| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155287 | A. BUILDING 00<br>B. WING | 01/13/2023 |

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| RENSSELAER CARE CENTER | 1309 E GRACE ST<br>RENSSELAER, IN 47978 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00387907 and IN00398489.<br><br>Complaint IN00387907 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690.<br><br>Complaint IN00398489 - Substantiated. State deficiency related to the allegations is cited at F9999.<br><br>Survey dates: January 9, 10, 11, 12, and 13, 2023<br><br>Facility number: 000185<br>Provider number: 155287<br>AIM number: 100290840<br><br>Census Bed Type:<br>SNF/NF: 65<br>Total: 65<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 47<br>Other: 12<br>Total: 65<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 1/19/23. | F 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Rensselaer Care Center agrees with the allegations and citations listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review | |
| F 0580<br>SS=D<br>Bldg. 00 | 483.10(g)(14)(i)-(iv)(15)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Brandi Costello | Executive Director | 02/07/2023 |

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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| | (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15) | | | |

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| | Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>Based on observation, record review, and interview, the facility failed to notify a resident of ultrasound results for 1 of 1 residents reviewed for notification of change. (Resident 49)<br><br>Finding includes:<br><br>Interview with Resident 49 on 1/9/23 at 10:40 a.m., indicated he had been having some problems with his "man parts" recently and might have an infection. He had a scan completed recently on his testicles, but staff had not told him the results yet.<br><br>Record review for Resident 49 was completed on 1/12/23 at 1:27 p.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder, hypertension, and chronic pain syndrome.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 12/14/22, indicated the resident was cognitively intact.<br><br>A Progress Note, dated 12/27/22 at 11:09 a.m., indicated the resident had complained of testicle pain and new orders were received for an ultrasound.<br><br>A Physician's Order, dated 12/27/22, indicated an order for an ultrasound of the testicles. | F 0580 | **F 580 Notify of Changes**<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***<br>· Resident 49 had no negative outcomes.<br>· Resident 49 was informed of the results of his testicle ultrasound on 1-13-23 upon return from the hospital.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?***<br>·All residents who have testing completed have the potential to be affected.<br>·Residents who had ultrasounds, or x-rays in the last 30 days were audited and no other deficiency found.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?***<br>·Residents and/or responsible party will be notified of test results | 02/10/2023 |

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| | A Physician's Order, dated 12/30/22, indicated the resident was to take Levaquin (an antibiotic) 500 mg (milligrams) daily for epididymitis (inflammation of the testicle) and left testicle lower pole lesion. There was a lack of documentation the resident had been informed of the new orders.<br><br>A Social Service Note, dated 1/5/23 at 1:12 p.m., indicated the resident had inquired about the ultrasound results and nursing was notified of his request.<br><br>Ultrasound of the scrotum and contents results indicated the ultrasound had been completed on 12/28/22 and reported on 12/29/22 at 7:59 a.m. There was lack of documentation the resident had been informed of the results.<br><br>Interview with the DON on 1/13/23 at 9:47 a.m., indicated she was unable to find documentation that the ultrasound results had been discussed with the resident. She had personally spoken with the resident about the antibiotic but was unable to provide any further documentation.<br><br>3.1-5(a)(2)<br>3.1-5(a)(3) | | within 24 hours of the facility receiving the results.<br>·DON/designee will provide education to licensed nursing staff on the notification process to the resident and/or responsible party with test results. All new licensed nursing staff hired will receive this education prior to providing resident care.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***<br>·DON/designee will audit test results to ensure that resident and /or responsible party have been notified 5 times a week x 2 months, then 3times a week x 2 months, then weekly for the duration of 6 months.<br>·The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br>Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0641<br>SS=A | 483.20(g)<br>Accuracy of Assessments | | | |

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| Bldg. 00 | §483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to hospice services for 1 of 16 MDS assessments reviewed. (Resident 47)<br><br>Finding includes:<br><br>Resident 47's record was reviewed on 1/11/23 at 9:44 a.m. Diagnosis included, but were not limited to, dementia and malignant cancer of the cervix. The resident was on hospice care. The resident was admitted to the facility on 8/18/21.<br><br>The Quarterly MDS assessment, dated 10/17/22, indicated the resident was not receiving hospice services.<br><br>Interview with MDS Coordinator on 1/11/23 at 10:19 a.m., indicated the resident had been admitted to hospice and the MDS had been coded incorrectly. | F 0641 | **F 641**- Accuracy of Assessments<br><br>***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***<br>1. Resident 47 had no negative outcomes. The resident involved has had modifications completed and submitted.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***<br>1. MDS will complete an in house audit on residents receiving hospice services to assure accuracy. Any issues identified will be corrected and a modification MDS submitted by day of compliance. This audit will include care plan reviews to assure care plan is accurate as well.<br>***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:***<br>1. CRS will educate MDS on appropriate coding r/t hospice services by date of compliance.<br>***How the corrective action will be monitored to ensure the deficient practice will not recur,*** | 02/10/2023 |

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| | | | ***i.e., what quality assurance program will be put in place:***<br>1. DON/designee will audit any residents MDS that is receiving hospice services to assure accuracy x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.<br>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%.<br>Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0655<br>SS=D<br>Bldg. 00 | 483.21(a)(1)-(3)<br>Baseline Care Plan<br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission. | | | |

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| | (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. | | | |
| | Based on observation, record review and interview, the facility failed to implement a baseline care plan related to skin conditions for 1 of 1 residents reviewed for non-pressure related skin conditions. (Resident 216)<br><br>Finding includes: | F 0655 | **F 655 Baseline Care plan**<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***<br>·Resident 216 experienced no | 02/10/2023 |

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| | On 1/10/23 at 10:43 a.m., Resident 216 was observed lying in bed. The resident had large purple discolorations to the left forearm. The resident indicated she had the same discolorations to her right forearm and had gotten the discolorations from a fall before admission to the facility.<br><br>On 1/11/23 at 11:12 a.m., Resident 216 was observed lying in bed with her eyes closed. The discolorations were still observed to her left forearm.<br><br>Record review for Resident 216 was completed on 1/12/23 at 1:52 p.m. Diagnoses included, but were not limited to, humeral fracture (breaking the bone in your upper arm) and left pubic rami fracture (break in one of the bones in the pelvis). The resident was admitted to the facility on 12/27/22.<br><br>The Admission Assessment, dated 12/27/22, indicated the resident had a bruise to her left hand, left elbow, right shoulder, right hand, and left lower leg.<br><br>The Baseline Care Plan, dated 12/27/22, had nothing marked for skin conditions or risk for skin conditions.<br><br>Interview with the Director of Nursing (DON) on 1/12/23 at 2:46 p.m., indicated the resident's Baseline Care Plan did not have anything marked about the skin discolorations but should have.<br><br>3.1-30(a) | | negative outcomes.<br>·Resident 216 Baseline Care Plan was updated on 1-12-23<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?***<br>·New admissions have the potential to be affected.<br>·DON/designee will review all new admission charts to ensure that Baseline care plan is completed and accurate.<br>·DON/Designee have reviewed all new admission charts for the last 30 days to ensure the Baseline Care Plan is completed and accurate.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?***<br>· The Director of Nursing and/or Nursing Administration team will educate licensed nursing personal on completion of Baseline Care plan within 48 hours of admission.<br>·All new hired licensed nurses will complete this education prior to providing resident care.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***<br>·DON and/or designee will audit the clinical record of all new residents for 6 months to ensure | |

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| | | | that Baseline Care Plan has been completed within 48 hours of admission. Any deficiencies noted will be corrected immediately.<br>·The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the lack of a Physician's order in place for a resident's arm sling for 1 of 2 residents reviewed for limited range of motion. (Resident 216) | F 0684 | **F 684**- Quality of Care<br>***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***<br>· Resident 216: MD contacted and new orders r/t right | 02/10/2023 |

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| | Finding includes:<br><br>On 1/10/23 at 10:43 a.m., Resident 216 was observed lying in bed with her right arm underneath a sheet. The resident indicated she had broken her arm at home and was having a lot of pain. She believed she was suppose to wear an arm sling when she was up out of bed. A black arm sling was observed on a chair across the room.<br><br>On 1/10/23 at 2:14 p.m., Resident 26 was observed lying in bed with her eyes closed. The black sling was still observed on a chair across the room.<br><br>On 1/11/23 at 11:12 a.m., Resident 26 was observed lying in bed with her eyes closed. The resident was then observed wearing the black sling on her right arm.<br><br>Record review for Resident 216 was completed on 1/12/23 at 1:52 p.m. Diagnoses included, but were not limited to, humeral fracture (breaking the bone in your upper arm) and left pubic rami fracture (break in one of the bones in the pelvis). The resident was admitted to the facility on 12/27/22.<br><br>A Progress Note, dated 12/30/22, indicated the resident had a right arm sling in use due to a humeral fracture.<br><br>A Physical Therapy Note, dated 1/11/23 at 1:41 p.m., indicated the resident verbalized pain 10 out of 10 with movement in the right upper extremity (RUE) upon approach. The resident was seated in a wheelchair without a sling on. The sling was donned by a therapist as requested due to increased pain. The nurse was immediately notified for pain medication per the resident's request. The nurse gave the resident pain | | arm sling; to include wearing directions, were obtained and immediately put in place. Resident and family were notified.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***<br>· All residents who have a sling or splint have the potential to be affected<br>· In house audit completed on residents who have a sling or splint to ensure all residents have orders and that orders include wearing directions. No other deficiencies noted.<br>***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:***<br>· Education will be completed to licensed nursing staff by 2-10-23 to ensure any resident who has the need for a sling or splint has appropriated orders from the physician. New licensed or certified nursing employees will receive this education prior to providing resident care.<br>***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:***<br>· DON/Designee will review 24/72 hour report 5 times a week x 6 months to ensure | |

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| | medication. The resident indicated the pain was decreased to 6 out of 10 in the RUE after the sling was in place.<br><br>The resident's record lacked any documentation of a Physician's Order with directions for use for the arm sling.<br><br>Interview with the Director of Nursing (DON) on 1/12/23 at 2:46 p.m., indicated she could not find a Physician's order for the arm sling but there should have been one. She would clarify with the Physician directions on when the resident should be wearing the arm sling.<br><br>3.1-37(a) | | sling/splint orders are obtained and in place for any resident requiring adaptive device.<br>· 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%.<br>Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br>Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an | | | |

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| | indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>Based on interview and record review, the facility failed to ensure a resident with a urinary tract infection (UTI) received the necessary treatment and services related to completing a laboratory test as ordered for 1 of 2 residents reviewed for urinary tract infections. (Resident B)<br><br>Finding includes:<br><br>The record for Resident B was reviewed on 1/10/23 at 3:11 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and chronic pain syndrome.<br><br>A Progress Note, dated 9/15/22 at 11:16 p.m., indicated staff had spoken with the resident's daughter and she requested a urinalysis (UA, urine test) because the resident had been sleeping nonstop and the last time that happened, she had an infection. The resident's urine was cloudy and had sediment and she had slept most of the shift. The Physician was notified. | F 0690 | **F 690- Bowel/Bladder Incontinence, Catheter, UTI**<br>***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***<br>1.Resident B had no negative outcomes from delay in obtaining U/A C&S. The urine had been sent out and course of antibiotics had been completed prior to the time of this survey.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***<br>1.All residents who have orders for U/A C & S have the potential to be affected.<br>2.Audit completed for prior 30 days to ensure all U/A C&S have | 02/10/2023 |

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| | A Progress Note, dated 9/16/22 at 10:48 a.m., indicated a new order was obtained for a urinalysis with culture, CBC (complete blood count, lab test) and CMP (comprehensive metabolic panel, lab test)<br><br>A Physician's Order, dated 9/16/22, indicated CBC, CMP, and UA on 9/16/22 for increased lethargy.<br><br>A Progress Note, dated 9/23/22 at 5:39 p.m., indicated the UA was obtained and sent to the lab. There was lack of documentation as to why the UA had not been completed until 9/23/22.<br><br>A Progress Note, dated 9/26/22 at 10:05 a.m., indicated the UA results had been received and were positive for E. coli (Escherichia coli, bacteria). The culture and sensitivity results were pending.<br><br>A Progress Note, dated 9/28/22 at 6:39 a.m., indicated there were new orders for Levaquin (an antibiotic) 500 mg (milligrams) daily for 10 days for a UTI.<br><br>Interview with the DON on 1/13/23 at 9:08 a.m., indicated the CBC and CMP had been completed on 9/16/22. She was unsure why the UA had not been completed until 9/23/22. The UA results had indicated a UTI and the resident was treated with antibiotics.<br><br>This Federal tag relates to Complaint IN00387907.<br><br>3.1-41(a)(2) | | been obtained and addressed within a timely manner. No other deficiencies noted.<br>***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:***<br>1.DON/Designee will educate licensed nursing staff by 2/10/23, on the importance of obtaining urine specimens at the time of the order.<br>2.New licensed nurses hired will complete this education during orientation prior to providing resident care.<br>***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:***<br>1.DON/Designee will review order listing report 5 times weekly for 6 months to identify all orders for U/A C&S and ensure that specimen was obtained and sent to the lab timely.<br>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: February 10, 2023. The Administrator at Rensselaer Care Center is | |

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| | | | responsible in ensuring compliance in this Plan of Correction. | |
| F 0697 SS=D Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on observation, record review and interview, the facility failed to ensure a resident who had complained of pain during therapy received pain medication for 1 of 2 residents reviewed for pain. (Resident 216)<br><br>Finding includes:<br><br>On 1/10/23 at 10:40 a.m., Resident 216 was observed lying in bed. The resident was grimacing and indicated she was in pain due to her arm being broken. She had a hard time participating in therapy due to her pain.<br><br>Record review for Resident 216 was completed on 1/12/23 at 1:52 p.m. Diagnoses included, but were not limited to, humeral fracture (breaking the bone in your upper arm) and left pubic rami fracture (break in one of the bones in the pelvis). The resident was admitted to the facility on 12/27/22.<br><br>A Physician's Order, dated 12/27/22, indicated acetaminophen (Tylenol) 325 mg (milligrams). Give 2 tablets every 4 hours as needed for pain.<br><br>The December 2022 Medication Administration | F 0697 | **F 697- Pain Management**<br>***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:***<br>1.Resident 216: MD contacted and order was received for scheduled analgesic.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:***<br>1.All residents receiving therapy have the potential to be affected.<br>2.An in-house audit was completed for all residents currently receiving therapy services to ensure appropriate analgesic orders in place. Any finding were addressed with physician and orders were obtained.<br>***What measures and what systemic changes will be made*** | 02/10/2023 |

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| | Record (MAR) indicated the resident had not received any Tylenol.<br><br>The January 2023 MAR indicated the resident had received Tylenol only one time on 1/3/23 for complaints of pain.<br><br>Occupational Therapy (OT) Notes indicated the following:<br>- 1/10/23 at 2:42 p.m., the resident reported right shoulder pain with all movement rated 8 out 10.<br>- 1/11/23 at 2:29 p.m., the resident reported "Oh yes, there is pain in my arm" but no numerical value was provided.<br>- 1/12/23 at 10:53 a.m., the resident reported mild RUE (right upper extremity) pain.<br><br>Physical Therapy (PT) Notes indicated the following:<br>- 1/10/23 at 12:47 p.m., the resident verbalized pain. The resident indicated a constant sharp pain at rest to the left shoulder and elbow rated at 4 out of 10. The resident indicated a constant sharp intermittent pain with movement rated at 7 out of 10.<br>- 1/11/23 at 1:41 p.m., the resident verbalized pain 10 out of 10 with movement in the RUE upon approach. The resident was seated in a wheelchair without a sling on. The sling was donned by a therapist as requested due to increased pain. The nurse was immediately notified for pain medication per the residents request. The nurse gave the resident pain medication. The resident indicated the pain was decreased to 6 out of 10 in the RUE after the sling was in place.<br><br>There was no documentation on the January 2023 MAR to indicate the resident received any pain medication on the above dates and times. | | ***to ensure that the deficient practice doesn't recur:***<br>1.DON/Designee will educate licensed nursing staff by 2/10/23 on performing pain assessment prior to therapy on all residents receiving therapy. Staff will include the question does movement or therapy cause you pain?<br>2.Any resident receiving therapy will be discussed in the morning meeting by the IDT, any pain concerns will then be addressed with physician.<br>3.New licensed nurses hired will complete this education during orientation prior to providing resident care.<br>***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:***<br>1.DON/Designee will audit 5 random residents currently receiving therapy 3 times a week x 8 weeks then 2 times a week x 8 weeks, then weekly for the duration of 6 months to ensure appropriate analgesic orders are in place.<br>2.Discussion of residents in therapy who may have pain will be an ongoing best practice.<br>3.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 | |

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| | Interview with the Director of Nursing (DON) on 1/12/23 at 2:46 p.m., indicated the resident had not expressed pain but she would look into it.<br><br>Interview with OT 1 on 1/12/23 at 2:56 p.m., indicated the resident had been having a hard time participating in therapy due to pain. Therapy had notified nursing to see about administering pain medication prior to therapy.<br><br>Interview with the DON on 1/13/23 at 9:11 a.m., indicated she had spoken with nursing and the resident had not expressed any pain to them. They had not heard from therapy the resident had been having pain in therapy. She spoke with therapy and they could not tell her what nurses they had told about the residents pain. She had spoken to the Physician and received an order to start scheduled Tylenol three times a day.<br><br>3.1-37(a) | | quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications | | | |

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| | for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to a laboratory test not completed as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 18)<br><br>Finding includes:<br><br>Resident 18's record was reviewed on 1/11/23 at 10:37 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, Diabetes Mellitus, hypertension and atrial fibrillation. The resident was admitted to the facility on 8/7/22.<br><br>A Physician's Order, dated 4/22/22, indicated to obtain a CBC (complete blood count), BMP (basic metabolic panel) and liver and lipid panel every 6 months in June and December.<br><br>There were no December 2022 lab results available for review.<br><br>Interview with LPN 1, on 1/12/23 at 1:31 p.m., indicated the labs had not been completed as ordered, but had been arranged to be completed on the next lab day.<br><br>3.1-48(a)(3) | F 0757 | **F 757** Drug Regimen is Free from unnecessary Drugs<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***<br>·Resident 18 had no negative outcomes r/t lab not being completed timely.<br>·MD was notified of delay in lab work and new order was received to obtain labs.<br>·Labs were immediately drawn and results relayed to MD.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken?***<br>·All residents who have lab draw orders have the potential to be affected.<br>·An audit for prior 30 days completed on all lab orders to ensure obtained.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** | 02/10/2023 |

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| | | | ·Nursing Management to educate licensed nursing staff on lab management procedure. All new licensed nursing staff will receive this education prior to providing resident care.<br>·DON/Designee will review all current residents to ensure that standing lab orders are placed in the lab book per order.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***<br>·The DON/designee will audit lab orders 5x/week x 4 weeks, then 3x/week x 4 weeks, then weekly times 4 months to ensure that any new lab orders obtained are place in the lab book for draw.<br>·The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: February 10, 2023. The Administrator at Rensselaer Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0805 SS=D | 483.60(d)(3)<br>Food in Form to Meet Individual Needs | | | |

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| Bldg. 00 | §483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>Based on observation, interview and record review, the facility failed to ensure food was prepared in form to meet individual needs related to incorrectly made pureed food. This had the potential to affect 3 residents who received a pureed diet.<br><br>Finding includes:<br><br>On 1/12/23 at 11:00 a.m., the Cook was observed preparing pureed pork loins with gravy. She had the pork loins and gravy in the blender already, there was not a recipe present. She pureed the food, and poured it into a metal container. The pureed food appeared watery and runny. She then removed the blender to wash.<br><br>At 11:15 a.m., she was observed preparing pureed green beans. She measured out three portions of green beans. She then added water from the tap, indicating the first line on the blender was two cups. There was no recipe present. She pureed the food, and poured it into a metal container. The pureed food appeared watery and runny.<br><br>Interview with the Cook after the green beans had been finished, indicated they were too thin and needed to be thickened. She added food thickener to the beans. She looked at the pureed pork loins and indicated they were also too thin and needed to be thickened<br><br>The recipe for pureed green beans was received from the Dietary Manager on 1/12/23, indicated, | F 0805 | **F 805 Food Form to meet individual needs**<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:***<br>· Residents on puree diet have the potential to be affected.<br>· No residents were adversely affected.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***<br>· Dietary Manager has reviewed Recipes, and Menu spreadsheets.<br>· Dietary Staff have been re-educated on Recipes, menu, and spreadsheets.<br>· Dietary staff are to follow the menu/ recipes as written when preparing foods to meet the resident's individual needs.<br>***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:***<br>· Dietary staff were educated regarding puree food preparation and following recipe directions on | 02/10/2023 |

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| | "...2. Drain green beans and place in food processor. 3. Process until smooth and product reaches an applesauce consistency....".<br><br>3.1-21(a)(3) | | 1/25/2023 by DM/designee. All new hired dietary staff will receive this education during orientation.<br>· Dietary Manager/designee will audit Menu preparation 3x weekly for 1 month, 2x weekly for 1 month, and monthly x 4 months.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:***<br>· Dietary Manager/designee will audit Menu preparation 3x weekly for 1 month, 2x weekly for 1 month, and monthly x 4 months.<br>· The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br>Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by | | | |

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| | federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, record review, and interview, the facility failed to ensure a sanitary kitchen was maintained related to not monitoring the chemical sanitizer level of the low temperature dishwasher. This had the potential to affect all 65 residents who received meals prepared in the kitchen. (Main Kitchen)<br><br>Finding includes:<br><br>On 1/12/23 at 11:00 a.m., a follow up visit to the kitchen was made. At 11:05 a.m., the Cook was observed using the dishwasher. She indicated it was a low temperature dishwasher. The wash temperature was 120 degrees and the rinse temperature was 135 degrees. When asked about monitoring the chemical sanitizer level of the dishwashing solution, the Cook was unsure.<br><br>Interview with the Dietary Manager at that time, indicated he had been unable to order testing strips. The company that serviced the dishwasher recently gave him a tube of testing strips so they | F 0812 | **F 812 Food Procurement, Store/Prepare/Serve-Sanitary**<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***<br>· No residents were affected by the deficient practice.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***<br>· 65 residents have the potential to be affected.<br>· The Dietary Director received education on 1/25/2023 related to the proper protocol and testing requirements of the dish machine to include chemical levels along with the sanitation policy to ensure proper food safety | 02/10/2023 |

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| | 155287 | A. BUILDING 00<br>B. WING | 01/13/2023 |

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| | could monitor the chemical levels, but he had not changed the log sheet yet. He indicated the level should be between 50-100 ppm (parts per million). He indicated the Dietary Aide (DA) was monitoring it.<br><br>Interview with the DA at that time, indicated she was not monitoring the chemical levels and was not aware of how to use the test strips.<br><br>The January 2023 Dish Machine Temperature Log indicated the wash and rinse temperatures were recorded three times daily, but there were no chemical levels recorded. There was a tube of testing strips next to the dishwashing log.<br><br>The current policy, "Sanitation and Maintenance", was received from the Administrator, on 1/12/23 at 11:48 a.m., indicated, "...Low Temp Dish Machine. b. The temperature and parts per million (PPM) of the sanitizer (50-100 ppm for chlorine) will be recorded on the Low Temperature Dish Machine Log a minimum of three times per day."<br><br>3.1-21(i)(3) | | requirements.<br>· Dietary Director educated all dietary staff on 1/25/2023 related to proper protocol and testing of the dish machine to include chemical levels along with the sanitation policy to ensure proper food safety requirements. All new hired dietary staff will receive this education during orientation.<br>***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:***<br>· Dietary Director/designee will conduct chemical level checks at random times 5 times a week x 2 months, then 3 times a week x 2 months, then weekly for the duration of 6 months on the dish machine to ensure compliance with the correct temperature during the sanitation of dishes.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***<br>· Dietary Director/designee will conduct chemical checks at random times 5 times a week x 2 months, then 3 times a week x 2 months, then weekly for the duration of 6 months on the dish machine to ensure compliance with the correct chemical levels during the sanitation of dishes.<br>· The results of these audits | |

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| | | | will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to provide a comfortable and homelike environment related to bare walls, lack of personalization and no baseboards on the memory care unit. This had the potential to affect all 21 residents who resided on the memory care unit. (Garden Unit)<br><br>Finding includes:<br><br>On 1/9/23 at 10:30 a.m., the Garden Unit was observed. There were three halls on the unit, all halls were painted beige. There were no baseboards on the walls, which exposed rough drywall where the walls met the floors. There were no pictures on the walls. There were no personalized items or name plates on resident doors, only a small tag with the first initial and last | F 0921 | **F 921**<br>**Safe/Functional/Sanitary/Comfortable Environ**<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***<br>· Baseboards installed on Garden Unit 1/26/2023.<br>· Shadow Boxes for Garden unit delivered 1/28/2023 and scheduled to be hung.<br>· Executive Director obtaining wall art for Garden unit to decorate walls.<br>***How other residents having the potential to be affected by the*** | 02/10/2023 |

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| | name to identify a room.<br><br>Interview with LPN 1, on 1/11/23 at 9:05 a.m., indicated they had removed the baseboards to paint before the pandemic happened.<br><br>Interview with the Administrator on 1/12/23 at 11:49 a.m., indicated they had plans to redecorate the Garden Unit but it had been delayed. She indicated the unit lacked personalization and was bland.<br><br>3.1-9(e) | | ***same deficient practice will be identified and what corrective action(s) will be taken:***<br>· All residents on Garden unit have the potential to be affected.<br>***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:***<br>· Environmental rounds have been completed by maintenance department and plan has been put into place to address baseboards on walls, exposed rough drywall, pictures on walls, and personalized items/name plates on resident doorways.<br>· The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine resident room rounds according to facility protocol.<br>· The Director of Maintenance and the Director of Housekeeping were educated by the Executive Director on maintaining Safe/functional/sanitary/comfortable environment on 1/31/2023. All new hired maintenance/housekeeping staff will receive this education during orientation.<br><br>***How the corrective action(s) will be monitored to ensure the*** | |

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| | | | ***deficient practice will not recur:***<br>· The Maintenance Director and/or designee will conduct observations in Garden unit 5x weekly for next 6 months to ensure the resident's environment is in good repair from missing baseboards and exposed rough drywall as well as having pictures on the walls and personalized items/name plates on resident doorways. Any concerns identified will be addressed immediately.<br>· The results of these audits 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: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |
| F 9999<br><br>Bldg. 00 | 3.1-13(g)(1) Administration and Management<br><br>(g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the | F 9999 | **F9999 Final Observations**<br>Administration and Management<br>***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient*** | 02/10/2023 |

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| | same hours. The responsibilities of the administrator shall include, but are not limited to, the following:<br>(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:<br>(A) epidemic outbreaks;<br>(B) poisonings;<br>(C) fires; or<br>(D) major accidents.<br><br>This state rule was not met as evidenced by:<br><br>Based on record review and interview, the facility failed to report a broken water pipe and disruption in water service on the memory care unit to the Indiana Department of Health (IDOH). This had the potential to affect all 21 residents who resided on the memory care unit. (Garden Hall)<br><br>Finding includes:<br><br>Interview with LPN 2 on 1/9/23 at 1:47 p.m., indicated the Garden Unit had not had water for about a week and a half recently. They brought gallons of water into the unit, would take residents to another unit for showers and used bathing wipes for bed baths.<br><br>Interview with QMA 1 on 1/9/23 at 2:10 p.m., indicated there had been no water on the unit for about a week recently. They brought gallons of water from other areas to use. They would toilet all the residents, then go up front in the building and turn the water main on long enough to flush the toilets, then turn the water back off. Some residents would allow staff to take them off the | | ***practice?***<br>· No residents were adversely effected by the deficient practices.<br>· Incident reported to Indiana Department of Health on 1/10/23.<br>***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***<br>· Executive Director reviewed Indiana State Reportable guidelines with surveyors.<br>***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:***<br>· Executive Director will review all potential reportable concerns with Regional Vice President and Regional Director of Clinical Services.<br>· All potential state reportable occurrences will be reviewed with Regional Vice President and Regional Director of Clinical Services timely.<br>· State reportable log will be sent to Regional Vice President and Regional Director of Clinical Services weekly for review.<br>***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:***<br>· Executive Director and/or designee will review all potential state reportable occurrences with Regional Vice President and | |

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| | unit to be showered, others would not, so they would give them bed baths using wash wipes. She indicated it was very difficult and disruptive to staff.<br><br>The facility's list of reportable events was reviewed on 1/9/23. There was no indication a water pipe had broken or there had been a disruption in water service to any area in the building recently.<br><br>Interview with the Administrator on 1/9/23 at 1:58 p.m., indicated a water pipe had burst on 12/26/22. A plumber had been out right away to assess, but was unable to make repairs initially. Water had been restored last Wednesday, January 4. She had not reported it to IDOH, as there was water in the rest of the building. She was not aware it was a reportable event.<br><br>The Indiana Department of Health Long-Term Care Abuse and Incident Reporting Policy, dated 12/8/22, indicated, "...17. Utility interruption of more than four (4) hours in length in one or more major utilities to the facility. Examples include but are not limited to fire alarm, sprinkler system, phone services, electrical, water supply...." was included as a reportable event.<br><br>This State Tag relates to Complaint IN00398489. | | Regional Director of Clinical Services timely.<br>· Executive Director and/or designee will submit State Reportable Log to Regional Vice President and Regional Director of Clinical Services weekly for review.<br>· The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br>Compliance date: February 10, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. | |