STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155287	A. BUILDING -- B. WING	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/26/25 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Emergency Preparedness survey, Rensselaer Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 120 certified beds. At the time of the survey, the census was 80. Quality Review completed on 03/03/25	E 0000		
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the LTC facility failed analyze the facility's response to and maintain complete documentation of all Emergency Preparedness Program drills. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	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	03/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jillian Sell	Executive Director	03/18/2025

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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	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Executive Director on 02/26/25 at 2:50 p.m., documentation for the actual event on 11/21/24 was incomplete. The documentation did not describe what occured and if the facility's response was analyzed in an after action report to ensure the staff followed the EPP to ensure the policies were effective. Based on an interview at the time of records review, the Maintenance Director stated no documentation for analyzing the LTC facility's response was available for review at the time of the survey. This finding was reviewed with the Executive		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. E039 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* A tabletop review of 11/21/2024 water outage event was completed. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* All residents had the potential to be affected. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* The facility will conduct a tabletop exercise after all of our disaster drills and upon emergency events. *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:*	

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	Director and Maintenance Director during the exit conference.		The tabletop results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 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: 3/14/2025. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/26/25 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Life Safety Code survey, Rensselaer Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000		

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	The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 120 and had a census of 80 at the time of this survey. All areas where residents have customary access were sprinklered except for two detached sheds that were used for general storage that were not sprinklered. Quality Review completed on 03/03/25			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview; the facility failed to ensure 1 of 1 smoking area was maintained by disposing cigarette butts in a metal or non-combustible container with self-closing cover devices. This deficient practice could affect six residents and two staff. Findings include: Based on observations and interviews during a facility tour with the Executive Director and Maintenance Director on 02/26/25 between 2:50 p.m. and 4:20 p.m., at the resident smoking area, there were over 10-20 cigarette butts disposed in an open metal tray. Additionally, there were over 50 cigarette butts disposed in a trash can mixed with trash. There was a non-combustible cigarette butt container available in the smoking area. Based on record review, the smoking policy states	K 0741	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	03/14/2025

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	in part on page four, 'at the end of the smoking time, ensure that cigarettes are extinguished, butts are disposed of properly (not on ground), ashtrays are emptied into non-combustible containters, cleaning/sweeping of smoking area.' Based on interview at the time of observations, the Maintenance Director agreed there were cigarette butts disposed of in an open tray and discarded in a trash can in the smoking area. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		set forth in this plan of correction. We respectfully request a desk review. K741 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* All cigarette butts were cleaned up and disposed of immediately. *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:* All residents had the potential to be affected. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* All staff have been educated that all cigarette butts are to extinguished and disposed of in an approved metal, self closed combustible container. All residents that smoke have been re-educated on the smoking policy. The administrator or designee will audit the smoking area for compliance three times a week and ongoing. *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:* The results of these audits will be	

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			discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 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: 3/14/2025. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	