident was screened by the rapy and noted to have not decline in ROM/Mobility  2. Program was added to Allege the residents having potential to be affected by the same deficient practice will to the identified and what corrective action will be taken:  1. All residents discharged for the ability to be program have the ability to be affected program have the ability to be affected by the action will be taken:	te the dents limit equate in of the will be at to tate facility tions ction. esk
		out those recommendations.  Y on 2/5/25 at 1:20 p.m., the		affected.  2. Residents who remain in facility and were discharged	

PRINTED: 03/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155287	B. WI	NG	_	02/07/	2025
	PROVIDER OR SUPPLIER			1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST ELAER, IN 47978		
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			1309 E	GRACE ST	vere  lans e to ice to tions e of	(X5) COMPLETION DATE
					put in place:  1. IDT team will review all ther recommendations in clinical meeting 5 times a week. IDT vaudit all new programs to ensuthey have been initiated. This be an ongoing process for bespractice.  2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%.  Frequency and duration of revwill be increased as needed, if compliance is below 100%	apy vill ure will of s will or a	

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Event ID:

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Facility ID: 000185

If continuation sheet Page 18 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	f f			SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING			COMPLETED	
		155287	B. WI	NG		02/07/	/2025	
	OVIDER OR SUPPLIER			1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST SELAER, IN 47978			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
					Compliance date: 3-7-25 The Administrator at Rensselaer C Center is responsible in ensur compliance in this Plan of Correction.			
	l83.25(g)(1)-(3) Nutrition/Hydration	status Maintenance						
F F T aa li in d o o T aa h n n s iii n a d o o	railed to monitor nuresident with a historesidents reviewed for Finding includes:  The record for Resident 9:54 a.m. Diagnostimited to, multiple malnutrition, and ad fine Quarterly Minimulated the resident daily decision making only for eating and with the current Care Plant risk for weight flumealth status, variable multitional supplementations to help appetite, supplementations to help appetite, supplementations and the current Physician resident received a resident received a resident received a resident received as for the significant and unaversident received a resident received a resident received a resident received as for the sident received a resident received a resident received as resident received received received received received received r	tiew and interview, the facility tritional intake for meals for a ry of weight loss for 1 of 3 for nutrition. (Resident 15)  Ident 15 was reviewed on 2/5/25 sees included, but were not sclerosis, protein-calorie ult failure to thrive.  In the mum Data Set, dated 11/21/24, at was cognitively intact for ang. She required setup help weighed 84 pounds.  In indicated the resident was actuations due to her current le meal intakes and refusals of tents. Her weight loss was roidable. Interventions not limited to, administer stimulate the resident's ts to be offered, and serve  Order Summary indicated the regular diet and whole milk and afternoon after lunch.	F 06	592	This plan of correction is preparand executed because the provisions of state and federal require it and not because Rensselaer Care Center agree with the allegations and citation listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize health and safety of the reside nor is it of such character to lir our capabilities to render adectorare. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or worrect by the date indicated to remain in compliance with state and federal regulations, the fath has taken or will take the action set forth in this plan of correction.  F692  What Corrective Action will be accomplished for those reside found to have been affected by this deficient practice:  1. Resident 15 was weighed of	es ons er the ents mit quate of the vill be o te oillity ons ion. k	03/07/2025	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155287	B. W	ING		02/07	2025
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			GRACE ST		
RENSSE	ELAER CARE CENT	TER			SELAER, IN 47978		
TALINOOL	LALIT OAKE OLIVI			INLINOC	TEACK, IN 47970		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		recent weight on 2/4/25 was			2-6-25. No wt loss was noted	from	
	•	25, the resident weighed 79			previous wt. Resident was		
	pounds. On 8/9/24, the resident weighed 88				interviewed by DON on 2-6-2		
	pounds.				verified that she had been offer		
	A Nutrition/Distant Nata dated 1/12/25 indicated				meals daily. She continues to		
	A Nutrition/Dietary Note, dated 1/13/25, indicated				on weekly weights and contin	ues	
	the resident received a regular diet and was				to be followed by dietitian.		
	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				How other residents having the		
					potential to be affected by the		
	consume. She had variable meal intakes and 9% weight loss over the last 180 days.				same deficient practice will be		
	weight loss over the	e last 180 days.			identified and what corrective		
	The CNA Tests AD	I (Astivities of Daily Living)			action will be taken:	4	
		L (Activities of Daily Living) - ency of documentation for three			1. All residents have to ability	ιο	
	-	a.m., 12:00 p.m., and 5:00 p.m.			be affected.	maal	
	(mealtimes).	a.m., 12.00 p.m., and 3.00 p.m.			2. House audit completed on		
	(ineartifies).				consumption documentation. areas of concern addressed.		
	The meal consumn	tion log indicated there was no			plans updated as needed.	Cale	
	_	the breakfast meal on 1/8, 1/10,			What measures and what		
	1/17, 1/19, 1/21, 1/2				systemic changes will be mad	le to	
	1/1/, 1/19, 1/21, 1/.	21, and 1/25/23.			ensure that the deficient pract		
	The meal consumpt	tion log indicated there was no			doesn't recur:	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	_	the lunch meal on 1/19, 1/21,			1.DON/Designee to provide		
	1/31, and 2/1/25.				education to CNA's in regard	to	
					accurate documentation on m		
	The meal consumpt	tion log indicated there was no			consumption. Education will b		
	_	the dinner meal on 1/8, 1/11,			completed by 3-5-25. No aide		
	1/19, 1/26, 1/27, an	d 1/31/25.			work past date of compliance		
					without this education being		
	During an interview	v on 2/6/25 at 3:59 p.m., the			completed.		
	Director of Nursing	g indicated she had no further					
	information regardi	ng the missing documentation			How the corrective action will	be	
	of the meal intakes.	The resident may have			monitored to ensure the defic	ient	
	refused those meals	s, as she often refused to eat.			practice will not recur, i.e., wh	at	
	They had been wor	king with her on finding foods			quality assurance program wi	ll be	
	that she would eat t	o help her gain weight.			put in place:		
					1. DON/Designee will audit fo	od	
	3.1-46(a)				consumption records of 10 ra	ndom	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155287	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/07/2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1309 E GRACE ST RENSSELAER, IN 47978		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	Suctioning Based on observation interview, the facility received the necessare treatments related to a resident with COV reviewed for respiration and incorrect oxygenesidents reviewed (65)  Findings include:  1. On 2/4/25 at 9:2 observed in his room door that indicated isolation precaution protective equipments.	eostomy Care and on, record review and ty failed to ensure residents ary respiratory care and o medications not initiated for VID-19 for 1 of 2 residents atory infections (Resident 70) in flow rates for 2 of 2 for oxygen. (Residents 10 and  8 a.m., Resident 70 was in. There were signs on his he was on contact and droplet s. There was a personal int bin outside the door with ks and faceshields. A family	F 0695	residents 5x a week x 60 days then 3 times a week x 60 days.  2. The results of these review be discussed at the monthly facility Quality Assurance Committee meeting monthly fotal of 3 months and then quarterly thereafter once compliance is at 100%.  Frequency and duration of rewill be increased as needed, compliance date: 3-7-25. The Administrator at Rensselaer Compliance is below 100%.  Compliance date: 3-7-25. The Administrator at Rensselaer Compliance in this Plan of Correction.  This plan of correction is prepand executed because the provisions of state and federa require it and not because Rensselaer Care Center agree with the allegations and citatic listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize health and safety of the reside nor is it of such character to life our capabilities to render adecare. Please accept this plan correction as our credible allegation of compliance that alleged deficiencies have or we correct by the date indicated the remain in compliance with state the state of the plan correction as our credible allegation of compliance that alleged deficiencies have or we correct by the date indicated the remain in compliance with state the plan correction as our credible allegation of compliance with state and co	s s will  or a  views  if  care ring  ared  03/07/2025  I law  es  ons  er  e the ents mit quate of  the vill be oo

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Event ID:

32LL11

Facility ID: 000185

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPLETED
		155287	B. WIN	G	_	02/07/2025
NAME OF A	DROLLIDED OF GLIPPLIE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	t .			GRACE ST	
RENSSE	LAER CARE CENT	ER		RENSS	SELAER, IN 47978	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	member present ind	licated he had COVID-19.			and federal regulations, the fa	-
	The regident's recor	d was reviewed on 2/4/25 at			has taken or will take the action	
					set forth in this plan of correct	
	1:20 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, cerebral				We respectfully request a des review.	n
	ischemia and acute kidney failure.				Teview.	
	isonomia and acute kidney famure.					
	The Annual Minim	um Data Set assessment, dated			F 695	
		the resident had mild cognitive			What Corrective Action will be	,
		eded partial to moderate			accomplished for those reside	ents
	assistance for bed n	nobility and transfers.			found to have been affected b	y
					this deficient practice:	
	A Health Status No	te, dated 1/31/25, indicated			1. Resident 70: Orders for Due	0
	new orders were rec	ceived for Vitamin C, Zinc,			Nebs, Mucinex, Vitamin C and	t l
	Mucinex, Duonebs	(breathing treatment) as			Zinc were immediately added	to
		as needed for positive			resident order list. Resident	
	COVID-19 diagnos	es.			assessed and no respiratory	
					distress or negative outcome	
	· ·	ders lacked orders for Vitamin			noted.	
		Duonebs or oxygen. The			2.Resident 10 Her oxygen lite	
	1	ry 2025 Medication			flow was corrected immediate	ly
		ord lacked documentation the			upon notification. Resident	
	medications had be	en initiated or administered.			assessed and no respiratory	
	D	2/4/25 + 2.47 +1			distress or negative outcome	
	_	on 2/4/25 at 2:47 p.m., the			noted .	_
	_	indicted the orders for the theen entered. She indicated it			3 Resident 65. His oxygen lite	
	would be corrected.				flow was corrected immediate	ıy
		07 a.m., Resident 10 was			upon notification. Resident	
		a wheelchair in her room. The			assessed and no respiratory distress or negative outcome	
		gen via nasal cannula. The			noted.	
		r was set on 2.5 liters.			How other residents having th	
	any gen concentrate	Set on 2.0 mors.			potential to be affected by the	
	On 2/5/25 at 10:11	a.m., Resident 10 was observed			same deficient practice will be	
		esident had on oxygen via			identified and what corrective	
		oxygen concentrator was set			action will be taken:	
	on 2.5 liters.	,,,			All residents on Oxygen have	ve
					the potential to be affected.	· =
	Record review for I	Resident 10 was completed on			2 House audit of residents or	n
		. Diagnoses included, but were			oxygen completed with no oth	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155287	B. W	ING		02/07/	/2025
		<u> </u>	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u>I</u>	
NAME OF F	PROVIDER OR SUPPLIER	8			GRACE ST		
DENCCE		TED					
KENSSE	LAER CARE CENT			KENSS	ELAER, IN 47978		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nic obstructive pulmonary			deficiency noted		
	disease, heart failur	e, and dementia.			3. Audit of all residents that		
					currently reside in facility who		
		mum Data Set (MDS)			have had any out patient		
	assessment, dated 12/6/24, indicated the resident				procedure or hospitalization in	the	
		lem. The resident required a			past 90 days to ensure accura	асу	
	_	sistance with transfers and			of medications. No other		
	received oxygen the	erapy.			deficiency noted.		
			1		What measures and what		
		10/16/23 and revised 10/19/23,	1		systemic changes will be mad		
		nt had oxygen therapy related			ensure that the deficient pract	ice	
	_	schange and shortness of			doesn't recur:		
	_	osis of chronic obstructive			All nursing staff including		
		An intervention included for			Licensed Nurses and CNA's a	ıs	
	oxygen via nasal ca	nnula at 2 liters continuously.			well as guardian angels will be	Э	
					educated on Oxygen liter flow		
	1	Physician's Order Summary			rate, where to find current liter	flow	
		order for oxygen at 2 liters			rate for residents and how to		
	continuously per na	sal cannula.			accurately read concentrator.		
					Nurses instructed to correct lit	er	
	_	v on 2/5/25 at 10:15 a.m., LPN 1			flow as needed. All other staff		
		nt was supposed to be on 2			educated to report any		
	liters of oxygen and	I she would adjust the flow			discrepancies to nurse. Educa	ation	
	rate.				to be completed by 3-5-25.		
					Licensed nurses, CNA's as we		
					as guardian angels will not wo		
		2 p.m., Resident 65 was			past date of compliance witho		
	1	ed. The resident had on			this education being complete		
	oxygen via nasal ca				How the corrective action will		
	concentrator was se	et on 1 liter.			monitored to ensure the defici		
			1		practice will not recur, i.e., wh		
		a.m., Resident 65 was observed			quality assurance program wil	l be	
		esident had on oxygen via nasal			put in place:		
		en concentrator was set on 1	1		DON/Designee will audit flo		
	liter.		1		rate of residents on Oxygen 5		
					times a week x 60 days then 3	3	
		Resident 65 was completed on			times a week x 60 days then		
		. Diagnoses included, but were			weekly x 60 days.		
		te, chronic obstructive			2. The results of these reviews	s will	
	pulmonary disease,	anxiety, hypertension, and	1		be discussed at the monthly		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SO			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		155287	B. W	ING		02/07/2025		
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	1		
NAME OF P	ROVIDER OR SUPPLIEF	₹			GRACE ST			
RENSSE	LAER CARE CENT	FR			SELAER, IN 47978			
	EALIT OF THE OLIVI				Territ, III 47370		•	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
	hemiplegia.				facility Quality Assurance			
					Committee meeting monthly	for a		
		S assessment, dated 1/20/25,			total of 3 months and then			
		nt was cognitively intact. The			quarterly thereafter once			
		partial moderate assistance		compliance is at 100%.				
	with transfers and r	eceived oxygen therapy.		Frequency and duration of reviews				
				will be increased as needed, if				
	· ·	11/30/23 and revised 9/16/24,	compliance is below 100%.					
		nt had oxygen therapy related			Compliance date: 3-7-25. The			
	_	schange secondary to asthma.			Administrator at Rensselaer			
		luded oxygen at 3 liters via			Center is responsible in ensu	ıring		
	nasal cannula when	napping and at night.			compliance in this Plan of			
					Correction.			
	•	POS indicated an order for						
		er nasal cannula when napping						
	and at night.							
	_	v on 2/5/25 at 10:22 a.m., RN 1						
		nt's oxygen should be at 3						
	liters and she would	d correct the flow rate on the						
	concentrator.							
	3.1-47(a)(6)							
			1		l			

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