| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155287 | A. Building<br>B. Wing | 02/07/2025 |

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| Rensselaer Care Center | 1309 E Grace St<br>Rensselaer, IN 47978 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>45666<br><br>Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 52)<br><br>Finding includes:<br><br>During a random observation on 2/4/25 at 9:42 a.m., Resident 52 was observed sitting in his room. There was a clear medication cup sitting on the table next to him with multiple pills inside. The resident indicated he was going to take them and the nurse had left them in his room this morning.<br><br>Resident 52's record was reviewed on 2/5/25 at 11:08 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, age-related cognitive decline, and type 2 diabetes mellitus.<br><br>The Quarterly Minimum Data Set assessment, dated 10/16/24, indicated the resident was moderately impaired for daily decision making. He received insulin injections, antibiotic, diuretic, antiplatelet, and hypoglycemic medications during the 7 day look-back period.<br><br>A Care Plan, dated 4/16/24, indicated the resident had a diagnosis of cognitive/communication deficit and had a moderately impaired cognitive status. He was able to make simple choices and decisions while requiring cues and reminders from staff at times. Interventions included, but were not limited to, cue, reorient, and supervise as needed.<br><br>The February 2025 Physician Order Summary indicated Resident 52 received the following medications for the AM medication pass: glimepiride 4 milligram (mg) 2 tablets, acetaminophen 325 mg 2 tablets, allopurinol 100 mg tablet, amlodipine besylate 10 mg tablet, aspirin 81 mg tablet, bisoprolol fumarate 5 mg tablet, cholecalciferol 10 microgram (mcg) tablet, ferrous sulfate 325 mg tablet, lactobacillus capsule, metformin 500 mg 2 tablets, potassium chloride 10 milliequivalents 2 tablets, spironolactone 25 mg tablet, and torsemide 10 mg tablet.<br><br>There were no self-administration assessments or physician's orders for the self-administration of any medications for Resident 52.<br><br>During an interview on 2/4/25 at 10:13 a.m., the Director of Nursing (DON) indicated Resident 52 did not self-administer any medications to her knowledge.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow-up interview on 2/4/25 at 11:14 a.m., the DON indicated there was no self-administration of medication assessment or orders to self-administer for Resident 52.<br><br>A policy titled, Self Administration of Medications indicated .2. Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition .4. Facility should regularly observe the resident self-administering medications to determine if the resident's functional and cognitive skills allow for the safe and appropriate continuation of resident self-administration . 5. Facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer .<br><br>3.1-11(a) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>32582<br><br>Based on observation, record review and interview, the facility failed to ensure a resident's ADL (activities of daily living) functions were maintained related to walking the resident daily as care planned for 1 of 1 resident reviewed for rehabilitation and/or restorative care. (Resident 70)<br><br>Finding includes:<br><br>On 2/4/25 at 9:28 a.m., Resident 70 was observed in his room with a family member. He was seated in a wheelchair, there was a rollator walker in his room. His daughter indicated the staff were not helping him walk with his walker like they used to. He needed staff assistance to walk with the walker.<br><br>The resident's record was reviewed on 2/4/25 at 1:20 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, cerebral ischemia and acute kidney failure.<br><br>The Annual Minimum Data Set assessment, dated 11/14/24, indicated the resident had mild cognitive impairment and needed partial to moderate assistance for bed mobility and transfers.<br><br>A Functional Goal Care Plan, dated 8/14/24, indicated the resident had limited physical mobility related to a stroke. Intervention was the walking program, to walk the resident using his rollator walker twice daily following with his wheelchair 6-7 days a week, offer safety cues and rest periods as needed.<br><br>The POC (point of care) tasks for the past 30 days indicated the resident was walked with staff on 1/11/24, 1/22/24, 1/23/24, 1/26/24 and 2/5/24. The remaining dates were marked as activity did not occur.<br><br>During an interview on 2/5/25 at 12:50 p.m., the Occupational Therapist indicated the resident had received physical therapy January thru April 2024. Therapy would make recommendations to nursing staff on discharge, but she did not know who was responsible to carry out those recommendations.<br><br>During an interview on 2/5/25 at 1:20 p.m., the Director of Nursing indicated therapy recommendations were in the POC tasks for CNAs to complete and they had no specific restorative nursing program. There was no additional documentation the resident was being walked twice daily.<br><br>3.1-38(a)(1) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>32582<br><br>Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and services related to a medication not resumed at the correct frequency for 1 of 1 residents reviewed for death (Resident B), lack of a treatment order for a dressing in place, and compression stockings not worn as ordered for 2 of 3 residents reviewed for non-pressure skin issues. (Residents D and C)<br><br>Findings include:<br><br>1. The closed record for Resident B was reviewed on 2/7/25 at 11:43 a.m. Diagnoses included, but were not limited to, paraplegia incomplete, unspecified convulsions, tachycardia and diabetes mellitus.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 11/25/24, indicated the resident was cognitively intact, required partial to moderate assistance for bed mobility and transfers and took an anticoagulant medication.<br><br>A Physician's Order, dated 12/5/24, indicated to give Eliquis (an anticoagulant medication) 5 milligrams (mg) twice daily until 12/12/24 for chronic pulmonary embolism.<br><br>The resident was having a suprapubic catheter (urine drainage that is surgically inserted through the skin) inserted and kidney stones removed on 12/16/24. The Eliquis was placed on hold prior to the procedure on 12/12/24.<br><br>A Health Status Note, dated 12/16/24, indicated the resident had returned from the hospital following the procedures. The resident was to resume Eliquis on 12/18/24.<br><br>The hospital inpatient discharge instructions, dated 12/16/24, indicated to resume the Eliquis on 12/18/24, medication was unchanged.<br><br>An Order Note, dated 12/16/24 and entered by LPN 2, indicated to give Eliquis 5 mg one time daily related to tachycardia.<br><br>A Health Status Note, dated 12/16/24, indicated the resident was being seen by the Nurse Practitioner(NP) for a post-op visit after having a suprapubic catheter and stent placement for kidney stones. The resident's medications included Eliquis 5 mg one time daily.<br><br>During an interview on 2/7/25 at 2:25 p.m., LPN 2 indicated she was unsure where the order to resume Eliquis at one time daily had come from, she remembered there had been some confusion about the order. She indicated she needed to talk to the Director of Nursing. No additional information was provided.<br><br>During an interview on 2/7/25 at 2:40 p.m., the NP indicated she did not change the resident's medications, she had copied them from his medication list.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 32788<br><br>2. On 2/6/25 at 10:22 a.m. Resident D was observed seated in her wheelchair in the unit dining room. There was a white bandage in place to her left forearm.<br><br>On 2/6/25 at 2:06 p.m. Resident D was observed seated in her wheelchair in the unit dining room. There was a white bandage in place to her left forearm.<br><br>Resident D's record was reviewed on 2/6/25 at 9:48 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, osteoporosis, and emphysema.<br><br>The Quarterly MDS assessment, dated 10/25/24, indicated the resident was cognitively impaired and dependent on staff for assistance with ADLs (activities of daily living).<br><br>A Progress Note, dated 1/29/25 at 5:31 p.m., indicated the resident had a new skin tear to the left forearm. The Nurse Practitioner was notified, and an order was received to cleanse the area with sterile water and apply steri strips.<br><br>A Physician's Order, dated 1/29/25, indicated to monitor the left forearm skin tear for redness and drainage two times a day. There were no orders for any bandage to the area.<br><br>During an interview on 2/6/25 at 3:49 p.m., the DON indicated there were no orders for a dressing to the left forearm. The resident had a skin tear at the end of January and had steri strips in place to the left forearm.<br><br>45666<br><br>3. During an observation and interview on 2/4/25 at 10:05 a.m., Resident C was seated in his motorized wheelchair. His bilateral lower extremities were both swollen, red in color, and had scattered discolorations. He had a small adhesive bandage located on his right lower leg. Resident C indicated that he was having skin issues with both lower legs and would be going to see a dermatologist soon. He did not have on any compression stockings at the time.<br><br>On 2/6/25 at 2:23 p.m., Resident C was observed in his wheelchair in the hallway. Both lower legs were covered with compression stockings.<br><br>On 2/7/25 at 9:43 a.m., 10:12 a.m., and 10:36 a.m., Resident C was observed in a wheelchair. His bilateral lower extremities were red in color and swollen. He had no compression stockings on.<br><br>Resident C's record was reviewed on 2/5/25 at 1:32 p.m. Diagnoses included, but were not limited to, chronic kidney disease, seborrheic dermatitis (inflammatory skin condition), and heart failure.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact for daily decision making. He had applications of nonsurgical dressings, and applications of ointments/medications other than to feet and received antibiotic and diuretic medications.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Care Plan, dated 2/5/25, indicated the resident had stasis dermatitis to the bilateral lower extremities. Interventions included, but were not limited to, encourage resident to elevate legs as tolerated and administer treatments as ordered.<br><br>A Care Plan, dated 9/19/24, indicated the resident had congestive heart failure (CHF) and may experience weight fluctuations related to diuretic medications. He had bilateral lower extremity edema. Interventions included, but were not limited to, administer diuretic medications per orders, encourage him to elevate his legs while sitting, and observe and report any signs or symptoms of CHF such as dependent edema of legs/feet, increased heart rate, or disorientation.<br><br>The February 2025 Physician Order Summary indicated the resident was to wear compression stockings during the day as tolerated by the resident, and remove compression stockings at bedtime.<br><br>The February 2025 Treatment Administration Record indicated the compression stockings were marked as administered in the morning on 2/4/25 and 2/7/25.<br><br>The Weekly Skin Integrity Data Collection, dated 1/7/25, 1/14/25, 1/22/25, and 1/29/25, indicated the resident had chronic edema to the bilateral lower extremities.<br><br>The Weekly Skin Integrity Data Collection, dated 2/5/25, indicated the resident had stasis dermatitis to bilateral lower extremities with seborrheic keratosis (seen by dermatology).<br><br>There were no orders or assessment for the area on the right lower leg covered with the adhesive bandage.<br><br>During an interview on 2/7/25 at 10:30 a.m., the Director of Nursing indicated the resident sometimes rolled down and removed the compression stockings himself and was very independent with his own care. The nurses were supposed to document if the compression stockings were on or off and the CNAs were responsible for putting the compression stockings on with care. The nurses should have documented correctly.<br><br>During an interview on 2/7/25 at 10:35 a.m., the Assistant Director of Nursing indicated the resident probably had scratched his leg and asked for a bandage. He would remove bandages on his own once an area stopped bleeding.<br><br>A policy titled, Basic Skin Management, indicated .3. It is the responsibility of the CNAs and therapy department to notify nursing if a change of the resident's skin is identified. Notification may be entered into PCC via eInteract and will alert nurse on the PCC Dashboard. 4. If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document an assessment/observation, obtain treatment orders, and notify MD and responsible party. 5. Orders are required for skin and wound care. There are wound care protocol orders in PCC under Orders- TX Template .<br><br>This citation relates to Complaints IN00452567 and IN00452961.<br><br>3.1-37(a) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>32582<br><br>Based on observation, record review and interview, the facility failed to ensure a resident's range of motion (ROM) was maintained related to not following therapy recommendations for routine ROM exercises for 1 of 2 residents reviewed for limited ROM and/ or positioning. (Resident 21)<br><br>Finding includes:<br><br>On 2/3/25 at 3:37 p.m., Resident 21 was observed seated in her recliner, her legs were elevated with the foot rest. She indicated her legs were paralyzed and flaccid and that she used to get range of motion exercises done by the staff, but not recently.<br><br>The resident's record was reviewed on 2/5/25 at 10:05 a.m. Diagnoses included, but were not limited to, paraplegia, diabetes mellitus and spinal stenosis.<br><br>The Quarterly Minimum Data Set assessment, dated 12/18/24, indicated the resident was cognitively intact, required substantial to maximum assist for bed mobility and was dependent for transfers and toileting. She had not received restorative nursing services.<br><br>A Physical Therapy Discharge Summary, dated 2/12/24, indicated restorative range of motion program. Interventions were to complete each range of motion is a slow rhythm motion, encourage resident to assist with the ROM, encourage resident to relax, face the resident to observe for signs of discomfort and never force extremity ranging.<br><br>During an interview on 2/5/25 at 12:50 p.m., the Occupational Therapist indicated the resident had received physical and occupational therapy January thru March 2024. Therapy would make recommendations to nursing staff on discharge from therapy, but she did not know who was responsible to carry out those recommendations.<br><br>During an interview on 2/5/25 at 1:20 p.m., the Director of Nursing indicated therapy recommendations were in the POC (point of care) tasks for CNAs to complete and they had no specific restorative nursing program. She indicated she went back to February 2024 and was unable to find where therapy recommendations for ROM had been implemented.<br><br>3.1-42(a)(2) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666<br><br>Based on record review and interview, the facility failed to monitor nutritional intake for meals for a resident with a history of weight loss for 1 of 3 residents reviewed for nutrition. (Resident 15)<br><br>Finding includes:<br><br>The record for Resident 15 was reviewed on 2/5/25 at 9:54 a.m. Diagnoses included, but were not limited to, multiple sclerosis, protein-calorie malnutrition, and adult failure to thrive.<br><br>The Quarterly Minimum Data Set, dated dated [DATE], indicated the resident was cognitively intact for daily decision making. She required setup help only for eating and weighed 84 pounds.<br><br>The current Care Plan indicated the resident was at risk for weight fluctuations due to her current health status, variable meal intakes and refusals of nutritional supplements. Her weight loss was significant and unavoidable. Interventions included, but were not limited to, administer medications to help stimulate the resident's appetite, supplements to be offered, and serve diet as ordered.<br><br>A current Physician Order Summary indicated the resident received a regular diet and whole milk and a soft cookie in the afternoon after lunch.<br><br>The resident's most recent weight on 2/4/25 was 78 pounds. On 1/3/25, the resident weighed 79 pounds. On 8/9/24, the resident weighed 88 pounds.<br><br>A Nutrition/Dietary Note, dated 1/13/25, indicated the resident received a regular diet and was consuming 1-100% of meals over the past week. The resident was at risk for malnutrition. She had a long list of foods/beverages/fortified foods/nutritional supplements that she refused to consume. She had variable meal intakes and 9% weight loss over the last 180 days.<br><br>The CNA Task ADL (Activities of Daily Living) - Eating had a frequency of documentation for three times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. (mealtimes).<br><br>The meal consumption log indicated there was no documentation for the breakfast meal on 1/8, 1/10, 1/17, 1/19, 1/21, 1/24, and 1/29/25.<br><br>The meal consumption log indicated there was no documentation for the lunch meal on 1/19, 1/21, 1/31, and 2/1/25.<br><br>The meal consumption log indicated there was no documentation for the dinner meal on 1/8, 1/11, 1/19, 1/26, 1/27, and 1/31/25.<br><br>During an interview on 2/6/25 at 3:59 p.m., the Director of Nursing indicated she had no further information regarding the missing documentation of the meal intakes. The resident may have refused those meals, as she often refused to eat. They had been working with her on finding foods that she would eat to help her gain weight.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3.1-46(a) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>32582<br><br>Based on observation, record review and interview, the facility failed to ensure residents received the necessary respiratory care and treatments related to medications not initiated for a resident with COVID-19 for 1 of 2 residents reviewed for respiratory infections (Resident 70) and incorrect oxygen flow rates for 2 of 2 residents reviewed for oxygen. (Residents 10 and 65)<br><br>Findings include:<br><br>1. On 2/4/25 at 9:28 a.m., Resident 70 was observed in his room. There were signs on his door that indicated he was on contact and droplet isolation precautions. There was a personal protective equipment bin outside the door with gowns, gloves, masks and faceshields. A family member present indicated he had COVID-19.<br><br>The resident's record was reviewed on 2/4/25 at 1:20 p.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, cerebral ischemia and acute kidney failure.<br><br>The Annual Minimum Data Set assessment, dated 11/14/24, indicated the resident had mild cognitive impairment and needed partial to moderate assistance for bed mobility and transfers.<br><br>A Health Status Note, dated 1/31/25, indicated new orders were received for Vitamin C, Zinc, Mucinex, Duonebs (breathing treatment) as needed and oxygen as needed for positive COVID-19 diagnoses.<br><br>The Physician's Orders lacked orders for Vitamin C, Zinc, Mucinex, Duonebs or oxygen. The January and February 2025 Medication Administration Record lacked documentation the medications had been initiated or administered.<br><br>During an interview on 2/4/25 at 2:47 p.m., the Director of Nursing indicted the orders for the medications had not been entered. She indicated it would be corrected.<br><br>32664<br><br>2. On 2/4/25 at 10:07 a.m., Resident 10 was observed sitting in a wheelchair in her room. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 2.5 liters.<br><br>On 2/5/25 at 10:11 a.m., Resident 10 was observed lying in bed. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 2.5 liters.<br><br>Record review for Resident 10 was completed on 2/5/25 at 12:12 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, and dementia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident had a memory problem. The resident required a partial moderate assistance with transfers and received oxygen therapy.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Care Plan, dated 10/16/23 and revised 10/19/23, indicated the resident had oxygen therapy related to ineffective gas exchange and shortness of breath due to diagnosis of chronic obstructive pulmonary disease. An intervention included for oxygen via nasal cannula at 2 liters continuously.<br><br>The February 2025 Physician's Order Summary (POS) indicated an order for oxygen at 2 liters continuously per nasal cannula.<br><br>During an interview on 2/5/25 at 10:15 a.m., LPN 1 indicated the resident was supposed to be on 2 liters of oxygen and she would adjust the flow rate.<br><br>3. On 2/4/25 at 2:02 p.m., Resident 65 was observed lying in bed. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 1 liter.<br><br>On 2/5/25 at 10:20 a.m., Resident 65 was observed in her room. The resident had on oxygen via nasal cannula. The oxygen concentrator was set on 1 liter.<br><br>Record review for Resident 65 was completed on 2/5/25 at 10:22 a.m. Diagnoses included, but were not limited to, stroke, chronic obstructive pulmonary disease, anxiety, hypertension, and hemiplegia.<br><br>The Quarterly MDS assessment, dated 1/20/25, indicated the resident was cognitively intact. The resident required a partial moderate assistance with transfers and received oxygen therapy.<br><br>A Care Plan, dated 11/30/23 and revised 9/16/24, indicated the resident had oxygen therapy related to ineffective gas exchange secondary to asthma. An intervention included oxygen at 3 liters via nasal cannula when napping and at night.<br><br>The February 2025 POS indicated an order for oxygen at 3 liters per nasal cannula when napping and at night.<br><br>During an interview on 2/5/25 at 10:22 a.m., RN 1 indicated the resident's oxygen should be at 3 liters and she would correct the flow rate on the concentrator.<br><br>3.1-47(a)(6) |