STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rensselaer Care Center	1309 E Grace St Rensselaer, IN 47978

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen was maintained related to proper chemical level in the dishwasher for 1 of 1 kitchen. (Main Kitchen) This had the potential to affect the 89 residents who received food from the kitchen.Finding includes:On 4/29/26 at 9:59 a.m., the Initial Kitchen tour was completed with the Dietary Manager (DM). The DM indicated the dishwasher was a chemical dishwasher and the chemical solution was tested every shift. She obtained a test strip and checked the chemical solution following the wash cycle. The test strip registered 0 parts per million (PPM). The DM indicated the chemical reading should be 100 PPM. She obtained a different bottle of test strips and again checked the chemical solution following the wash cycle. The test strip color remained unchanged and had not registered any PPM reading. The DM indicated she was not sure why the test strips had not registered any chemical level. She would call the dishwasher service company.The Low Temperature Dish Machine Log, dated 4/2026, indicated on 4/29/26 at breakfast the rinse temperature was 120 degrees Fahrenheit and the chemical level was 100 PPM.A current facility policy titled Ware Washing-Dish Machine/Manual Process, indicated .Low Temp Dish Machine.2. The temperature and parts per million [PPM] of the sanitizer [50-100 PPM] will be recorded on the Low Temperature Dish Machine Log a minimum of three times per day.410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to provide education of the benefits and risks of the COVID-19 vaccine and failed to offer the COVID-19 vaccine to the employees of the facility, which had the potential to affect all the residents who reside in the facility.Finding includes:During an interview on 4/30/26 at 2:43 p.m., the Minimum Data Set Assessment (MDS) Nurse indicated COVID-19 education and vaccination had not been offered to her.During an interview on 5/1/26 at 1:59 p.m., the Nurse Consultant indicated the COVID-19 education and vaccine had not been offered to the staff.During an interview on 5/6/26 at 9:50 a.m., the Administration indicated there were 99 staff members including therapy who were employed by the facility.A facility COVID-19 policy, dated 11/25/25, indicated the facility would provide education regarding the benefits and potential side effects associated with the COVID-19 vaccine and offer the vaccine unless it was medically contraindicated, or the the staff were already immunized.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure medications and treatments were stored properly related to an expiration date torn off a medication, multi-use vial of medication undated, biological medication not destroyed timely and unlabled biologicals for 1 of 2 Medication Rooms and 2 of 3 Medication and Treatment Carts observed.Findings include:1. During an observation of the East Wing Medication cart on 4/30/26 at 11:14 a.m., there was an opened bottle of nitroglycerin (chest pain) 0.4 milligrams with Resident 28's name. The expiration date on the bottle was torn off by the tape on the lid. The date opened was 11/16/24. RN 2 indicated the bottle of nitroglycerin would be removed and re-ordered. 2. During an observation of the Skilled Medication Room on 4/30/26 at 11:28 a.m., there was an opened container of Cetaphil Cream stored on the shelf. RN 1 indicated the name on the label was no longer a resident at the facility. There was an opened bottle of miconizide nitrate 2% (anti-fungal powder) stored on the shelf with no name or label. RN 1 indicated he was unsure to whom the powder belonged.There was an opened and partially used vial of Tuberculin (TB test) solution stored in the refrigerator with no opened date on the vial. RN 1 indicated he would destroy the vial.There was an opened and used tube of antibiotic ointment stored without a plastic bag and without a label in the treatment cart. RN 1 indicated he was unsure to whom the ointment belonged.A facility medication storage policy, dated 6/30/25, and received from the Infection Control Nurse as current, indicated medications and biologicals were to have an expiration date on the label and were to be stored separately from other medications. Staff were to record the date opened on the medication container. Any multi-dose vial injectable medication was to be dated when opened and discarded within 28 days, unless manufacturer specifies a different date for the opened vial. The facility was to destroy and reorder medications and biological's with worn, incomplete, or missing labels.410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC 16.2-3.1-25(o)410 IAC 16.2-3.1.25(r)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed to self-administer medications quarterly per the care plan for 1 of 1 resident reviewed for self-administration of medication. (Resident 1)Finding includes:During an observation and interview on 4/30/26 at 9:23 a.m., Resident 1 was observed sitting up in her bed. There was a tube of nystatin (anti-fungal cream) on the bedside table with a medication label on it. The resident indicated she applied the cream herself and she knew how to use the cream appropriately.On 5/1/26 at 9:57 a.m., the nystatin cream was observed on the bedside table in Resident 1's room.Resident 1's record was reviewed on 5/1/26 at 12:05 p.m. Diagnoses included, but were not limited to, paraplegia (paralysis on lower half of body) and cognitive communication deficit.The Quarterly Minimum Data Set assessment, dated 4/15/26, indicated the resident was cognitively intact. The resident had limited range of motion on both sides of upper and lower extremities.A Medication Self-Administer Review, dated 11/27/24, indicated the resident was able to self-administer the following medications unsupervised: vitamin D, K1, and K2 by mouth one capsule daily, ultimate multivitamin by mouth one capsule daily, triple complex magnesium by mouth two capsules daily, calcium magnesium zinc and vitamin D3 by mouth three tablets daily, magnesium glycinate 500 milligrams by mouth one tablet daily, and calm forte (sleep aid) 2 tablets by mouth at bedtime.There was no other self-administration assessment completed after 11/27/24.A Care Plan, dated 1/2/25, indicated the resident was able to administer medications to herself. Interventions included, but were not limited to, assess resident for self-administration of medications quarterly.A Physician's Order, dated 4/10/26, indicated nystatin external cream 100,000 unit/gram apply to groin twice daily for 14 days and apply to groin topically every 8 hours as needed.A Physician's Order, dated 4/10/26, indicated the resident could self-administer medications brought to her by the nursing staff. It was her request for the nurse to leave pills in a cup at bedside.During an interview on 5/6/26 at 10:30 a.m., the Director of Nursing indicated there were no other self-administration assessments completed. A facility policy titled, Self-Administration of Medication, and noted as current, indicated, .3. The assessment will contain at a minimum the following: a. The medications are appropriate and safe for self-administration.7. A reassessment by the interdisciplinary team is conducted quarterly and with any significant change in the condition of the resident to assure that safe self-administration of medications is still feasible.410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plans were implemented and in place for pain and hypotension for 2 of 20 resident's care plans reviewed. (Resident 5 and 7)Findings include: 1. Resident 5's record was reviewed on 5/6/26 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, stage 3 chronic kidney disease and heart failure. A Physician's Order, dated 11/16/25, indicated to give midodrine HCL tablet 10 milligrams (mgs) three times daily for hypotension (low blood pressure), hold if systolic blood pressure is greater than 120. The order was discontinued on 3/23/26.A Physician's Order, dated 3/23/26, indicated to give midodrine HCL tablet 10 mgs, every eight hours as needed if SBP is less than 120. There was no care plan related to hypotension, During an interview on 5/6/26 at 1:58 p.m., the Director of Nursing indicated there should be a care plan for hypotension. 2. Resident 7's record was reviewed on 5/1/26 at 11:25 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, peripheral autonomic neuropathy and peripheral vascular disease. The admission Minimum Data Set (MDS) assessment, dated 3/30/26, indicated the resident was cognitively intact and had pain that occasionally interfered with day to day activities and received interventions for pain. A Physician's Order, dated 3/26/25, indicated to give tramadol (pain medication) 50 milligrams (mgs) every six hours as needed for pain. The Medication Administration Record indicated the resident took the tramadol 1-3 times daily. A Physician's Order, dated 3/26/26, indicated to give gabapentin (for neuropathy) 300 mgs, three times daily. There was no pain care plan in the resident's record. During an interview on 5/1/26 at 2:02 p.m., the MDS nurse indicated there should be a pain care plan and she must have forgotten to initiate it. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received the necessary care and services related to medications not given as ordered and interventions and medications not provided for a resident with constipation for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for hospitalization. (Residents 16 and 6)Findings include:1. Resident 16's record was reviewed on 5/4/26 at 8:27 a.m. The diagnoses included, but were not limited to, hypertension, hypothyroidism, and excessive weight loss. a. A Physician's Order, dated 5/13/25, indicated megestrol acetate (stimulates the appetite), 40 milligrams (mg) per milliliter (ml), 10 ml was to be administered twice a day. The April 2026 Medication Administration Record (MAR) indicated the a.m. dose of megestrol acetate had not been administered on 4/18/26. b. A Physician's Order, dated 6/2/25, indicated metoprolol tartrate (anti-hypertensive), 25 mg twice daily. Do not give the medication if the systolic blood pressure is less than 110 or diastolic blood pressure less than 50. The February 2026 MAR indicated the blood pressure (BP) on 2/27/26 was 109/77 and the morning dose of metoprolol tartrate was administered. The March 2026 MAR, indicated the metoprolol tartrate was administered when the blood pressure was outside the parameters on the following dates:On 3/1/26 the p.m. BP was 107/66.On 3/5/26 the a.m. BP was 106/63.On 3/14/26 the a.m. BP was 100/66.On 3/15/26 the a.m. BP was 100/68 and the p.m. BP was 108/70.On 3/23/26 the p.m. BP was 108/72.On 3/24/26 the a.m. BP was 104/70.On 3/31/26 the p.m. BP was 108/67. The April 2026 MAR, indicated the metoprolol tartrate was administered when the blood pressure was outside the parameters on the following dates:4/1/26 the a.m. BP was 106/68.4/2/26 the a.m. BP was 108/68.4/15/26 the a.m. BP was 100/68.4/16/26 the a.m. BP was 100/68 The April 2026 MAR also indicated the metoprolol tartrate had not been administered at the p.m. dose on 4/5/26, the a.m. and p.m. dose on 4/18/26, and the p.m. dose on 4/26/26. c. A Physician's Order, dated 6/2/25, indicated levothyroxine (hypothyroidism) 25 micrograms, one tablet was to be administered daily. The May 2026 MAR indicated the medication had not been administered at 5:00 a.m. on 5/3/26. During an interview on 5/4/26 at 2:09 p.m., the Nurse Consultant indicated the medications were not given as ordered. A facility medication administration policy, dated 9/9/25 and received as current from the Nurse Consultant, indicated medications were to be administered per the physician orders. 2. The closed record for Resident 6 was reviewed on 4/30/26 at 3:19 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the uterus and constipation. The resident was admitted to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment, dated 12/1/25, indicated the resident was cognitively intact. The Bowel and Bladder Elimination Task documentation, dated 11/26/25 through 12/1/25, indicated the resident had not had any bowel movements. A Nurse Practitioner Note, dated 11/28/25, indicated the resident had complained of constipation and indicated she had not had a bowel movement for a while. The Nurse Practitioner indicated she would add additional medication for constipation. The assessment and plan indicated an order for bisacodyl (a laxative medication) rectal suppository 1 unit rectally every 24 hours as needed for constipation. A Physician's Order, dated 11/28/25, indicated bisacodyl rectal suppository, insert one unit rectally every 24 hours as needed for constipation. The Medication Administration Record (MAR), dated 11/2025 and 12/2025, indicated the bisacodyl suppository had not been administered. A Nurse Practitioner Note, dated 12/1/25, indicated the resident had continued complaints of constipation and staff reported resident had not had any bowel movement since arrival to the facility. An abdominal X-ray was ordered. Abdominal x-ray results, dated 12/1/25, indicated ileus (paralyzed bowel) versus obstructive bowel gas pattern. CT (computed tomography, a medical imaging test that uses X-rays and a computer to create detailed cross-sectional images of the body) may be indicated. A Progress Note, dated 12/1/25 at 8:39 p.m., indicated the Nurse Practitioner had been notified of the abdominal X-ray results and the resident was sent to the emergency room for evaluation. A Progress Note, dated 12/2/25 at 12:21 a.m., indicated the hospital was called for an update on the resident. The resident had a CT scan completed, was diagnosed with a bowel obstruction, and would be transferred to another hospital. During an interview on 5/1/26 at 1:45 p.m., the Nurse Consultant indicated the resident had been sent to the local hospital for evaluation. There they completed a CT of the abdomen, which indicated a bowel obstruction but with the lead point being a mass probably related to her uterine cancer. A current facility policy titled Bowel Protocol, indicated .2. The facility in coordination with the resident's attending practitioner will implement standing orders to address a lack of bowel movement. a. These orders may vary within the facility for each attending practitioner. b. These orders may vary depending on the individual needs of a resident. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure safety was maintained related to a lack of a smoking safety assessment for 1 of 5 residents reviewed for accidents. (Resident 74)Finding includes:On 4/29/26 at 12:51 p.m. Resident 74 was observed going out to the courtyard with his daughter to smoke. The resident's daughter remained with him while he was smoking. At 1:04 p.m., Activities staff was observed taking residents out to the courtyard to smoke where they joined Resident 74. She remained outside with the residents while they were smoking.Resident 74's record was reviewed on 5/1/26 at 10:34 a.m. Diagnoses included, but were not limited to, nicotine dependence.A Care Plan, dated 2/4/25, indicated the resident was a smoker and could go out to smoke at the designated smoking times or with family. The interventions indicated a smoking evaluation would be completed quarterly.The most recent Smoking Safety Evaluation was completed on 11/6/24 and indicated the resident demonstrated the ability to safely smoke with supervision.During an interview on 5/1/26 at 10:15 a.m., the Nurse Consultant indicated Social Services had just completed a smoking evaluation on 4/30/26. There were no other evaluations completed since 11/6/24. A current facility policy titled Smoking Facility, indicated .Resident Smoking Determination. 1. Residents who currently smoke will have a smoking assessment completed upon admission, readmission, with significant change, and quarterly by a licensed nurse .410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure urinary catheter care was completed and the catheter was kept off the floor for 2 of 2 residents reviewed for catheters. (Residents 1 and 32)Findings include:1. During an observation and interview on 4/30/26 at 9:17 a.m., Resident 1 was observed sitting up in her bed. She indicated she had a urinary catheter and an ostomy (an opening in the abdomen to allow for waste/stool drainage). She did not receive routine peri-care/catheter care. At the time, the catheter collection bag was attached to the side of the bed and was resting directly on the floor as the bed was in a low position. The catheter bag was not contained in a basin.On 5/1/26 at 9:57 a.m., Resident 1 was observed sitting in the recliner chair in her room. The catheter collection bag was sitting on the floor next to the recliner. The catheter bag was not contained in a basin.On 5/4/26 at 11:49 a.m., Resident 1 was observed sitting in the recliner chair in her room. The catheter collection bag was sitting on the floor next to the recliner. The catheter bag was not contained in a basin.Resident 1's record was reviewed on 5/1/26 at 12:05 p.m. Diagnoses included, but were not limited to, paraplegia (paralysis on lower half of body) and cognitive communication deficit.The Quarterly Minimum Data Set assessment, dated 4/15/26, indicated the resident was cognitively intact and had an indwelling catheter.A Care Plan, revised on 2/4/26, indicated the resident had an indwelling catheter. Interventions included, but were not limited to, position catheter bag and tubing below level of bladder, change catheter as needed.A Care Plan, revised on 4/22/26, indicated the resident had her catheter bag in a basin on the floor to facilitate drainage per the resident's preference. Interventions included, but were not limited to, catheter care per orders, and make sure basin is next to the bed.A Physician's Order, dated 4/10/26, indicated indwelling catheter to straight drainage, size 20 French with 30 cc bulb; change for infection, obstruction, or when the closed system is compromised every 24 hours as needed.There were no orders or documentation in the resident's record to indicate catheter care was provided.During an interview on 5/4/26 at 11:53 a.m., LPN 9 indicated she had hung the catheter bag on the side of the recliner, but the bag must have slipped down.During an interview on 5/6/26 at 10:31 a.m., the Director of Nursing was notified of the concern and had no further information to provide. 2. On 4/29/26 at 10:09 a.m., Resident 32 was observed sleeping in bed. He had a urinary catheter collection bag connected to the side of the bed and the bed was in a low position. The catheter collection bag was resting directly on the floor. It was not contained in a basin.On 5/1/26 at 10:03 a.m., Resident 32 was observed sleeping in bed. He had a catheter collection bag connected to the side of the bed and the bed was in a low position. The catheter collection bag was sitting on the floor. It was not contained in a basin.Resident 32's record was reviewed on 5/4/26 at 9:22 a.m. Diagnoses included, but were not limited to, obstructive and reflux uropathy (blockage in the urinary tract that stops urine from flowing) and hydronephrosis with ureteral stricture (urine flow blockage causing backpressure and kidney swelling).The Quarterly Minimum Data Set assessment, dated 3/1/26, indicated the resident was severely cognitively impaired and he had an indwelling urinary catheter.A Care Plan, revised on 3/3/26, indicated the resident had an indwelling urinary catheter. Interventions included, but were not limited to, catheter care every shift and position the catheter bag and tubing below the level of the bladder.The May 2026 Physician's Order Summary indicated the resident had an indwelling catheter to straight drainage with a 16 French catheter and 10 cc bulb, change catheter bag as needed, and catheter care every shift.During an interview on 5/6/26 at 10:31 a.m., the Director of Nursing was notified of the concern and had no further information to provide.A facility policy titled, Indwelling Urinary Catheter Foley Management, and noted as current, indicated, .2. Maintain unobstructed urine low.b. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.7. Routine hygiene is appropriate.410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure a resident with a colostomy (opening in the colon that lets stools pass from the body) received appropriate treatment and services related to a lack of documentation of completed colostomy bag changes and stoma care for 1 of 1 resident reviewed for ostomies. (Resident 1)Finding includes:During an interview on 4/30/26 at 11:26 a.m., Resident 1 indicated she had a colostomy and a urinary catheter that the staff had to help her with managing.Resident 1's record was reviewed on 5/1/26 at 12:05 p.m. Diagnoses included, but were not limited to, paraplegia (paralysis on lower half of body) and colostomy status.The Quarterly Minimum Data Set assessment, dated 4/15/26, indicated the resident was cognitively intact and had an indwelling catheter and an ostomy.A Care Plan, revised on 4/22/26, indicated the resident had a colostomy. Interventions included, but were not limited to, ostomy care as needed.The May 2026 Physician's Order Summary had no orders for a colostomy or the care to be provided for the colostomy.During an interview on 5/6/26 at 10:30 a.m., the Director of Nursing had no further information to provide.A facility policy titled, Colostomy and Ileostomy Care, indicated, .The services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(3)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure pain medication and non-pharmacological interventions were administered as ordered for 1 of 3 residents reviewed for pain management. (Resident 33)Finding includes:During an interview on 4/30/26 at 9:58 a.m., Resident 33 indicated she had a lot of pain with her right arm and shoulder. The facility staff had recently changed her pain medicine schedule. She was having a hard time getting the staff to administer the medications as she needed them and she did not want to have to keep track of how often and what time medications were requested.Resident 33's record was reviewed on 5/1/26 at 3:08 p.m. Diagnoses included, but were not limited to, osteoarthritis, low back, left and right arm pain, and intervertebral disc degeneration.The Annual Minimum Data Set assessment, dated 4/17/26, indicated the resident was cognitively intact. The resident received scheduled and as needed pain medications and non-pharmacological interventions for pain.A Care Plan, revised on 4/30/26, indicated the resident had pain in her neck due to osteoarthritis. Interventions included, but were not limited to, medications and neck pack as ordered.A Physician's Order, dated 11/1/24, indicated Nurse to apply warm neck wrap to resident's neck daily for 20 minutes. Check the skin to neck before and after application.The April 2026 Treatment Administration Record indicated the neck wrap was not marked as administered on 4/7, 4/12, 4/18, 4/22, 4/26, and 4/28/26.A Physician's Order, dated 4/9/26, indicated hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg), one tablet by mouth every 8 hours as needed, crush and mix it into pudding.The April 2026 Medication Administration Record indicated the resident received the hydrocodone-acetaminophen oral tablet on 4/25/26 at 8:00 p.m. and again at 9:30 p.m.A Physician's Order, dated 4/14/26, indicated tramadol oral tablet 50 mg by mouth four times a day, crush and mix in pudding. The April 2026 Medication Administration Record indicated the resident's tramadol was not marked as administered on 4/15/26 at 12:00 p.m. and 6:00 p.m., 4/16/26 at 6:00 a.m., 4/18 at 6:00 a.m. and 12:00 p.m., and 4/26/26 at 6:00 a.m. During an interview on 5/6/26 at 2:11 p.m., the Director of Nursing indicated she had no further information to provide.A facility policy titled, Administration of Medications, indicated, .2. Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration.c. Right Dose. Check the MAR and the doctor's order before medicating.e. Right Time and Frequency. Check the order for when it would be given and when was the last time it was given.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155287	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rensselaer Care Center	1309 E Grace St Rensselaer, IN 47978

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident's blood pressure was monitored for an as needed (prn) blood pressure medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 5)Finding includes:Resident 5's record was reviewed on 5/6/26 at 11:45 a.m. Diagnoses included, but were not limited to, heart failure and stage 3 chronic kidney disease. A Physician's Order, dated 11/16/25, indicated to give midodrine HCL tablet 10 milligrams (mg) three times daily for hypotension (low blood pressure), hold if systolic blood pressure (SBP, top number) is greater than 120. The order was discontinued on 3/23/26.A Physician's Order, dated 3/23/26, indicated to give midodrine HCL tablet 10 mg every eight hours as needed if SBP is less than 120. The March 2026 Medication Administration Record (MAR) indicated midodrine had not been administered after 3/23/26. The April and May 2026 MAR indicated the midodrine had never been administered. There were no blood pressures recorded in the MAR or in the vital signs section of the medical record since 3/23/26. During an interview on 5/6/26 at 1:58 p.m., the Director of Nursing indicated there were no blood pressures recorded since 3/23/26 for the prn midodrine. She was unsure why the blood pressures had not been checked when the new order was initiated.410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6)