STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. BUILDING 00 B. WING	08/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00384696 and IN00387167. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00384696 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F923. Complaint IN00387167 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F880. Survey dates: August 3 & 4, 2022 Facility number: 000185 Provider number: 155287 AIM number: 100290840 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 9 Medicaid: 50 Other: 12 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/8/22.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure residents who had fallen received timely and thorough assessments for injuries after the falls for 2 of 3 residents reviewed for falls. (Residents B and D). Findings include: 1. Resident B's record was reviewed on 8/4/22 at 12:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 6/13/22, indicated a severely impaired cognitive status, no behaviors were present, required extensive assistance of one for bed mobility and transfers, supervision with ambulation, had no upper or lower extremity impairments, and had no falls. A fall risk assessment, dated 6/13/22, indicated a high risk for falls. A Nurse's Progress Note, dated 6/25/22 at 5:12 a.m., indicated the resident had been assisted to the toilet. The CNA turned to obtain the washcloths off the counter, the resident "jumped up" from the toilet and "ran" out of the bathroom. She had been incontinent of urine on the floor while she ambulated and slipped in the urine. The resident was observed on the floor, lying on her right side by the the CNA. The resident was	F 0689	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. **F 689**- Free of Accident Hazards/Supervision/Devices ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Resident B has had no	08/26/2022

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	assessed, she denied pain and was then assisted to the bed. The Physician, Director of Nursing (DON) and the Responsible Party was notified. There was no assessment of the range of motion of the extremities or that the extremities or head had been assessed for injuries or deformities. The Neurological (neuro) Check List, dated 6/25/22, indicated the initial neuro check was completed at 4:45 a.m. and the lower leg strength was equal and strong. The checks at 5:15 a.m., 5:30 a.m., 6 a.m., 6:30 a.m., 7 a.m., 7:30 a.m., 9:30 a.m., and 11:30 a.m., indicated the bilateral leg strength was equal and strong. A Change of Condition Form, dated 6/25/22 at 11:30 a.m., indicated the resident had abdominal pain, edema, falls, and uncontrolled pain which started 6/25/22 in the morning. The resident had pain and swelling of the left leg, occasionally moaned or groaned, had facial grimacing which was worse with movement, all resulted due to a fall. The left leg had swelling and outward rotation with uneven leg lengths. There was pain when the leg was moved. The Physician had been notified at 11:45 a.m. and an order was obtained for the resident to be transferred to the hospital. A Nurse's Note, dated 6/25/22 at 11:30 a.m., indicated the resident had slept all morning related to being awake all night. While a CNA had been providing care, the resident had complained of pain to the left leg. An assessment of the left leg was completed. The resident was keeping the left leg in a slightly bent position the knee and thigh area was swollen. The left leg had a slight outward rotation and an uneven appearance with the right leg. The Physician was notified and received an order to transfer to the Emergency room.		further incidents. 2. Resident D has had no further incidents. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Audit to be completed on all active falls to ensure completion of resident assessment and neurological assessments. This audit will also include noting edema of lower extremities as well as any abnormalities in ROM. Any issues identified were/will be addressed. 2. All falls moving forward will be reviewed the next business day to ensure completion of resident assessment and neurological assessments if indicated. Any issues identified will be addressed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be completed by nursing management to licensed nursing staff to ensure proper fall management process is followed including complete assessment of resident, MD and Responsible party notification. New licensed nursing associates will receive this education prior to working. 2. Education will be completed by nursing	

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	Transportation to the hospital arrived around 12:20 p.m., an assessment was completed and a temporary splint was placed on the left leg. The Hospital Emergency Room H&P, dated 6/25/22, indicated a possible left hip or knee injury. The patient fell at some point overnight or early morning. She went beck to bed and when she woke up, they noticed shortening of the left leg and pain. The left hip was tender and the left knee had swelling present. There was decreased range of motion in the left leg due to pain. The X-ray of the left femur indicated a large amount of soft tissue swelling around the fracture site. The diagnosis was closed fracture of the left distal femur. The resident was transferred to another hospital for a surgical repair of the left femur fracture. The X-ray Report, dated 6/25/22, indicated a comminuted fracture at the surgical site of the left knee insertion into the femoral prosthesis and a large amount of left knee swelling. The facility investigation of the fall indicated: - On 6/25/22, Nurse 2's written and signed statement indicated the resident was assisted to the toilet and sat down. CNA 3 turned around and obtained some washcloths off the bathroom counter. The resident then "jumped" off the toilet and "ran" into the room (bedroom). As she ambulated, she was incontinent of urine and slipped and fell at the foot of the bed. CNA 3 found the her on the floor, lying on the right side. The resident was assessed and placed back into bed. - On 6/25/22, CNA 3's written and signed statement indicated, about 4:45 a.m. the resident was assisted to the toilet with the assistance of		management to licensed and certified nursing staff to assure any skin issue or abnormal finding needs reported and documented in the clinical record. MD and Responsible party need notified and care plan and Kardex to be updated to reflect new orders and/or include any new. New licensed or certified nursing employees will receive this education prior to working. ***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:*** 1. DON/Designee will review incident reports 5 times weekly to ensure complete assessment, notification, and proper fall management process x 6 months. Audits will be presented to QAPI x 6 months and QAPI will determine need for further audits. Competencies and education will be completed by date of compliance by Nursing Management. 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: 8/26/22. The	

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	Nurse 2. Nurse 2 then left the room. CNA 3 had her back to the resident and was getting the washcloths on the sink to assist with morning care, and the resident. "got up". She had urinated on the floor and slipped and fell. - On 6/26/22, CNA 4's written and signed statement indicated, she had been informed of the fall during report from the night shift CNA. It was reported the staff required extra help afterwards to assist the resident from the floor to the bed. After report, Resident B was observed asleep in bed. Resident B was "periodically"observed during the morning. At 10:45 a.m., the resident started to awaken, she sat up and was encouraged to stand up and follow the CNA to the bathroom. The resident had said, "no, my leg". She again tried to stand and was unable to due to pain in the leg. Care was provided in bed and it was reported the resident could not stand, was complaining of pain, and the area above the knee appeared swollen. - On 6/26/22, Nurse 5's written and signed statement indicated the resident had been sleeping at 6 a.m. The night shift had reported the resident had fallen during the night. "...we left (sic) her sleep d/t [due to] her rough night..." She was checked on multiple times during the morning. The vital signs were checked and she continued to sleep. She appeared comfortable. When the CNA had attempted to provide care, the resident was unable to stand. The CNA had noticed a swollen area above the left knee. The resident was assessed at 11:30 a.m. and the left leg was swollen and the bilateral legs length were uneven. The Physician was notified and an order received for transfer to the Emergency Room. Nurse 2 was interviewed on 8/4/22 at 1:36 p.m. She indicated the resident had been awake and		Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	roaming most of the night. She and CNA 3 had assisted the resident into the bathroom. The resident sat on the toilet and then Nurse 2 had left the room. The resident was assessed after the fall, while still on the floor. There had been no deformities of the leg. Nurse 6 had come to the Unit and assisted Nurse 2 with assisting the resident off the floor. Nurse 2 indicated the resident could not stand and she felt this was due to the cognitive status and she was unable to understand what they were asking her to do. They assisted her back to bed and she then fell asleep. She was assessed per protocol and there were no concerns. There was no grimacing and she was irritated with staff when she was awakened for the post fall assessments. The Physician gave orders to monitor her since there had been no injuries. During an interview on 8/4/22 at 1:51 p.m., CNA 4 indicated the resident was on her assignment on day shift. She had received information in report the resident had been awake all night, and had fallen after she transferred herself off the toilet due to urine on the floor. The resident was sound asleep during the morning and due to being up all night, she had let her sleep. When she awoke, she attempted care on the resident. She attempted to help her stand and the resident was unable to bear weight and had symptoms of pain. Nurse 5 was notified and assessed her. The resident had been sleeping and had no signs or symptoms of pain. During an interview on 8/4/22 at 2:33 p.m., Nurse 5 indicated she had been informed the resident had fallen during the night and had been awake all night. She was sleeping so was not woken up. She exhibited no signs or symptoms of pain. When she checked on her, she had not raised the sheet up and had not looked at the leg.. CNA 4 had attempted to assist her out of bed and the resident			

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	complained of pain, the Physician was notified and she was transferred to the hospital. The Neurological Check List, dated 6/25/22, indicated the leg strength had been assessed. During an interview on 8/4/22 at 2:49 p.m., the Director of Nursing indicated the Nurses had not assessed the leg and range of motion and have been re-educated on assessments. During an interview on 8/4/22 at 3:48 p.m., Nurse 6 indicated Nurse 5 requested her assistance to help get the resident off the floor. When she got to the room, the resident was saying, "get me off the floor". There were no facial grimaces and no other signs or symptoms of pain. She had not been crying nor screaming. They place a sheet underneath of her and lofted her off the floor. They had not attempted to stand her. There was no swelling of the leg or knee observed. After they had placed her in bed, she left the area and went back to her other assigned unit. 2. Resident D's record was reviewed on 8/4/22 at 4:07 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Care Plan, dated 8/31/21, indicated a risk for falls. The interventions included neuro-checks as necessary per facility guidelines and observe for 72 hours for signs and symptoms of pain and change in mental status. A Quarterly Minimum Data Set assessment, dated 6/3/22, indicated poor long and short term memory problems, no behaviors, required limited assistance with ambulation, and had no falls. A Nurse's Progress Note, dated 7/18/22 at 6:51			

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	a.m., indicated the resident had been found on the floor by the door, lying on her left side. She was assessed for injury, toileted and assisted to bed. Neuro checks were started per facility policy. The resident denied pain and no injury was found. The next Nurse's Progress Note was dated 7/18/22 at 5:48 p.m. and indicated there were no injuries observed from the fall. Neuro checks were within normal limits. The Fall Assessment/Neuro Check, initiated on 7/18/22 at 4:45 a.m., indicated no documented neuro checks had been completed on 7/18/22 at 4:45 a.m., 5 a.m., 5:15 a.m., and 5:30 a.m.. There had been no further neuro checks completed after 7/19/22 at 3:30 p.m. During an interview on 8/4/22 at 5:03 p.m., the Director of Nursing indicated the neuro assessments were to be completed as scheduled in the Electronic Record (as above). The facility's Procedure for Fall Management, dated 4/7/22 and received from the Director of Nursing as current, indicated the resident was to be fully evaluated before moving them after a fall. The assessment was to determine the extent of the resident's injuries, which included deformities. Document any deviations from the resident's baseline condition and notify the Physician. The resident's limb strength and motion was to be assessed. Even if the resident had no signs of distress, assessments were to be increased for 72 hours after the fall and neurological status was to be assessed. The resident was to be assessed for pain. This Federal tag relates to Complaint IN00387167.			

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	3.1-45(b)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and or contain COVID-19, related to lack of handwashing after resident care and not sanitizing multiple resident use equipment	F 0880	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	08/26/2022

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	after use for a random observation for infection control. (Resident G) Finding includes: Nurse 1 was observed on 8/4/22 at 7:02 a.m. She prepared Resident G's morning medication and entered the resident's room. She checked the resident's blood pressure and administered the medication, then exited the room with the blood pressure equipment and without performing hand hygiene. Nurse 1 then went to the Medication Cart and signed the medications out on the MAR and started to prepare Resident H's medication and was stopped. She then completed hand hygiene. The blood pressure equipment had not been sanitized upon the exiting the resident's room. The Infection Control Preventionist sanitized the blood pressure equipment after being informed the sanitization had not occurred at 8/4/22 at 8:30 a.m. She acknowledged the equipment was to be sanitized after each use. A Hand Hygiene policy, dated 11/10/20, and received from the Director of Nursing (DON) as current indicated, hand hygiene was to be completed before and after all resident contact. A policy, titled, "Cleaning and Disinfecting of Non-Critical Patient Care Equipment", dated 6/3/21, and received from the DON as current, indicated the equipment was to be sanitized before and after use with a EPA-registered hospital disinfectant. This Federal tag relates to Complaints IN00384696		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. **F 880**- Infection Prevention/Control ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. No residents were affected by alleged deficient practice. 2. Nurse #1 was immediately educated on hand hygiene and cleaning and disinfection of non-critical patient care equipment. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. Clinical nursing is to make observational rounds ongoing to assure compliance with	

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	and IN00387167. 3.1-18(b) 3.1-18(l) .		hand hygiene as well as cleaning and disinfecting of non-critical patient care equipment. No other issues have been noted at this time. Any issues identified will be addressed immediately. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Education will be provided by Nursing Management to licensed nursing staff and medication aide's r/t the appropriate hand hygiene with medication administration and the use of multi-use equipment by date of compliance. 2. Competency checks will be completed by date of compliance for hand hygiene and cleaning/disinfecting of non-critical patient care equipment. Education will be provided during orientation for new hires. ***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:*** 1. Clinical managers will observe hand hygiene and disinfection of non-critical patient care equipment 3 times weekly x 3 months, then 2 times weekly x 3 months rotating shifts to assure compliance. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months	

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			then QAPI will determine the need for further audits. 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: 8/26/22. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
F 0923 SS=E Bldg. 00	483.90(i)(2) Ventilation §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Based on observation, record review, and interview, the facility failed to ensure residents had adequate ventilation as needed and/or preferred through an outside window, related to screens removed from the outside windows and windows could not be opened for fresh air as needed/preferred. This had the potential to affect 27 residents who requested screens be available on the windows for ventilation. Finding includes: The outside resident room windows on the front of the West Unit (400 hall) were observed without screens on the windows on 8/3/22 at 5 p.m.	F 0923	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	08/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. BUILDING 00 B. WING	08/04/2022

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	During an interview on 8/3/22 at 5:12 p.m., Resident E indicated the windows could not be opened in the room because there were no screens on the windows. The facility had taken all the screens off the windows last year and never told them why they were removed. Residents were told they could not open the windows. He indicated he would like to be able to open the window. During an interview on 8/3/22 at 6:25 p.m., Resident F indicated the windows in the room could not be opened due to the screens were all removed. She would like to be able to open the window to get fresh air in the room. During an interview with the Maintenance Supervisor on 8/4/22 at 8:47 a.m., he indicated all the screens were all removed per orders of a past Administrator. He was not sure of the reason the screens were removed. During an interview on 8/4/22 at 10 a.m., the AIT (Administrator in Training) indicated she was unaware the screens were removed. The residents would be interviewed and screens would be replaced for those who would like to open the windows. A list of residents who requested screens be replaced on the outside windows was received from the AIT on 8/4/22 at 11:41 p.m. There were 27 resident who would like the screens replaced so they could open their windows. This Federal tag relates to Complaint IN00384696. 3.1-19(f)(2)		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 923**- Ventilation ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Screens placed on the windows of the 27 residents that requested them. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. In house audit completed on resident preference for opening window in their room. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. Facility administration, which includes ED and Maintenance Director, will be educated on the federal regulation in regards to adequate outside ventilation prior to date of compliance. 2. Maintenance Director to complete a facility wide audit to ensure all windows are functioning properly prior to date of	

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			compliance. ***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:*** 1. Facility administration to complete observations to ensure residents are able to open windows for fresh air as per their preference at a minimum of 5x/week for 2 months, then 3x/week for 2 months, then 1x/week for 2 months. 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: 8/26/22. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	