DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		<u></u>	COMPLETED	
		155287	B. WI	B. WING		01/30/	2023
	STREET ADDRESS, CITY, STATE, ZIP COD			ADDRESS CITY STATE ZID COD			
NAME OF P	PROVIDER OR SUPPLIER				GRACE ST		
DENICOE	LAED CADE CENT	·FD					
KENSSE	LAER CARE CENT	ER		KENSS	ELAER, IN 47978		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Ŭ	An Emergency Prep	paredness Survey was	E 00	000	This plan of correction is prepa	ared	
		diana Department of Health in		,,,,	and executed because the		
	accordance with 42	-			provisions of state and federal	law	
					require it and not because		
	Survey Date: 01/30)/23			Rensselaer Care Center agree	es	
	, <i>. 1700</i>				with the allegations and citation		
	Facility Number: 00	00185			listed. Rensselaer Care Cente		
	Provider Number: 1				maintains that the alleged	•	
	AIM Number: 1002				deficiencies do not jeopardize	the	
					health and safety of the reside		
	At this Emergency I	Preparedness survey,			nor is it of such character to lin		
		nter was found in compliance			our capabilities to render adeq		
		eparedness Requirements for			care. Please accept this plan of		
		caid Participating Providers			correction as our credible	71	
	and Suppliers, 42 C.				allegation of compliance that the	he	
	una Suppliers, 12 C	1103.73			alleged deficiencies have or w		
	The facility has 157	certified beds. At the time of			correct by the date indicated to		
	the survey, the cens				remain in compliance with stat		
	the survey, the cens	us was 75.			and federal regulations, the fac		
	Quality Review con	anleted on 02/06/23			has taken or will take the actio		
	Quality Review con	npicted on 02/00/23					
					set forth in this plan of correction We respectfully request a desi		
					review.	`	
					l leview.		
K 0000							
Bldg. 01							
Blug. 01	Δ Life Safety Code	Recertification and State	K 00	000	This plan of correction is prepa	ared	ı
	_	as conducted by the Indiana	K U	000	and executed because the	aicu	
	_	th in accordance with 42 CFR			provisions of state and federal	law	
	483.90(a).	in in accordance with 42 Cl K			require it and not because	law	
	103.70(a).				Rensselaer Care Center agree) e	
	Survey Date: 01/30/	/23			with the allegations and citation		
	Darvey Date. 01/30/	23			listed. Rensselaer Care Cente		
	Facility Number: 00	00185			maintains that the alleged	'	
	Provider Number: 1				deficiencies do not jeopardize	the	
	AIM Number: 1002				health and safety of the reside		
	7 11101 Trainioci. 1002				nealth and salety of the reside	1110	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Brandi Costello **Executive Director** 02/17/2023

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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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155287 B. WING 01/30/2023

NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP COD			
			GRACE ST			
RENSSE	ELAER CARE CENTER	RENSS	RENSSELAER, IN 47978			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
			nor is it of such character to limit			
	At this Life Safety Code survey, Rensselaer Care		our capabilities to render adequate			
	Center was found not in compliance with		care. Please accept this plan of			
	Requirements for Participation in		correction as our credible			
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),		allegation of compliance that the			
	Life Safety from Fire and the 2012 edition of the		alleged deficiencies have or will be			
	National Fire Protection Association (NFPA) 101,		correct by the date indicated to			
	Life Safety Code (LSC), Chapter 19, Existing		remain in compliance with state			
	Health Care Occupancies and 410 IAC 16.2.		and federal regulations, the facility			
			has taken or will take the actions			
	The facility was determined to be Type V (111)		set forth in this plan of correction.			
	construction and was fully sprinklered. The		We respectfully request a desk			
	facility has a fire alarm system with hardwired		review.			
	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 157 and had a census					
	of 73 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 02/06/23					
0200	NFPA 101					
SS=E	Means of Egress Requirements - Other					
Rlda 01	Means of Egross Paguiroments Other					

Bldg. 01

Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 2 of 10 doors to facility restrooms was provided with door latches that required only

K 0200

K200 Means of Egress Requirements-Other What corrective action(s) will be 02/22/2023

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2023 155287 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN 47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE one operation to open. LSC 19.2.2.1 states doors accomplished for those complying with 7.2.1 shall be permitted. residents found to have been 7.2.1.5.10.2 requires the releasing mechanism shall affected by the deficient open the door leaf with not more than one practice? releasing operation. This deficient practice could Sliding bolt door latch on affect as many as 10 residents, 4 staff, or 2 visitors main entrance restrooms were within the facility. removed on 01/30/2023. How other residents having the Findings include: potential to be affected by the same deficient practice will be Based on observation during a tour of the facility identified and what corrective with the Maintenance Director on 01/30/23 at 2:21 action(s) will be taken: p.m., the men's and lady's restroom doors nearest Audit completed during to the main entrance to the facility were equipped walk through and no other issues with both a code locked door handle assembly were noted at this time. and a sliding bolt door latch assembly inside the What measure will be put into restroom. Based on interview at the time of place or what systemic changes observation, the Maintenance Director will be made to ensure that the acknowledged the restroom doors as having both deficient practices does not a code locked door handle assembly and a sliding recur: bolt door latch assembly and stated that he would Environmental rounds have have the issue taken care of as soon as he could. been completed by Maintenance During the exit conference with the facility Director and plan has been put Regional Vice President and the Maintenance into place to ensure all facility Director at 3:01 p.m., no additional information or doors meet Life Safety evidence could be provided contrary to this Regulations by only having one deficient finding. locking mechanism present. The Maintenance Director 3.1-19(b)and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. The Director of Maintenance was educated by the **Executive Director on maintaining** that all doors within facility meet Life Safety regulations on

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155287	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE S COMPLE 01/30/2	ETED
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP COL E GRACE ST SELAER, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE PROPRIATE	(X5) COMPLETION DATE
				How the corrective acts will be monitored to ensemble deficient practice will not and/or designee will consobservations in facility who next 6 months to ensure facility is in compliance who safety to ensure only one mechanism present on fadoors. Any concerns idea to be addressed immediate to the monitor of the second of th	sure the ot recur: Director duct eekly for the vith Life e locking acility ntified will ely. se audits monthly ethly for a en of reviews ded, if %. lary 22, at is	
K 0211 SS=E Bldg. 01	in accordance with of egress is continual obstructions to	- General ays, corridors, exit cations, and accesses are n Chapter 7, and the means auously maintained free of full use in case of s modified by 18/19.2.2 1.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2023 155287 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN 47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and staff interview, the K 0211 K 211 Means of Egress- General 02/22/2023 facility failed to maintain the means of egress free What corrective action(s) will be from obstructions in 1 of 6 corridors within the accomplished for those facility. LSC 19.2.3.4(4) states, projections into the residents found to have been required width shall be permitted for wheeled affected by the deficient equipment, provided that all of the following practice? conditions are met: Nightstand present in (a) The wheeled equipment does not reduce the hallway outside of memory care clear unobstructed corridor width to less than 60 unit removed 1/30/2023. in. (1525 mm.) How other residents having the (b) The health care occupancy fire safety plan and potential to be affected by the training program address the relocation of the same deficient practice will be wheeled equipment during a fire or similar identified and what corrective emergency. action(s) will be taken: (c) The wheeled equipment is limited to the Walk through completed 1/30/2023 with no other concerns i. Equipment in use and carts in use noted. ii. Medical emergency equipment not in use What measure will be put into iii. Patient lift and transport equipment place or what systemic changes This deficient practice could affect approximately will be made to ensure that the 16 residents, 4 staff and 2 visitors. deficient practices does not recur: Findings include: Environmental rounds have been completed by maintenance Based on observation during a tour of the facility department and plan has been put with the Maintenance Director on 01/30/23 at 1:59 into place to ensure that all aisles, p.m., there was a wooden 3 drawer nightstand passageways, corridors, exit sitting in the corridor immediately outside the discharges, exit location, and Memory Care unit. This nightstand was not accesses are free from wheeled and was used to provide hand sanitizer obstruction. to visitors and staff. Based on an interview at the The Maintenance Director time of the observation, the Maintenance Director and/or designee will include stated that he would put a wall mounted hand identified areas in the current sanitizer dispenser there and remove the preventative maintenance program nightstand immediately. During the exit and conduct routine rounds conference with the facility Regional Vice according to facility protocol. President and the Maintenance Director at 3:01 The Director of p.m., no additional information or evidence could Maintenance was educated by the be provided contrary to this deficient finding. **Executive Director on maintaining** Life Safety regulations in regards

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/30/2023
	PROVIDER OR SUPPLIE		1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST SELAER, IN 47978	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY 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) COMPLETION DATE
	3.1-19(b)			to aisles, passageways, corric exit discharges, exit location, accesses are free from obstru 2/14/2023.	and
				How the corrective action(s will be monitored to ensure deficient practice will not recondition of the monitored will not recondition of designee will conduct observations in the facility 5x weekly for next 6 months to ensure aisles, passageways, corridors, exit discharges, exit location, and accesses are free from obstruction. Any concernidentified will be addressed immediately. The results of these audition 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 recompliance is below 100%. Compliance date: February 2 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	the cur: ttor t ee as dits ally or a
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System Spinkler System 2012 EXISTING Nursing homes, a				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155287	B. W	NG		01/30	/2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			GRACE ST		
RENSSE	LAER CARE CENT	TER			SELAER, IN 47978		
TILITOOL				TILLITOO	T. T		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	by construction ty						
		approved automatic					
	sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler						
	Systems.	ne installation of Sprinkler					
	*	onstruction, alternative					
		res are permitted to be					
		rinkler protection in specific					
		or local regulations prohibit					
	sprinklers.	. сеса еданалене р. с					
	l .	klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	6 square feet and	sprinkler coverage covers					
	the closet footprin	t as required by NFPA 13,					
	Standard for Insta	llation of Sprinkler					
	Systems.						
		, 19.3.5.3, 19.3.5.4,					
		19.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	K 351 Sprinkler		02/22/2023
		he ceiling construction in 1 of 6			System-Installation		
		ance with NFPA 13, Standard			What corrective action(s) wil	l be	
		of Sprinkler Systems. NFPA 13,			accomplished for those		
		on 6.2.7.1 states plates,			residents found to have been	า	
		er devices used to cover the nd a sprinkler shall be metallic			affected by the deficient		
	_	r use around a sprinkler. This			practice?		
		ould affect as many as 6			 Sprinkler in near mechanical in Core hall had 3, 	/Qth	
	residents, 2 staff an	-			inch gap around ceiling	Our	
	residents, 2 stair an	a i visitoi.			construction, repaired 1/30/23		
	Findings include:				How other residents having		
					potential to be affected by th		
	Based on observation	on during a tour of the facility			same deficient practice will k		
	with the Maintenance Director on 01/30/23 at 1:56				identified and what correctiv		
	p.m., the sprinkler i	in the corridor nearest to the			action(s) will be taken:		
	_	n the "Core" hall had a 3/8ths			· Walk through completed	t	
	inch gap around it t	hat would allow the passage			2/16/2023, with no additional		
		to the attic area. Based on			concerns noted.		
		e of observation, the			What measure will be put int		
	Maintenance Direct	tor acknowledged the gap			place or what systemic chan	ges	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/30/2023	
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
TAG	around the escutche fill in the gap as soo conference with the President and the Mp.m., no additional	en and advised that he would on as possible. During the exit facility Regional Vice faintenance Director at 3:01 information or evidence could by to this deficient finding.	TAG	will be made to ensure that deficient practices does not recur: Environmental rounds been completed by maintenade department and plan has beinto place to ensure all ceiling construction at sprinkler adhabited Safety regulation. The Maintenance Direct and/or designee will include identified areas in the current preventative maintenance proposed according to facility protocol. The Director of Maintenance was educated Executive Director on maintabife Safety regulations related ceiling construction on 2/14/2. How the corrective action(will be monitored to ensure deficient practice will not receive action) will be monitored to ensure deficient practice will conduct observations in the facility with for next 6 months to ensure environment meets Life Safety regulations related to ceiling construction. Any concerns identified will be addressed immediately. The results of these at will be discussed at the mon facility Quality Assurance Committee meeting monthly total of 3 months and then quarterly thereafter once compliance is at 100%.	have ance en put gere to ector to ogram by the anning ed to 2023. (s) e the ecur: ector eekly the etty

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STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING <u>01</u>		COMPLI	ETED	
	155287	B. WING	G		01/30/	2023	
NAME OF PROVIDER OR SUPP. RENSSELAER CARE CE	NTER		1309 E GRACE S RENSSELAER, I				
` ′	RY STATEMENT OF DEFICIENCIE		ID PRO	OVIDER'S PLAN OF CORRECTION		(X5)	
` `	CIENCY MUST BE PRECEDED BY FULL			CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA	TE	COMPLETION	
K 0374 SS=E Subdivision of Barrie Subdivision of Barrier Doors 2012 EXISTIN Doors in smok solid bonded w construction th Nonrated prote are permitted. fixed fire windo are self-closing require latching in the direction provides a min for swinging or 19.3.7.6, 19.3. Based on observ failed to ensure would restrict th 20 minutes. LSC barriers shall co 8.5.4.1 requires the opening leav necessary for pr	Building Spaces - Smoke Building Spaces - Smoke Building Spaces - Smoke Ge barriers are 1-3/4-inch thick rood-core doors or of at resists fire for 20 minutes. Sective plates of unlimited height Doors are permitted to have assemblies per 8.5. Doors or automatic-closing, do not go, and are not required to swing of egress travel. Door opening imum clear width of 32 inches horizontal doors. 7.8, 19.3.7.9 ration and interview, the facility 1 of 7 sets of smoke barrier doors are movement of smoke for at least 19.3.7.8 requires doors in smoke mply with LSC Section 8.5.4. LSC doors in smoke barrier shall close ring only the minimum clearance oper operation. This deficient ffect as many as 30 residents, 5		Frequer will be in compliant Compliant 2023. The Renssel response compliant Correction C	ncy and duration of revolutes as needed, if nce is below 100%. Ince date: February 25 the Administrator at laer Care Center is sible in ensuring nce in this Plan of on. Subdivision of Building-Smoke Barrier Doors or rective action(s) will be be to by the deficient	g s Il be	DATE 02/22/2023	

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Findings include:

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ensure doors close appropriately,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155287	B. W	ING		01/30/2023	3
				STREET	ADDRESS CITY STATE ZIB COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1309 E GRACE ST				
RENGGE	LAER CARE CENT	FR			SELAER, IN 47978		
INLINUUE	LALIN OANE OEM			ILLINOS			
(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	IE	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will be installed upon delivery,	prior	
		on during a tour of the facility			to date certain.		
		ce Director on 01/30/23 at 1:56			How other residents having	I	
		ke barrier doors in the main			potential to be affected by th	I	
		ining area did not close			same deficient practice will l	I	
		a one-half inch gap between			identified and what correctiv	е	
		erview during the time of			action(s) will be taken:	.	
	· ·	laintenance Director			· Walk through completed	1	
	-	e smoke barrier doors did not			1/30/2023, with no additional		
		nd stated that he would adjust			concerns noted.		
		could. During the exit			What measure will be put int		
		e facility Regional Vice			place or what systemic chan	-	
		Iaintenance Director at 3:01			will be made to ensure that t	he	
	*	information or evidence could			deficient practices does not		
	be provided contrar	y to this deficient finding.			recur:		
	2.1.10(1)				Environmental rounds h		
	3.1-19(b)				been completed by maintenan		
					department and plan has beer	i put	
					into place to ensure all smoke		
					barrier doors meet Life Safety		
					regulations.		
					The Maintenance Direct	or	
					and/or designee will include		
					identified areas in the current	aram	
					preventative maintenance pro and conduct routine rounds	gram	
					according to facility protocol. The Director of		
					Maintenance was educated by	, the	
					Executive Director on maintain		
					Life Safety regulations related	-	
					smoke barrier doors on 2/14/2		
					33.0 Samor Good on 2/14/2		
					How the corrective action(s)		
					will be monitored to ensure		
					deficient practice will not red		
					The Maintenance Direct		
					and/or designee will conduct	.=.	
					observations in facility 3x wee	klv	
					for next 6 months to ensure th	· I	
			1		1	-	

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	r of health and hu! R medicare & medic					1 APPROVED NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155287		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 01/30/2023		
	PROVIDER OR SUPPLIEF		1309 E	ADDRESS, CITY, STATE, ZIP COD GRACE ST SELAER, IN 47978	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E '	(X5) COMPLETION DATE
				environment meets regulations related to smoke barrier doors. Any concerns identified will be addressed immediately. The results of these audi will 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 reviewill be increased as needed, if compliance is below 100%. Compliance date: February 22 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	its y r a ews	
K 0511 SS=E Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life. 1, 9.1.1, 9.1.2				
	failed to ensure all	on and interview, the facility electrical panels in the red from non-authorized	K 0511	K 511 Utilities- Gas and Electr What corrective action(s) will accomplished for those		02/22/2023

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

specified in 230.62(B).

personnel. NFPA 70, 2011 edition states 230.62

enclosed as specified in 230.62(A) or guarded as

(A) Enclosed. Energized parts shall be enclosed

so that they will not be exposed to accidental

Energized parts of service equipment shall be

Event ID:

FEHX21

Facility ID: 000185

practice?

residents found to have been

The electrical panel on

East Hall was observed unlocked,

affected by the deficient

and immediately locked on

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02/28/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/30/2023 155287 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1309 E GRACE ST RENSSELAER CARE CENTER RENSSELAER, IN 47978 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE contact or shall be guarded as in 230.62(B). 01/30/2023. (B) Guarded. Energized parts that are not enclosed How other residents having the shall be installed on a switchboard, panelboard, or potential to be affected by the control board and guarded in accordance with same deficient practice will be 110.18 and 110.27. Where energized parts are identified and what corrective guarded as provided in 110.27(A)(1) and (A)(2), a action(s) will be taken: means for locking or sealing doors providing Walk through completed access to energized parts shall be provided. This 1/30/2023, with no additional deficient practice could affect staff in the service concerns noted. What measure will be put into place or what systemic changes Findings include: will be made to ensure that the deficient practices does not Based on observation during a tour of the facility recur: with the Maintenance Director on 01/30/23 at 1:06 Environmental rounds have p.m., the electrical panel on the East Hall between been completed by maintenance resident rooms #016 and resident room #018 was department and plan has been put

unlocked when checked. Based on interview at the time of observation, the Maintenance Director stated that he understood that the electrical panels needed to be locked for safety purposes and added that he would resecure it immediately. During the exit conference with the facility Regional Vice President and the Maintenance Director at 3:01 p.m., no additional information or evidence could be provided contrary to this deficient finding.

3.1-19(b)

into place to ensure all electrical panels in corridors are secured from non-authorized personnel. The Maintenance Director

and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol.

The Director of Maintenance was educated by the Executive Director on importance of ensuring all electrical panels are secured on 02/14/2023.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

The Maintenance Director and/or designee will conduct observations in the facility 5x weekly for next 6 months to ensure all electrical panels are kept secured from non-authorized

	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 01/30/2023	
	PROVIDER OR SUPPLIER		1309 E	ADDRESS, CITY, STATE, ZIP COD E GRACE ST SELAER, 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	
K 0761 SS=F Bldg. 01	interview, the facili inspection and testin assemblies were con LSC 19.1.1.4.1.1. (dividing fire barrier permitted only in compared to by approved self-cle (See also Section 8. required to have a factorial self-cle fire door assemblies and their including all frames and sills in accordant NFPA 80, Standard Opening Protectives.	on, records review, and ty failed to ensure annual ng of 1 of 1 fire door mpleted in accordance with Communicating openings in s required by 19.1.1.4.1 shall be prridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings are protection rating by Table ected by approved, listed, semblies and fire window r accompanying hardware, the closing devices, anchorage, the with the requirements of for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire	K 0761	personnel. Any concerns iden will be addressed immediately. The results of these aud 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, it compliance date: February 2 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction. K 761 Maintenance, Inspective & Testing- Doors What corrective action(s) with accomplished for those residents found to have been affected by the deficient practice? No annual inspection of fire door assemblies were available for review, inspection was completed on 1/31/2023. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All occupants have the potential to be affected.	on 02/22/2023 on 02/22/2023 on fthe help be	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155287	B. WI	NG		01/30	/2023
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			GRACE ST		
DENISSE	LAER CARE CENT	TEP.			SELAER, IN 47978		
NENOSE	LAER CARE CENT	IER		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
	door assemblies sha	all be inspected and tested not			What measure will be put int	o	
	less than annually,	and a written record of the			place or what systemic chan	ges	
	inspection shall be	signed and kept for inspection			will be made to ensure that t	he	
	by the AHJ. NFPA	80, 5.2.3.1 states functional			deficient practices does not		
	testing of fire door	and window assemblies shall			recur:		
	be performed by in-	dividuals with knowledge and			· Environmental rounds h	ave	
	understanding of th	e operating components of			been completed by maintenan	ice	
	the type of door bei	ing subject to testing. NFPA			department and plan has beer	n put	
	80, 5.2.4.1 states fir	re door assemblies shall be			into place to address annual		
	visually inspected f	from both sides to assess the			inspection of Fire door		
	overall condition of	f door assembly.			assemblies.		
					· The Maintenance Direct	tor	
	NFPA 80, 5.2.4.2 s	tates as a minimum, the			and/or designee will include		
	following items sha	all be verified:	identified areas in the current				
	(1) No open holes of	or breaks exist in surfaces of	preventative maintenance program				
	either the door or fr	rame.			and conduct routine rounds		
	(2) Glazing, vision	light frames, and glazing beads			according to facility protocol.		
		rely fastened in place, if so			· The Director of		
	equipped.				Maintenance was educated by	/ the	
	(3) The door, frame	e, hinges, hardware, and			Executive Director on requiren	nent	
	noncombustible thr	reshold are secured, aligned,			for annual inspection of Fire de	oor	
	and in working ord	er with no visible signs of			assemblies on 2/14/2023.		
	damage.				How the corrective action(s))	
	(4) No parts are mis	ssing or broken.			will be monitored to ensure t	the	
	(5) Door clearances	s do not exceed clearances			deficient practice will not red	cur:	
	listed in 4.8.4 and 6	5.3.1.7.			· The Maintenance Direct	tor	
	(6) The self-closing	g device is operational; that is,			and/or designee will conduct		
	the active door com	pletely closes when operated			observations in facility monthly	y for	
	from the fully open	ed position.			next 6 months to ensure the		
	(7) If a coordinator	is installed, the inactive leaf			completion of all required annu	ual	
	closes before the ac	ctive leaf.			inspections are complete and		
	(8) Latching hardw	are operates and secures the			to date, and will be ongoing. A	-	
	door when it is in th	he closed position.			concerns identified will be	-	
	(9) Auxiliary hardw	vare items that interfere or			addressed immediately.		1
	prohibit operation a	are not installed on the door or			· The results of these aud	dits	
	frame.				will be discussed at the month		
	(10) No field modif	fications to the door assembly			facility Quality Assurance	-	
	1 1	ed that void the label.			Committee meeting monthly for	or a	

(11) Gasketing and edge seals, where required, are

inspected to verify their presence and integrity.

total of 3 months and then

quarterly thereafter once

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING		onstruction 01	(X3) DATE SURVEY COMPLETED	
155287		155287	B. WING			01/30/2023	
NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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 This deficient practice could affect all occupants. Findings include: Based on observations made during record review with the facility Maintenance Director on 01/30/23 at 10:19 a.m., no annual inspection of the fire door assemblies were available for review. Based on observation during the tour between 11:45 a.m. and 2:42 p.m., the facility had an oxygen transfilling room with a rated fire door on it. Based on interview at the time of the observation, the Maintenance Director stated he thought a fire door assembly inspection was completed but could not locate any documentation as of the time of this survey. During the exit conference with the facility Regional Vice President and the Maintenance Director at 3:01 p.m., no additional information or evidence could be provided contrary to this deficient finding.					riews f	(X5) COMPLETION DATE
	contrary to this defi	cient finding.					

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