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| | 155704 | A. BUILDING 00<br>B. WING | 01/18/2024 |

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| WALDRON REHABILITATION AND HEALTHCARE CENTER | 505 N MAIN ST<br>WALDRON, IN 46182 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00424182, IN00424732, IN00425127, IN00425169 and IN00425984<br><br>Complaint IN00424182 -- Federal/state deficiencies related to the allegations are cited at F584 and F692.<br><br>Complaint IN00424732 -- Federal/state deficiencies related to the allegations are cited at F689.<br><br>Complaint IN00425127 -- Federal/state deficiencies related to the allegations are cited at F692 and F584.<br><br>Complaint IN00425169 -- Federal/state deficiencies related to the allegations are cited at F689.<br><br>Complaint IN00425984 -- No deficiencies related to the allegations are cited.<br><br>Survey dates: January 16, 17 and 18, 2024<br><br>Facility number: 000423<br>Provider number: 155704<br>AIM number: 100290450<br><br>Census Bed Type:<br>SNF/NF: 51<br>Total: 51<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 37 | F 0000 | 2-2-2024<br><br>ISDH<br>ATT: Brenda Buroker<br>Director of Division Long Term Care 2 North Meridian Street<br>Indianapolis, Indiana 46204<br><br>CCN/Provider Number:155704<br>AIM Number: 1200290450<br>Facility ID: 00423<br>Survey Event ID 2PXT11<br><br>Re: Complaint Survey<br>Waldron Rehabilitation and Health<br>505 N Main St<br>Waldron, IN.46182 Dear Ms. Buroker:<br>On January 18, 2024, a Complaint Survey (IN00424182, IN00424732, IN00425169, IN00425984) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies.<br>Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance.<br>We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Nicole Clapp | ED | 02/01/2024 |

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| | Other: 8<br>Total: 51<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on January 24, 2024 | | 2-2-2024.<br><br>Please feel free to call me with any further questions.<br>1-765-525-4371. Respectfully submitted,<br>Nicole Clapp<br>Executive Director | |
| F 0584<br>SS=D<br>Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment<br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition; | | | |

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| | §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>Based on observation, interview and record review, the facility failed to maintain a safe, clean, sanitary and comfortable environment for a resident shower room and a resident's recliner was observed with a dried brown substance present. These deficient practices have the ability to adversely affect any residents who utilize the shower room and Resident F. (Resident F)<br><br>Findings include:<br><br>1. During an observation of the shower room, located across from the Rehab Hall's Nurse's Station on 1-16-24 at 7:20 p.m., with LPN 3, the tile floor of the shower appeared discolored with brown and tan stains, one wet wash cloth was observed in left back corner of the shower. Behind and adjacent to the wall of the toilet were two balled-up pieces of tissue paper located on the floor. LPN 3 indicated she had heard the facility is planning to be replace the shower floor tile soon, but was unsure of a date. LPN 3 indicated she had noticed the discoloration of the tile and it did not look appealing to her. "I don't know that I would want to walk on that shower floor barefoot." LPN 3 indicated she has | F 0584 | **F 584D**<br>**Safe/Clean/Comfortable/Homelike Environment**<br><br>**The facility respectively requests a desk review for this citation.**<br><br>This Plan of Correction is the center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.<br><br>**1)Immediate actions taken for those residents identified:** | 02/02/2024 |

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| | personally cleaned the shower floor with bleach products and still cannot get rid of the stains.<br><br>In an interview with Resident J on 1-16-24 at 4:58 p.m., he indicated he does not like to use the shower room located across from the Rehab Nurse's station. "It looks dirty to me, maybe just stained, but I won't put my bare feet on that floor.".<br><br>In an interview on 1-17-24 at 2:22 p.m., with the Executive Director, she indicated the tile replacement for this shower room has not been scheduled for replacement at this time. She indicated several treatments have been attempted to clean the tile in the shower in the recent past.<br>In an interview on 1-17-24 at 2:35 p.m., with the Corporate Nurse, she explained she was informed by her superiors the tile replacement is on the schedule to be conducted. "I was told the bathroom tile is on the list to be done next. But, I can't tell you an exact date for that. I would guess within the next few months."<br>2. The clinical record for Resident F was reviewed on 1/17/2024 at 11:00 a.m. The medical diagnosis included stroke.<br><br>An Annual Minimum Data Set Assessment, dated for 12/11/2023, indicated Resident F needed assistance with activities of daily living.<br><br>An observation on 1/17/2024 at 1:40 p.m. indicated there was a thick brown substance on the recliner with a wet washcloth laying partially over the area.<br><br>An interview with Resident F on 1/17/2024 at 1:40 p.m. indicated that they usually clean her room and she would like her recliner cleaned before she got back up. | | ·The identified recliner was cleaned.<br>·The identified shower tiles were sanded and cleaned.<br>**2)How the facility identified other residents:**<br>·A facility audit was conducted for those residents that currently utilize a recliner to determine cleanliness.<br>·Any identified issues were immediately corrected.<br>·Facility shower room tiles were inspected, no other areas were identified.<br>**3)Measures put into place/ System changes:**<br>Education provided to nursing staff on the requirements of F584 and the provision of a safe, clean, homelike environment.<br>**4)How the corrective actions will be monitored:**<br>The responsible party for this plan of correction is the Executive Director/ Housekeeping Manager who will audit 3 times weekly for cleanliness related shower room and resident recliners.<br>The results of these audits will be reviewed in QAPI monthly for 6 months and or until 100% compliance is achieved for 3 consecutive months.<br>The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as | |

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| | An observation and interview on 1/17/2024 at 2:00 p.m. indicated that there was brown residue on the recliner with a wet washcloth laying partially over the area. Medical Records came to the room and cleaned the area as best she could. She indicated that she would have housekeeping spot clean the recliner.<br><br>A policy, entitled "Homelike Environment", was provided by the Administrator on 1/18/2024 at 10:00 a.m. The policy indicated, " ...The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include ...Clean, sanitary, and orderly environment ..."<br><br>This Federal tag relates to Complaints IN00425127 and IN00424182.<br><br>3.1-19(f)<br>3.1-19(g)<br>5.1-5(a) | | indicated.<br>**5)Date of compliance: 2-2-2024**<br>**_____Quality Indicator: HOMELIKE ENVIRONMENT**<br><br>**Threshold: 100%**<br><br>**Recommended Frequency: 3 TIMES WEEKLY VARIOUS SHIFTS**<br><br>***Directions:*** *Through observation, staff interview and record review, determine the status of the items listed. "No" responses indicate potential areas of concern. Place a "Y" for "yes" or an "N" for "no" in the box to respond to the indicator. If the question doesn't apply to a resident, mark N/A for not-applicable. If the threshold is not reached, an action plan must be developed.*<br><br>*RESIDENTS REVIEWED:*<br><br>**Indicator** | |

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| | | | **Y**<br>**N**<br>**Comments**<br>1<br>SHOWER ROOM IS CLEAN, WITHOUT LINEN OR DEBRIS ON FLOOR?<br><br>2<br>RESIDENT RECLINERS ARE CLEAN?<br><br>3<br>SHOWER TILES ARE CLEAN?<br><br>4<br><br>5<br><br>6<br><br>7<br><br>8 | |

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| | | | 9<br><br>Percentage of Compliance = (# of yes responses x 100)<br>Percentage of Compliance:<br>____<br><br>Total # Responses Threshold Reached? Yes No<br><br>Signature of Assessor<br>Date | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Based on interview, observation, and record review, the facility failed to ensure resident specific fall interventions of antiroll back brakes | F 0689 | **F 689D Free of Accidents/Hazards/Supervision/ Devices**<br>**The facility respectively** | 02/02/2024 |

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| | and bright color tape were applied to wheelchair brakes 1 of 3 residents reviewed for falls. (Resident G)<br><br>Findings include:<br><br>The clinical record for Resident G was reviewed on 1/17/2024 at 2:51 p.m. The medical diagnosis included Alzheimer's disease.<br><br>A Quarterly Minimum Data Set Assessment, dated 11/10/2023, indicated that Resident G had multiple falls and was cognitively impaired.<br><br>A fall care plan for Resident G indicated interventions of anti-roll back to wheelchair, dated 3/7/2023, and bright colored tape to the wheelchair brakes, dated 12/18/2023.<br><br>An observation on 1/17/2024 at 2:49 p.m. indicated Resident G was laying in bed at this time. She had a wheelchair next to her bed that did not have antiroll back brakes nor had color tape to the wheelchair brakes.<br><br>An observation and interview on 1/17/2024 at 3:00 p.m. indicated CNA 2 came to Resident G's room. She confirmed that no antiroll back brakes or color tape to her wheelchair brakes.<br><br>An interview with the Director of Nursing on 1/28/2024 at 12:40 p.m. indicated that the direct care staff are responsible for ensuring fall interventions are in place for each resident.<br><br>A policy, entitled "Fall Management and Fall Risk", was provided by the Administrator on 1/18/2024 at 10:00 a.m. The policy indicated " ...If falling occurs despite initial interventions, staff will implement additional or different interventions | | **requests a desk review for this citation.**<br>This Plan of Correction is the center's credible allegation of compliance.<br>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.<br>**1.) What corrective actions will be accomplished for those residents found to have been affected by the practice?**<br>·Residents G was assessed and care plan interventions updated.<br>**2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken:**<br>·Any resident has the potential to be affected.<br>·An audit was conducted to determine care plan interventions were in place for those residents identified to be at risk.<br>·Identified concerns were addressed immediately.<br>**3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.** | |

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| | ..."<br><br>This Federal tag relates to Complaint IN00425169 and IN00424732.<br><br>3.1-45(a)(2) | | ·Care Plans will be reviewed to determine interventions are appropriate for these residents identified to be at risk for falls.<br>·DON /designee will audit 5 residents weekly to determine compliance with the fall prevention.<br>· Identified issues will be addressed through re-education.<br>·Staff educated in components of F689 and the prevention of Accidents and Hazards/ Supervision, to include intervention implementation and care plan updating.<br>·Identified concerns will be addressed with 1-1 education.<br>·Nursing staff will be educated on fall prevention upon hire and at least annually and prn.<br><br>**4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place.**<br>·The DON or designee will audit 5 residents weekly to determine compliance with the care plan fall interventions and prevention.<br>·The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months.<br>·The QA Committee will identify any trends or patterns and make recommendations to revise the | |

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| | | | plan of correction as indicated.<br>**5. Date of Correction 2-2-2024** | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on interview and record review, the facility failed to ensure 1 of 5 residents reviewed for nutrition had an admission weight obtained in less than 14 days from time of admission. (Resident B)<br><br>Findings include:<br><br>The clinical record of Resident B was reviewed on 1-16-24 at 4:06 p.m. It indicated he admitted to the facility on 11-30-23 with diagnoses that included, but were not to, a recent left femur fracture, muscle wasting and atrophy, cognitive | F 0692 | **F 692D Nutrition Hydration Status Maintenance**<br><br>**The facility respectively requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of* | 02/02/2024 |

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| | communication deficit, dementia, paranoid schizophrenia and prostate cancer.<br><br>An admission nursing assessment, dated 12-2-23, indicated his admission weight, dated 5-1-2021, was 175.4 pounds (#). This resident had previously been a resident from 1-29-2021 to 5-10-2021.<br><br>Current weights for Resident B were documented as 150 # on 12-13-23, and 148.5 # on 1-4-24.<br><br>A nutrition assessment, dated 12-4-23, "76 yo [years old] M [male] readmit with fracture of L. [left]femur and dx [diagnosis] of cancer of bone, ARF, [acute renal/kidney failure] and anemia. Monthly wt [weight] pending. Previous BMI [body mass index] fo [sic] 27.5, while on the higher side is appropriate for age. Resident is on a regular diet. High protein needs r/t [related to] cancer. Poor intake at this time, will monitor another week and add supplement if warranted. ADL [activities of daily living]-total dependence. No issues with chewing or swallowing noted. Skin intact. Labs reviewed above. New admit will be followed by CAR [clinically at risk team or interdisciplinary team]. Care plan initiated. Will continue to monitor and follow."<br><br>A nurse practitioner visit note, dated 12-12-23, indicated, "[Name of Resident B] is being seen as follow up to [name of facility] on 11-30-2023 ...Weekly weights x4 orders, however no admission weight or subsequent weights found."<br><br>A physician visit note, dated 1-2-2024, indicated, "Pt [patient] has had 1 [one] documented weight since admission, that was on 12-15-23. Reported to have poor appetite, for which he does take [brand name of liquid dietary supplement] w/o | | *this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1 Immediate actions taken for those residents identified:**<br>Resident B was weighed.<br>Registered dietician reviewed resident B and documented in progress notes, orders reviewed, and care plan revisions made, as necessary.<br>Resident receives ordered diet.<br><br>**2.) How the facility identified other residents:**<br>A new admission audit was conducted of facility residents to determine weights were completed and documented correctly.<br>Any issues identified were immediately addressed.<br><br>**3.) Measures put into place/ System changes:**<br>Licensed Nursing staff were educated on admission weights policy and documentation requirements.<br>Admission weights will be reviewed for completion and documentation during review of | |

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| WALDRON REHABILITATION AND HEALTHCARE CENTER | 505 N MAIN ST<br>WALDRON, IN 46182 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | [without] difficulty."<br><br>In an interview with Director of Nursing (DON) on 1-18-24 at 11:05 a.m., she indicated she had recently noted the missing admission weight for Resident B. "The only thing I can tell you is this is that he came in while we were in the midst of an outbreak of Covid, we had a lot of staff out with Covid, including myself. So, I was not in here to monitor like I would normally have done. He is no longer being followed by IDT [the interdisciplinary team] for his weight or nutrition. His appetite has improved and is doing pretty good in therapy."<br><br>On 1-18-24 at 9:05 a.m., the Executive Director provided a copy of a policy entitled, "Weight Policy," with a review date of 5-1-2022. This policy indicated, "New Admission weights [are to be conducted] weekly, for the first 4 weeks after admission ...Residents identified as nutritional risk may be weighed weekly or bi-weekly per physician order or IDT recommendations ...Weekly weights may be discontinued if weight has remained stable for at least 4 weeks, as determined by the IDT, Dietician [sic] or Physician ..."<br><br>This Federal tag relates to Complaints IN00424182 and IN00425127.<br><br>3.1-46(a)(1) | | admission audits.<br><br>**4. How the corrective actions will be monitored:**<br>Oversight of this plan of correction is the facility Executive Director who will review with the Director of Nursing new admission weights for completion and documentation.<br>Audits that are conducted three times weekly to ensure weights have been obtained and documented.<br>New admissions are reviewed during daily clinical meeting 5times weekly.<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br>The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br><br>**5. Date of Compliance**<br>**2-2-2024** | |