STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155287	A. BUILDING -- B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RENSSELAER CARE CENTER	1309 E GRACE ST RENSSELAER, IN 47978

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/30/23 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Emergency Preparedness survey, Rensselaer Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 157 certified beds. At the time of the survey, the census was 73. Quality Review completed on 02/06/23	E 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 it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/30/23 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840	K 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	

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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	At this Life Safety Code survey, Rensselaer Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 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		nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other 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

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	one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect as many as 10 residents, 4 staff, or 2 visitors within the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/30/23 at 2:21 p.m., the men's and lady's restroom doors nearest to the main entrance to the facility were equipped with both a code locked door handle assembly and a sliding bolt door latch assembly inside the restroom. Based on interview at the time of observation, the Maintenance Director acknowledged the restroom doors as having both a code locked door handle assembly and a sliding bolt door latch assembly and stated that he would have the issue taken care of as soon as he could. 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)		***accomplished for those residents found to have been affected by the deficient practice?*** · Sliding bolt door latch on main entrance restrooms were removed on 01/30/2023. ***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:*** · Audit completed during walk through and no other issues were noted at this time. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by Maintenance Director and plan has been put into place to ensure all facility doors meet Life Safety Regulations by only having one locking mechanism present. · 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 maintaining that all doors within facility meet Life Safety regulations on 2/14/2023.	

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			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 facility weekly for next 6 months to ensure the facility is in compliance with Life Safety to ensure only one locking mechanism present on facility doors. Any concerns identified will be addressed immediately. · 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 22, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 6 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/30/23 at 1:59 p.m., there was a wooden 3 drawer nightstand sitting in the corridor immediately outside the Memory Care unit. This nightstand was not wheeled and was used to provide hand sanitizer to visitors and staff. Based on an interview at the time of the observation, the Maintenance Director stated that he would put a wall mounted hand sanitizer dispenser there and remove the nightstand 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.	K 0211	**K 211 Means of Egress- General** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · Nightstand present in hallway outside of memory care unit removed 1/30/2023. ***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:*** · Walk through completed 1/30/2023 with no other concerns noted. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to ensure that all aisles, passageways, corridors, exit discharges, exit location, and accesses are free from obstruction. · 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 maintaining Life Safety regulations in regards	02/22/2023

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	3.1-19(b)		to aisles, passageways, corridors, exit discharges, exit location, and accesses are free from obstruction 2/14/2023. ***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 aisles, passageways, corridors, exit discharges, exit location, and accesses are free from obstruction. Any concerns identified will be addressed immediately. · 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 22, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required			

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	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect as many as 6 residents, 2 staff and 1 visitor. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/30/23 at 1:56 p.m., the sprinkler in the corridor nearest to the Mechanical room in the "Core" hall had a 3/8ths inch gap around it that would allow the passage of smoke up and into the attic area. Based on interview at the time of observation, the Maintenance Director acknowledged the gap	K 0351	**K 351 Sprinkler System-Installation** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · Sprinkler in near mechanical in Core hall had 3/8th inch gap around ceiling construction, repaired 1/30/23. ***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:*** · Walk through completed 2/16/2023, with no additional concerns noted. ***What measure will be put into place or what systemic changes***	02/22/2023

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	around the escutcheon and advised that he would fill in the gap as soon as possible. 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)		***will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to ensure all ceiling construction at sprinkler adhere to Life Safety regulation. · 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 maintaining Life Safety regulations related to ceiling construction on 2/14/2023. ***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 weekly for next 6 months to ensure the environment meets Life Safety regulations related to ceiling construction. Any concerns identified will be addressed immediately. · 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%.	

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			Frequency and duration of reviews will 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.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 30 residents, 5 staff, and 2 visitors. Findings include:	K 0374	**K 374 Subdivision of Building Spaces-Smoke Barrier Doors** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · Smoke barrier doors in main lobby to main dining room did not close completely, new hinges purchased 2/3/2023 to ensure doors close appropriately,	02/22/2023

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	Based on observation during a tour of the facility with the Maintenance Director on 01/30/23 at 1:56 p.m., the set of smoke barrier doors in the main lobby to the main dining area did not close completely leaving a one-half inch gap between them. Based on interview during the time of observations, the Maintenance Director acknowledged these smoke barrier doors did not close completely and stated that he would adjust them as soon as he could. 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)		will be installed upon delivery, prior to date certain. ***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:*** · Walk through completed 1/30/2023, with no additional concerns noted. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to ensure all smoke barrier doors meet Life Safety regulations. · 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 maintaining Life Safety regulations related to smoke barrier doors on 2/14/2023. ***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 facility 3x weekly for next 6 months to ensure the	

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			environment meets regulations related to smoke barrier doors. Any concerns identified will be addressed immediately. · 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 22, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental	K 0511	**K 511 Utilities- Gas and Electric** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · The electrical panel on East Hall was observed unlocked, and immediately locked on	02/22/2023

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	contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 01/30/23 at 1:06 p.m., the electrical panel on the East Hall between resident rooms #016 and resident room #018 was 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)		01/30/2023. ***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:*** · Walk through completed 1/30/2023, with no additional concerns noted. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put 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	

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			personnel. Any concerns identified will be addressed immediately. · 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 22, 2023. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire	K 0761	**K 761 Maintenance, Inspection & Testing- Doors** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · No annual inspection of the fire door assemblies were available for review, inspection was completed on 1/31/2023. ***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:*** · All occupants have the potential to be affected.	02/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. BUILDING 01 B. WING	01/30/2023

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	door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully opened position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.		***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to address annual inspection of Fire door assemblies. · 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 requirement for annual inspection of Fire door assemblies on 2/14/2023. ***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 facility monthly for next 6 months to ensure the completion of all required annual inspections are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · 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	

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	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. 3.1-19(b)		compliance is at 100%. Frequency and duration of reviews will 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.	