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	05/06/2024

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00432012 and IN00432816. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00432012 - No deficiencies related to the allegations are cited. Complaint IN00432816 - Federal/State deficiencies related to the allegations are cited at F689 and F805. Survey dates: May 2, 3, 4, and 6, 2024 Facility number: 000185 Provider number: 155287 AIM number: 100290840 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 5 Medicaid: 62 Other: 8 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/10/24.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Rensselaer Care Center agrees with the allegations and citations listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is 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 0689 SS=J 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
Brandi Costello	Executive Director	05/24/2024

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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	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 adequate supervision was provided to prevent a cognitively-impaired resident on the Memory Care Unit with a history of food stuffing from ingesting and aspirating a large amount of unchewed food, for 1 of 3 residents reviewed for dining room supervision. This deficient practice resulted in the death of Resident B. The immediate jeopardy began on 4/16/24 when a cognitively impaired resident on the memory care unit with a history of stuffing food into her mouth and swallowing without chewing, was found unresponsive with sausage in her mouth and airway after the dinner meal. The resident had a care plan to be supervised during meals. The staff working did not supervise the resident and failed to ensure the entire dining room was within view of staff during the meal to ensure the resident did not stuff food into her mouth from other residents' plates that were left on the tables. The resident was found unresponsive after the evening meal with a large amount of unchewed sausage in her mouth and airway. The Heimlich Remover and CPR (Cardio Pulmonary Resuscitation) were completed, resulting in more sausage being found in the resident's mouth. The resident was unable to be revived, even after EMS (Emergency Medical Services) arrived and took over care, and was pronounced deceased by EMS. The cause of death provided by the Coroner was aspiration of	F 0689	**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 expired 4.16.24. *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.All residents with a mechanically altered diet have the potential to be affected. 2.Audit completed on all current residents' diets for physician's diet order, diet care plans to match, and dietary tray cards to match. 3.All resident care plans and CNA care guides were reviewed for matching level of meal assistance. 4.The past 30 days of grievances, risk management, and progress notes were reviewed for purposes of assessing other events of potential choking and/or changes in resident eating conditions, to ensure appropriate steps were taken. *What measures and what systemic changes will be made to*	05/29/2024

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	food. The Executive Director (ED) was notified of the immediate jeopardy at 11:02 a.m. on 5/3/24. The immediate jeopardy was removed on 5/4/24, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding includes: An Indiana Department of Health (IDOH), Incident Report, dated 4/16/24, indicated at 6:25 p.m., Resident B was observed lying on her bed by Agency CNA 1. The CNA notified Agency LPN 2 and Agency LPN 2 assessed the resident. The resident was unresponsive, and the Agency LPN 2 observed food in the resident's mouth. Agency LPN 2 completed a finger sweep of the resident's mouth and removed visible food. CPR was then initiated, and EMS was notified. EMS arrived at the facility at 6:40 p.m. and took over the care. The resident was pronounced deceased at 7:08 p.m. by the EMS and the Coroner was notified and arrived at the facility at 7:15 p.m. The report did not include sufficient documentation to determine who initiated CPR, who notified EMS, and who or when the Coroner was notified. The facility follow-up investigation on the IDOH Incident Report, dated 4/23/24, indicated the following interviews were completed by the facility: Agency CNA 1 indicated she was in the Dining Room serving food and Resident B was wandering in and out of the Dining Room during the evening meal. At approximately 6:25 p.m., she began rounds to check on the residents and found Resident B lying in bed. She called the resident's name three times and completed a		*ensure that the deficient practice doesn't recur:* 1.All clinical staff to be educated by date of compliance on the following items. Staff that weren't onsite will be educated prior to their next shift worked: 1.Proper set up and assistance with meal trays including removing tray and placing on food cart when resident finishes eating/no longer doing family dining but trays coming from kitchen for meals/residents on Dementia unit were audited for food related behaviors and will be seated at same table for direct observation 2.Proper positioning of residents at mealtime/proper positioning of staff to observe residents and have in line of sight/staff to be facing doorways of dining room through meals in the Dementia unit 3.Proper consistency of diets and liquids 4.Supervision of cognitively impaired residents during mealtimes/seating chart redone with position of staff and residents during meal times/entry doors to be closed during meal times as tolerated to encourage residents to stay in dining room and complete meal as well as deter residents from going in and out of dining room during meal times, 5.Checking resident tray cards when setting up resident	

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	sternal rub and there was no response and reported this to the Nurse immediately. Agency LPN 3 indicated she had been giving report to Agency LPN 2, when Agency CNA 1 reported the resident was unresponsive. She went with Agency LPN 2 and immediately assessed the resident. Agency LPN 2 completed a finger sweep of the resident's mouth and initiated CPR. Agency LPN 3 assisted with suctioning and more food was removed from the resident's mouth. When EMS arrived they took over. Agency LPN 2 indicated Agency CNA 1 came to the desk while she was receiving report from Agency LPN 3 and informed them the resident was unresponsive. Both Nurses responded immediately. She had assessed the resident and observed polish sausage in the resident's mouth. She completed a finger sweep and removed all visible food. She had attempted to do a thrust on the resident's chest and was able to visibly see more sausage, which she removed from the resident's mouth. CPR was initiated beginning with chest compressions. EMS took over the care when they arrived and pronounced the expiration of the resident at 7:08 p.m. CNA 4 indicated Resident B received her evening meal between 5:20 and 5:30 p.m. Resident B only ate some of her mashed potatoes, then left the dining room. Resident B then walked back into the Dining Room and he observed her trying to take food off of other residents' plates who had finished and had left food on their plate. He attempted to redirect Resident B and asked her to sit down and finish her meal. Resident B walked out of the dining room at approximately 5:45 p.m. and that was the last time he saw her. He then cleaned all the tables and took the dishes to the		meal tray to ensure matching 6.Following MD diet orders 2.All dietary staff to be educated by date of compliance on the following. Staff that weren't onsite will be educated prior to their next shift worked: 1.Preparing diet consistencies per policy. 2.Preparing correct diet per the resident tray card 3.Sending tray card with each tray 3.All new licensed or certified nursing and dietary 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.Nursing management/Designee will observe 3 meals weekly on Dementia unit to ensure staff and residents are properly positioned and meals match tray cards x 6 months to ensure compliance. A Department Head or Designee will be assigned to oversee the dining room on the Dementia unit for at least 1 meal daily ongoing to ensure compliance. 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. Frequency	

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	kitchen. Activity Aide 5 indicated she had been feeding another resident in the Dining Room and saw Resident B only for a split second and then the resident left the Dining room. During staff interviews on 5/2/24 at 9:36 a.m., CNA 6, LPN 7, and CNA 8 were at the Nurses' Station. CNA 6 indicated the resident ambulated independently. CNA 6 and LPN 7 indicated Resident B would take anyone's food if no one was watching and "cram" the food in her mouth. LPN 7 indicated the resident was "quiet and sneaky with food". CNA 6 indicated if they saw her taking food, they were to re-direct her back to her own food. Staff would stay with her and cue her to slow down and swallow before taking the next bite. She typically would put the food directly into her mouth and did not carry the food with her. CNA 6 indicated at the time of the incident, the food was served "homestyle", so the food was brought down on an open cart and they served the food. CNA 8 indicated the plates could not be removed from the table until after everyone was done eating. Resident B's record was reviewed on 5/2/24 at 10:45 a.m. The diagnoses included, but were not limited to, dementia and psychotic disorder with delusions. The Nurses' Progress Notes indicated: On 1/14/24 at 9:54 a.m., Resident B would fill her mouth with all the food items given to her without chewing the food. She would not accept redirection and continued to rapidly fill her mouth with as much food as it would hold. She then drank fluids to wash the food down.		and duration of reviews will be increased as needed. Compliance date: 5/29/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	On 1/14/24 at 4 p.m., Resident B continued to put all food items in her mouth at the same time and continued to wash the food down with fluids without chewing. Foods were given one item at a time for resident safety. On 1/18/24 at 4:26 a.m., Resident B ate another resident's food and drank their water. She was redirected and responded aggressively to the staff. On 1/18/24 at 5:30 p.m., Resident B continued to shove food into her mouth in large quantities without chewing then attempted to wash the food down with a drink. She was unable to be redirected. Items were given one at a time with same results. On 1/19/24 at 7:48, Resident B was taking food from other trays. Staff attempted to redirect and were unsuccessful. On 1/23/24 at 8 a.m. Resident B was pacing in the Dining Room and taking food off of other resident's plates. Staff attempted to redirect. She would then take food off of the food cart. After multiple attempts to redirect she sat down and ate her own meal. The Physician and Family were notified. On 2/2/24 at 2:43 p.m., Resident B was observed taking food from other residents' plates. On 2/6/24 at 2:24 p.m., Resident B consumed her food rapidly by placing large amounts of food in her mouth at one time. She had attempted to take food off of other residents' plates. A Quarterly Minimum Data Set (MDS)			

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	assessment, dated 2/9/24, indicated Resident B had a severely impaired cognitive status, had physical, verbal, and other types of behaviors 1-3 days per week. She had no impairment of the upper and lower extremities. She required supervision while eating, was independent with bed mobility and transfers, and required supervision with ambulation. She was not on a special diet, received an antipsychotic medication and an anti-anxiety medication. A Care Plan for repetitive requests during mealtime, dated 2/13/24, indicated Resident B put excess amounts of food in her mouth and did not take the time to chew or swallow safely. The plan interventions included, but were not limited to, limiting meals to two helpings, offer food/drink and redirect as needed, offer one food item at a time, and provide supervision. There were no interventions for the behavior added to the care plan after 2/9/24. The comprehensive plan of care did not include documentation to indicate Resident B took food from the plates of other residents. A Nurse's Progress Note, dated 2/23/24 at 5:24 p.m., indicated Resident B continued to place large amounts of food in her mouth and drank fluids to swallow. A Physician's Order, dated 2/28/24, indicated the resident wanted cardiopulmonary resuscitation (CPR) completed if needed, and an order, dated 3/1/24, indicated the resident was to have a regular diet with ground meat. The Nurses' Progress Notes, indicated: On 3/22/24 at 4:18 p.m., Resident B attempted to			

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	take other resident's food during the meal. She placed a large amount of food in her mouth and swallowed without chewing. On 4/16/24 at 7 p.m., writer (Agency LPN 2) was receiving report from the off-going Nurse (Agency LPN 3) at 6:25 p.m. when CNA (Agency CNA 1) called writer to the resident's room. Resident B had hot dog bites in her throat and she was absent of vital signs (temperature, pulse, respirations, blood pressure) and pale in color. The off-going Nurse was instructed to call EMS and the crash cart was obtained. Polish sausage was "scooped" out of the resident's mouth and the Heimlich Maneuver was initiated while the resident laid in bed and the resident's head was turned to the side. More Polish sausage pieces came out at that time. Writer continued to pull more Polish sausage from the resident's mouth. EMS arrived and relieved the Nurse (Agency LPN 2). During an observation on 5/2/24 at 11:37 a.m., there were 17 residents, 2 CNAs, 1 LPN and 1 Activity Aide in the Memory Care Dining Room to assist the residents with the noon meal. During an interview on 5/2/24 at 2:11 p.m., CNA 4 indicated, when the incident occurred, there were two CNAs (CNA 4 and Agency CNA 1) and an Activity Aide/CNA (Activity Aide 5) in the Dining Room. The meals were brought back in metal containers and the CNAs had to serve the food to the residents. CNA 4 started serving the meal about 5:15 p.m. - 5:20 p.m. Resident B's food was first to be served because she was trying to grab the food out of the containers. The Dietary Staff never sent down the dietary cards or the ground meat. CNA 4 asked the nurse (Agency LPN 3) to call the kitchen, but he was not sure if			

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	she did. When this had happened before, they were told to cut the meat up into little pieces. The Polish sausage was served to Resident B, the sausage was cut into dime size pieces. Resident B sat down and only ate her mashed potatoes. She did not eat the sausage. She kept getting up. CNA 4 indicated he was unable to re-direct her. He had been attempting to serve the other residents in the Dining Room. Resident B walked out of the dining room, she had only eaten her potatoes. She had not eaten her sausage or vegetable. Every resident received sausage that evening except one. Resident B was wandering in and out of the Dining Room and the staff could not get her to sit down. CNA 4 indicated he never saw her grab any food, though he was sitting with his back to the entry doors into the Dining Room. He indicated when she walked out of the Dining Room, there was nothing in her hands and she always would puff her cheeks out, so he could not tell if she was holding food in her mouth. Resident B had not been chewing. When all the residents were through eating, the plates were picked up and scraped into the garbage can. He then took the items to the kitchen, and clocked out on break around 6:04 p.m. He indicated the resident would hoard food in her room and she never ate any of her own sausage. During an interview on 5/2/24 at 2:30 p.m., Agency CNA 1 indicated the residents were being served supper in the Dining room. She indicated CNA 4 had cut the resident's sausage into small bites. The staff were trying to get Resident B to stay in the Dining Room to eat. Activity Aide 5 was passing drinks out to everyone. Agency CNA 1 then indicated she had sat down to assist two residents with their meals. From where she was sitting, she did not have a clear view of both entry doors. She observed Resident B come in and out			

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	of the Dining Room twice. She never saw the resident take food off of another tray. The last time she saw Resident B in the Dining room was about 5:45 p.m. She never saw Resident B with Polish sausage in her mouth and she never ate her own serving of the sausage. During an interview on 5/2/24 at 2:52 p.m., Activity Aide 5 indicated she assisted with passing out the meals and then sat down to feed a resident. She saw Resident B just standing there and then she was gone. She did not have full view of the entry doors. During an interview on 5/3/24 at 8:10 a.m., Agency LPN 2 indicated she was receiving report from Agency LPN 3 when the CNA notified her of Resident B's status. She immediately went to the resident's room. The resident was lying on her back and she saw Polish sausage chunks unchewed on the outside of the resident's mouth. The chunks looked like they would be as if the sausage was cut in sections, though she was unable to approximate the size. The resident was unresponsive. She gave instructions for the CNA to get the crash cart and to call EMS. She performed a finger sweep of the resident's mouth and proceeded to initiate the Heimlich Maneuver and more sausage chunks came out of the mouth. She had not seen any more, so she began CPR and another large amount of sausage came out of her mouth. CPR was stopped and she again completed the Heimlich Maneuver and another finger sweep and had not seen any more food in the mouth or throat and started CPR again. EMS arrived and took over the resident's care. She indicated the meals were always done when she came in to work. She was aware the resident would hold food in her mouth and would try to take fluids and food off of the medication cart.			

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	During an interview on 5/3/24 at 9:40 a.m. Agency LPN 3 indicated, during the evening meal, she was passing medications in the Dining room. It was hard to get the residents to sit down. There were 2 CNAs and an Activity Aide. The residents were served their meal and the residents who needed help were being assisted by the CNAs and Activity Aide. She then went back to the Nurses' Desk and indicated she could see the Dining Room from the desk. She stated she could see the residents but not the tables when she looked through the window to the Dining Room from the desk. She had not seen Resident B go in and out of the Dining Room, though that didn't mean the resident wasn't in there, as this was her third time at the facility, and she was trying to get to know the residents. She indicated the staff had reported the resident ate fast and wandered in and out of the room. Agency LPN 3 indicated, on 4/15/24, she administered Resident B's medications between 9 and 10 a.m. and she still had eggs in her mouth from breakfast that was served around 8 a.m. Agency LPN 3 indicated she asked the staff then about the resident and was told she would hold food in her mouth all the time. During an interview on 5/3/24 at 10:00 a.m., the Dietary Manager (DM) indicated the meals were served "homestyle". The meal was sent to the memory care unit in covered metal pans for nursing staff to serve on plates, and dietary staff were expected to send properly prepared food and each resident's meal ticket with specialized instructions with the meal. The DM indicated nursing staff were expected to follow the specialized dietary instructions on the meal tickets; however, the dietary staff forgot to send the ground meat and the meal tickets to the unit on 4/16/24. The DM indicated the Cook on duty			

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	4/16/24, reported the nursing staff had not alerted the dietary staff that the ground meat and the meal tickets with specialized instructions were not received. The DM indicated cutting the sausage into small bites was not equivalent to the specialized texture of ground meat. During an interview on 5/3/24 at 10:15 a.m., the Director of Nursing (DON) indicated there was no care plan that indicated Resident B took food off of the other resident's plates. She indicated there were always staff in the Dining Room to supervise the residents. During an interview with the County Coroner on 5/3/24 at 11:41 a.m., he indicated the cause of death was due to aspiration of food, dementia, hypertension, and diabetes mellitus. During an interview on 5/6/24 at 1:41 p.m., the DON indicated there was no protocol or policy for a certain staff member to monitor Resident B. All of the staff in the Dining Room were to monitor and supervise the residents. The protocol of not picking up the finished plates had been the procedure for a long time and the Memory Care Unit started "homestyle" dining in early March of 2024. She educated the staff when this started and she reminded them to not pick up the plates until everyone was finished eating so that the meal time would be more homelike. The DON acknowledged there had not been new interventions added for the behaviors of the resident stuffing her mouth with food and that there was no care plan for the resident taking food off other residents' plates. A facility policy for meal service, dated 8/24/23 and received from the DON as current, indicated the resident was to be positioned appropriately for meals. The residents were to be monitored in			

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	case additional assistance was needed. The tray was to be removed when the resident was finished eating. The immediate jeopardy that began on 4/16/24 was removed 5/4/24 when the facility assessed all residents for the need of additional supervision and if at-risk interventions were implemented. Residents in need of additional supervision were reviewed for appropriate care and interventions, and care plans updated. Nursing staff were inserviced regarding supervision and safety during meals. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This citation relates to Complaint IN00432816. 3.1-45(a)			
F 0805 SS=K Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to ensure ground meat was provided in accordance with the physician orders and failed to ensure specialized dietary instructions were provided to nursing staff for 6 of 6 residents on a memory care unit reviewed for a mechanically altered with ground meat diet. (Residents B, G, H, J, K, and L) This deficient practice resulted in a cognitively impaired resident with a history of food stuffing, ingesting the	F 0805	**F 805**- Food in Form to Meet Individual Needs *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1.Resident B expired 4.16.24. 2.Resident G: no negative outcomes 3.Resident H: no negative	05/29/2024

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	regular meat, the resident's airway becoming blocked, and the resident expired. (Resident B). The immediate jeopardy began on 4/16/24 when a cognitively impaired resident on the memory care unit with a history of stuffing food into her mouth and swallowing without chewing, was found unresponsive with sausage in her mouth and airway after the evening meal. The resident had an order for a diet with ground meat for meals. There were no dietary cards nor ground meat provided for the evening meal on 4/16/24. The staff working provided the resident with polish sausage cut into pieces. The resident was found unresponsive after the evening meal with a large amount of unchewed sausage in her mouth and airway. The Heimlich Remover and CPR (Cardiopulmonary resuscitation) were completed resulting in more sausage being found in the resident's mouth. The resident was unable to be revived, even after EMS (Emergency Medical Services) arrived and took over care, and was pronounced deceased by EMS. The cause of death provided by the Coroner was aspiration of food. The Executive Director (ED) was notified of the immediate jeopardy at 11:02 a.m. on 5/3/24. The immediate jeopardy was removed on 5/4/24, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding include: 1. An Indiana Department of Health (IDOH) Incident Report, dated 4/16/24, indicated at 6:25 p.m., Resident B was observed lying on her bed by Agency CNA 1. The CNA notified Agency LPN 2 and Agency LPN 2 assessed the resident. The resident was unresponsive, and the Agency LPN 2 observed food in the resident's mouth.		outcomes 4.Resident J: no negative outcomes 5.Resident K: no negative outcomes 6.Resident L: no negative outcomes *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.All residents with a mechanically altered diet have the potential to be affected. 2.Audit completed on all current residents' diets for physician's diet order, diet care plans to match, and dietary tray cards to match. 3.All resident care plans and CNA care guides were reviewed for matching level of meal assistance. 4.The past 30 days of grievances, risk management, and progress notes were reviewed for purposes of assessing other events of potential choking and/or changes in resident eating conditions, to ensure appropriate steps were taken. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.All clinical staff to be educated by date of compliance on the following items. Staff that weren't onsite will be educated prior to their next shift worked: 1.Proper consistency of	

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	Agency LPN 2 completed a finger sweep of the resident's mouth and removed visible food. CPR was then initiated, and EMS was notified. EMS arrived at the facility at 6:40 p.m. and took over the care. The resident was pronounced deceased at 7:08 p.m. by the EMS and the Coroner was notified and arrived at the facility at 7:15 p.m. The report did not include sufficient documentation to determine who initiated CPR, who notified EMS, and who or when the Coroner was notified. Resident B's record was reviewed on 5/2/24 at 10:45 a.m. The diagnoses included, but were not limited to, dementia and psychotic disorder with delusions. A quarterly Minimum Data Set (MDS) assessment, dated 2/9/24, indicated Resident B had severely impaired cognitive status, had physical, verbal, and other types of behaviors 1-3 days per week. She had no impairment of the upper and lower extremities. She required supervision while eating, was independent with bed mobility and transfers, and required supervision with ambulation. She was not on a special diet, received an antipsychotic medication, and an anti-anxiety medication. A Physician's Order, dated 2/23/24, indicated a regular mechanical soft diet with ground meat. A care plan for repetitive requests during mealtime, dated 2/13/24, indicated Resident B put excess amounts of food in her mouth and did not take the time to chew or swallow safely. The plan included, but was not limited to, interventions of limiting meals to two helpings, offer food/drink and redirect as needed, offer one food item at a time, and provide supervision. A mechanically altered diet with ground meat interventions had		diets and liquids 2.Checking resident tray cards when setting up resident meal tray to ensure matching 3.Procedure to follow when meal tray is inconsistent with tray card (staff member to discard meal tray, notify kitchen staff to have meal tray replaced) 4.Following MD diet orders 2.All dietary staff to be educated by date of compliance on the following. Staff that weren't onsite will be educated prior to their next shift worked: 1.Preparing diet consistencies per policy. 2.Preparing correct diet per the resident tray card 3.Sending tray card with each tray 3.All new licensed or certified nursing and dietary 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.Dietary manager/designee will audit 5 resident tray cards to diet being served 5x/week for 4 weeks, the 3x/week for 4 weeks, then 1x/week for 4 weeks, then monthly for 3 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance	

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	not been added to the care plan. During an interview on 5/2/24 at 2:11 p.m., CNA 4 indicated on 4/16/24, the meal was delivered to the memory care unit in metal containers and the CNAs had to serve the food to the residents. The Dietary Staff never sent the dietary cards or the ground meat for the evening meal. CNA 4 asked Agency LPN 3 to call the kitchen, but he was not sure if she did. When this had happened before, they were told to cut the meat up into little pieces. The Polish sausage was served to Resident B. CNA 4 cut the Polish sausage into dime size pieces and served the meal to Resident B. During an interview on 5/3/24 at 10:00 a.m., the Dietary Manager (DM) indicated the meals were served "homestyle". The meal was sent to the memory care unit in covered metal pans for nursing staff to serve on plates, and dietary staff were expected to send properly prepared food and each resident's meal ticket with specialized instructions with the meal. The DM indicated nursing staff were expected to follow the specialized dietary instructions on the meal tickets; however, the dietary staff forgot to send the ground meat and the meal tickets to the unit on 4/16/24. The DM indicated the Cook on duty 4/16/24, reported the nursing staff had not alerted the dietary staff that the ground meat and the meal tickets with specialized instructions were not received. The DM indicated cutting the sausage into small bites was not equivalent to the specialized texture of ground meat. During an interview on 5/3/24 at 8:10 a.m., Agency LPN 2 indicated she was receiving report from Agency LPN 3 when Agency CNA 1 notified them of Resident B's status. She immediately went to the resident's room. The resident was lying on her		Committee meeting monthly for a total of 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Compliance date: 5/29/24. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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	back and she saw Polish sausage chunks unchewed on the outside of the resident's mouth. The chunks looked like they would be as if the sausage was cut in sections, though was unable to approximate the size. The resident was unresponsive. Agency LPN 2 gave instructions for Agency CNA 1 to get the crash cart and to call EMS. Agency LPN 2 performed a finger sweep of the resident's mouth and proceeded to initiate the Heimlich Maneuver and more sausage chunks came out of the mouth. She had not seen any more, so she began CPR and another large amount of sausage came out of her mouth. CPR was stopped and the Heimlich Maneuver and another finger sweep was completed and there was no more food observed in the mouth or throat, and started CPR again. EMS arrived and took over the resident's care. Agency LPN 2 indicated the meals were always done when she came in to work. She was aware the resident would hold food in her mouth and would try to take fluids and food off of the medication cart. 2. On 5/3/24 at 11:00 a.m. a list was provided by the DON that indicated there were five residents on the memory care unit who had physician orders for mechanical soft diets with ground meat. a. Resident G's record was reviewed on 5/3/24 at 1:33 p.m. The diagnoses included, but were not limited to dementia and dysphasia. A quarterly MDS assessment, dated 3/30/24, indicated a severely impaired cognitive status and supervision was required for eating. A Care Plan, dated 4/8/24, indicated a diagnosis of dysphasia and a mechanically altered diet was required.			

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	A Physician's Order, dated 4/30/24, indicated a mechanically altered diet was to be served. b. Resident H's record was reviewed on 5/3/24 at 1:50 p.m. The diagnoses included, but were not limited to dementia, Parkinson's disease, and dysphagia. A quarterly MDS assessment, dated 2/9/24, indicated a severely impaired cognitive status supervision was required for eating. A Care Plan, dated 2/20/24, indicated a diagnosis of dysphasia and a mechanically altered diet was required. A Physician's Order, dated 2/28/24 indicated a mechanically altered diet was to be served. c. Resident J's record was reviewed on 5/3/24 at 2:06 p.m. The diagnoses included, but were not limited to dementia and dysphasia. A quarterly MDS assessment, dated 3/5/24, indicated a severely impaired cognitive status and supervision with eating was required. A Care Plan, dated 2/9/24, indicated a risk for weight fluctuations. The interventions included to serve a diet as ordered by the physician. There were no care plans for the dysphasia diagnosis and mechanically altered diet. A Physician's Order, dated 2/27/24, indicated a mechanically altered diet was to be served. d. Resident K's record was reviewed on 5/3/24 at 2:29 p.m. The diagnoses included, but were not			

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	limited to dementia. A quarterly MDS assessment, dated 3/5/24, indicated a severe impairment for decision making and required moderate assistance with eating. A Care Plan, dated 2/9/24, indicated a risk for weight fluctuations. The interventions included to serve a diet as ordered by the physician. There was no care plan for the mechanically altered diet. A Physician's Order, dated 2/28/24, indicated a mechanically altered diet was to be served 3. During a meal observation on the dementia care unit, on 5/4/24 at 5:01 p.m., Activity Aide/CNA 5 was observed to serve breaded shrimp to Resident L. The breaded shrimp was observed to not be mechanically altered. Activity Aide/CAN 5 cut the breaded shrimp into small pieces and assisted the resident with her meal. Resident L's record was reviewed on 5/3/24 at 2:54 p.m. The diagnoses included, but were not limited to, dementia. An annual MDS assessment, dated 1/19/24, indicated a severe impairment for decision making and supervision was required for eating. A Care Plan, dated 2/2/22, indicated assistance was required for eating. The interventions indicated a diet as ordered by the physician would be served. There was no care plan for the mechanically altered diet.			

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	A Physician's Order, dated 4/24/24, indicated a mechanically altered diet was to be served due to difficulty chewing. During an interview, on 5/4/24 at 6 p.m., the Regional Vice-President provided a dietary spreadsheet and indicated it was for the current menu cycle. The spreadsheet indicated the alternate meat to be served for a mechanically altered ground meat diet during the evening meal, on 5/4/24, was ground breaded shrimp. The facility mechanically altered diet policy, dated 3/15/22 and received from the Executive Director as current, indicated the diet consisted of easy to chew and easy to swallow foods. The meats were to be served as ground and moist and foods that were in large chunks and were too hard to chew would be avoided. A facility meal service policy, dated 8/24/23, and received from the Director of Nursing as current, indicated the resident would be identified to verify accuracy of the diet being served. The meal was to be verified to ensure it matched the correct diet that was prescribed for the resident. The immediate jeopardy that began on 4/16/24 was removed 5/4/24 when the facility assessed all residents for their current diet orders, audits to residents' care plans and dietary tray cards were completed, and any discrepancies were corrected. Nursing staff were in-serviced regarding checking resident tray cards when setting up resident trays and removing trays when residents were done eating. Dietary staff were in-serviced on preparing diet consistencies and sending tray cards to the units. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is			

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	not immediate jeopardy because of the facility's need for continued monitoring. This citation relates to Complaint IN00432816. 3.1-21(a)(3)			