STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/09/2024				
	PROVIDER OR SUPPLIER ON REHABILITATION	N AND HEALTHCARE CENTER	505 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, IN 46182		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	Licensure Survey. Survey dates: October Survey dates: October 1002 Provider number: 1002 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type Medicaid: 35 Other: 12 Total: 47 These deficiencies is accordance with 41	reflect State Findings cited in	F 0000	ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Recertification and State Licensure Survey Waldron Rehabilitation and He 505 N Main St Waldron, IN.46182 Dear Ms. Buroker: On October 3, a recertification State Licensure Survey was conducted by the Indiana State Department of Health. Enclos please find the Statement of Deficiencies with our facilities of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of paper compliance. We respectfully request a desl review that the facility has achieved substantial complian with the applicable requirement as of the date set forth in the F of Correction as of November 2024 Respectfully submitted, Nicole Clapp Executive Director	ealth and e ed Plan ce ets	

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

Nicole Cherry HFA 10/25/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3GKC11 Facility ID: 000423 If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
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(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0550	483.10(a)(1)(2)(b)	(1)(2)					
SS=D	Resident Rights/E	xercise of Rights					
Bldg. 00							
			F 05	550	F 550 D Resident Rights		10/28/2024
		on, interview, and record					
	-	failed to promote residents'			The facility requests paper		
		privacy for a resident during			compliance for this citation.		
		ing incontinent care in a timely			This Plan of Correction is the	•	
		esidents reviewed for dignity.			center's credible allegation of	of	
	(Resident 23 and Co	onfidential Resident)			compliance.		
					Preparation and/or execution		
	Findings include:				of this plan of correction doe	es	
					not constitute admission or		
	1. During an observation on 10/8/24 at 12:13 p.m.,				agreement by the provider of		
		on Aide (QMA) 1 and Certified			the truth of the facts alleged	or	
	, , ,	2 assisted Resident 23 to the			conclusions set forth in the		
		room. QMA 1 and CNA 2			statement of deficiencies. The		
	-	Resident 23 in the bathroom			plan of correction is prepare	d	
		esident preferred privacy. The			and/or executed solely		
		ooks for a privacy curtain, but			because it is required by the		
	-	cy curtain hanging to provide			provisions of federal and sta	te	
	-	ray. QMA 1 and CNA 2 did not			law.		
		ed to the privacy curtain. The					
		vas opened four times while					
		ng the restroom, exposing the			1 Immediate actions taken for	or	
	resident to the hallw	vay.			those residents identified:		
					Residents # 23 was assessed	for	
	_	with the Maintenance			incontinence needs and		
		at 12:26 p.m., they indicated it			development of toileting plans		
	_	responsibility to ensure the			Resident# Confidential: Facilit	•	
	privacy curtains wer	re in place.			wide audit completed. Care pl		
					were reviewed and revised as		
	_	with the Maintenance			approp1·iate related to inconti	nent	
		at 12:32 p.m., they indicated			needs.		
	· ·	ken the privacy curtains down,			2 How the facility identified		
		them and they were putting			other residents:		
	the curtains back up	at that time.			Any resident had the potential		
					be affected. Audit was conduc		
	During an interview	with the Director of Nursing			to identify those residents that	are	

(DON) on 10/9/24 at 1:09 p.m., they indicated

incontinent. Interviews were

DENTIFICATION AIMBER 155704 NAME OF PROVIDER OR SIPPL LER WALDRON REHABILITATION AND HEALTHCARE CENTER WALDRON, IN 45182 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PRITTE (CATI DEFICIENCY MIST BE PRECEDED BY PILL) TAG Resident? 3 Jon thaving the privacy curtain up during inclining could have impacted the resident's dignity. 2. A confidential resident's record was reviewed on 10/8/2024 at 1.30 p.m. The medical diagnoses included depression and anxiety. The most recent Minimum Data Set Assessment indicated the confidential resident was cognitively intact, occasionally incontinent of bladder, and dependent on staff for assistance with tolleting. The most recent Minimum Data Set Assessment indicated the confidential resident was cognitively intact, occasionally incontinent of bladder, and dependent on staff for assistance with tolleting. The most recent Winimum Data Set Assessment indicated the confidential resident was cognitively intact, occasionally incontinent of brade and was at risk for skin break down relited to incontinence. An intervention was to provide the resident was incontinent of bladder medical diagnosts incontinent of bladder to the confidential resident interview. During a confidential resident interview conducted during the survey, the resident indicated they were made to wait a long time for their call light to be answered, upwards to an hour. They were able to verify they use the wall mounted clock in their room to keep track of the time. The word and bladder, but they cannot get assistance to the bulmroom in a timely manner, resulting them in having incontinence of bladder frequently. They stated they had bladder incontinence episodes due to having to wait for assistance as recently as in the last week, but this was a long-standing issue for the last "few months". When the confidential resident had incontinence episodes, they would feel "terrible" and "embarrased" the commendation to revise the unit 190% compliance is achieved X3 consecutive months. The QA Committee will be recommendati	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
		155704	B. WI	NG	_	10/09	/2024
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		505 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, IN 46182	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE	DATE
F 0657 SS=D	During a confidentiduring the survey, the get everything done all the residents toil having enough "help A policy entitled, "I provided by the Dir at 1:50 p.m. The pohave the right to a dute be treated with recognition of their 3.1-3(t)	al staff interview conducted hey indicated they attempt to but they cannot always get eted and showered due to not p". Resident Rights", was ector of Nursing on 10/8/2024 licy indicated, "Residents lignified existence" and " considerations, respect, and dignity"		IAU	plan of correction as indicated 5 Date of compliance: 10-28-2024	l.	DATE
Bldg. 00	failed to hold quarter 3 residents reviewed The clinical record 10/7/24 at 10:35 a.m were not limited to, failure, and generalism. During an interview 11:00 a.m., they indregular care plan me A Quarterly Minima assessment, dated 8 was cognitively inta The electronic healt Resident 8 had a quarter serview.	and record review, the facility orly care plan meetings for 1 of d for care plans. (Resident 8) for Resident 8 was reviewed on m. The diagnoses included, but chronic kidney disease, heart fized anxiety disorder.	F 06	557	F657 D Care Timing and Revi The facility request paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/o execution of this plan of correct does not constitute admission 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 is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Identified resident 8 was assessed, and the care plan meeting was scheduled, and	or ction or the se it	10/28/2024

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10/30/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155704 B. WING 10/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N MAIN ST WALDRON REHABILITATION AND HEALTHCARE CENTER WALDRON, IN 46182 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and another quarterly care plan meeting, on representatives were invited. 7/9/24; indicating no care plan meetings were Care plans were reviewed and done for six months, then not again for another revised appropriately. five months. 2) How the facility identified other residents: During an interview with the Social Service Any resident had the potential to Director (SSD) on 10/7/24 at 1:31 p.m., they be affected, however none were indicated care plan meetings were to be held identified to have been negatively quarterly, and she did not know how the quarterly impacted. meetings got missed. Care plan meetings will be held in conjunction with assessments. A Comprehensive Care Plan Policy provided by 3) Measures put into place/ the Administrator, on 10/8/24 at 10:15 a.m., System changes: indicated, "...4. Each resident's comprehensive • In-service conducted for the person-centered care plan is consistent with the interdisciplinary team to review resident's rights to participate in the development scheduling and invitations to and implementation of his or her plan of care, resident's representatives for including the right to: a. Participate in the participation in the care plan planning process...c. Participate in establishing meetings. the expected goals and outcomes of care...5. The · Resident care plans will be resident is informed of his or her right to reviewed/updated on admission, participate in his or her treatment and provided readmission, change of condition, advance notice of care planning conferences...." quarterly and annually. • Notation will be placed in 3.1-35(d)(2)(B)residents clinical record if the resident and their representative is determined not practicable for the development of the resident's care plan. 4) How the corrective actions will be monitored:

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• The Director of Nursing /designee will randomly review 5 residents 'care plan records weekly ensuring that resident representatives have been invited

to the care plan meeting. Documentation will reflect invitation to resident representative to attend care plan meeting.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155704	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/09/2024		
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		505 N N	DDRESS, CITY, STATE, ZIP COD MAIN ST ON, IN 46182		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervisi Based on observation review, the facility device of a gait belt fall for 1 of 2 resident (Resident 23) Findings include: During an interview (DON) on 10/8/24 and Resident 23 was an for transfers, on 9/2 were not utilizing a and the resident did condition that would used. During an observation Qualified Medication Nurse Aide (CNA)		F 06	89	• Any issues identified will be immediately addressed. • The results of these audits who have been affected by the provided by the provisions of federal and state 1.) What corrective actions will accomplished for those resident #23 was reviewed by the plan of care.	or eved ch or eved ch of t event che	10/28/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILT 155704 B. WING		JILDING	CONSTRUCTION X3) DATE SURVEY 00 COMPLETED 10/09/2024				
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		505 N I	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, IN 46182		
	SUMMARY (EACH DEFICIEN REGULATORY OF resident was totally and gait belt for the bent over at the wai During an interview 10/8/24 at 12:34 p.r. should be used duri all residents unless with ambulation and Manager indicated and Resident 23. During an interview 10/8/24 at 12:40 p.r. should have been untransferring Resident Review of the recon 1:27 p.m., indicated were not limited to, weakness, unsteadin coordination, muscl disease. The plan of care for	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION dependent of the two staff transfer and the resident was st. With the Therapy Manager on m., they indicated gait belts ing transfer and ambulation for the resident was independent d transfer. The Therapy a gait belt should be used for With the Therapy Manager on m., they indicated the staff tilizing a gait belt when int 23, on 9/20/24, when she fell. In of Resident 23, on 10/9/24 at I the diagnoses included, but vascular dementia, anxiety, mess on feet, lack of le wasting, and Alzheimer's Resident 23, dated 6/4/24,		505 N I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADERICIENCY) same practice and what correaction will be taken: All residents are at risk to be affected by the deficient practice. Review of each resident plan care and risk for falls will be completed by the IDT on or be 11/8/24. Identified needs for assistive devices required to ensure adequate supervision to prevent accidents will be reviewed and updates made to plan of care as needed. 3.) What measures will be put place or what systematic char you will make to ensure that the practice does not recur. • Care Plans will be reviewed determine interventions are appropriate for these residents identified to be at risk for falls. • DON or designee will audit 5 residents weekly to determine compliance with the fall preventions.	ctive ice. of efore and o into nges to	(X5) COMPLETION DATE
	indicated the reside to impaired safety a Alzheimer's disease cuff strain, incontin The State Optional assessment for Resi	nt was at risk for falls related awareness due to dementia, e, hypertension, right rotator ence and impaired mobility. Minimum Data Set (MDS) dent 23, dated 7/12/24, nt was moderately impaired for			and assistive devices Identified issues will be addressed through re-education Staff educated in component F689 and the prevention of Accidents and Hazards/ Supervision, to include intervestimplementation, gait belt use a	on. ts of ention	
	daily decision maki extensive assistance and toileting.	ng. The resident required e of two people with transfers ce note for Resident 23, dated			care plan updating. • Identified concerns will be addressed with 1•1 education. • Nursing staff will be educate fall prevention and gait belt us	d on	

9/20/24, indicated the resident had a witnessed fall

in the bathroom. The resident was lowered down

and prn.

upon hire and at least annually

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/09/2024						
	PROVIDER OR SUPPLIE ON REHABILITATION	N AND HEALTHCARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, IN 46182					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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			
	The Interdisciplina dated 9/23/24, indito the floor in the r	ry (IDT) note for Resident 23, cated the resident was lowered estroom. There were no injuries nt would be evaluated by		 4.) How the corrective actions we be monitored to ensure the practice will not recur and what quality assurance program will put into place. • The DON or designee will audresidents weekly to determine compliance with the fall interventions, gait belt use, and prevention. • The results of these audits will be reviewed in the Quality Assurance Meeting monthly x6 months or until an average of 9 compliance or greater is achiev x3 consecutive months. • The QA Committee will identifiany trends or patterns and mak recommendations to revise the plan of correction as indicated. 5. Date of Correction 10-28-202 	be dit 5 I II IO% red fy se			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/	Wk, Full Time DON						
	failed to have a Reday, 7 days a week coverage reviewed affect all 47 resider Findings include:	and record review, the facility gistered Nurse (RN) 8 hours a for 5 of 5 months of RN. This had the potential to atts that resided in the facility.	F 0727	F727 F The facility request paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correct does not constitute admission of agreement by the provider of the	tion or			

Administrator, on 10/4/24 at 1:00 p.m., indicated

truth of the facts alleged or

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155704 B. WING 10/09/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N MAIN ST WALDRON REHABILITATION AND HEALTHCARE CENTER WALDRON, IN 46182 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE there were no RNs in the facility for seven out of conclusions set forth in the 30 days in April 2024, seven out of 31 days in statement of deficiencies. The May 2024, four out of 30 days in June 2024, six out plan of correction is prepared of 30 days in September 2024, and two out of eight and/or executed solely because it days in October 2024. is required by the provisions of federal and state law During an interview with the Administrator on 10/8/24 at 2:27 p.m., they verified the facility did 1. Immediate actions taken for not have RN coverage in April, May, June, those residents identified: September, and/or October of 2024. No residents were identified to have been affected During an interview with the Administrator on 2. How the facility identified other 10/8/24 at 2:34 p.m., indicated she was not aware residents: of any residents being affected by the facility not All residents are at risk to be having an RN in the building during those months affected by the deficient practice. and there were no incomplete tasks that only an 3. Measures put into RN could do. place/system changes: Staffing will be reviewed daily by The sufficient staffing policy provided by the the administrator/ director of Director of Nursing (DON), on 10/9/24 at 1:50 p.m., nursing to determine appropriate indicated the facility would have a Registered staffing/RN coverage 8 hours daily/ Nurse (RN) at least 8 hours a day, and 7 days a 7 days a week week. The administrator and director of nursing were educated on the 3.1-17(b)(3)requirement of F727 4. How the corrective actions will be monitored: Daily review of staffing patterns to ensure RN coverage for 8 consecutive hours 7 days each week The results of these audits will be reviewed in the monthly quality assurance meeting for 6 months or until 100% is achieved x3 consecutive months. c. The QA committee will identify any trends or patterns and make recommendations to revise the

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plan of correction as indicated.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		· ′	JILDING	CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED 10/09/2024			
		100704	D. W1			10/09/	2027
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD MAIN ST		
WALDRO	ON REHABILITATIO	ON AND HEALTHCARE CENTER			RON, IN 46182		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					5 DOC 10-28-2024		
F 0802	483.60(a)(3)(b)						
SS=E		Support Personnel					
Bldg. 00	,						
=			F 08	302	802 E		10/28/2024
	Based on observation	on, interview, and record					
	review, the facility	failed to have knowledgeable			The facility request paper		
		ing a chemical dishwasher for 6			compliance for this citation		
		vees reviewed for kitchen.			This Plan of Correction is the		
		Cook 4, Cook 5, Dietary Aid 6,			center's credible allegation of		
	Dietary Aid 7, and	Dietary Aid 8)			compliance. Preparation and/		
					execution of this plan of corre		
		en was conducted with Cook 4			does not constitute admission		
		a.m. Cook 4 indicated she was			agreement by the provider of	the	
		ishwasher strip testing should			truth of the facts alleged or		
		ed Cook 4 was using the wrong			conclusions set forth in the		
		the chemical dishwasher. She			statement of deficiencies. The)	
		proper temperatures that Cook 4 did not know what the			plan of correction is prepared	aa it	
		dings should be for chemical			and/or executed solely because is required by the provisions of		
	sanitization parts po				is required by the provisions of federal and state law	וו	
	samuzanon parts po	er minion (ppin).			F 802		
	During an observat	ion of the chemical dishwasher			1 002		
		anager (DM) on 10/3/24 at			1. Immediate actions taken fo	r	
		s using the wrong chemical			those residents identified:		
	-	the chemical dishwasher. An			No residents were identified to	0	
		as being read and the DM did			have been affected		
	not know why.				2. How the facility identified of	ther	
					residents:		
	-	w with the DM on 10/3/24 at			All residents are at risk to be		
		dicated high temperature logs			affected by the deficient pract	ice.	
	~ `	the chemical dishwasher, but			3. Measures put into		
	_	as not being logged and			place/system changes:		
		icated, we test daily, we just			The director of food services a		
	did not start a log fo	or chemical monitoring.			all dietary staff were educated	d on	
		tal al. Ad. Chin.			the requirements of F802		
		v with the Administrator on			All dietary staff were educated	d on	
	10/4/24 at 11:00 a.i	m., they indicated education on			the usage of the dishwasher.		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/09/2024			
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	505 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST PRON, IN 46182	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	service man when h Dietary Manager co was provided to the The Dietary Policy provided by the Adr p.m., indicated, "I dishwasher/spray ty chemicals to sanitiz temperatures of 120	and Procedure Manual ministrator, on 10/4/24 at 1:00 ow temperature pe dish machines using e should have wash degrees Fahrenheit and final ould read 50 parts per million		All new and on coming dietary staff will be checked off on the job duties. 4. How the corrective actions be monitored: All dietary staff educated on the usage of the dishwasher and checked off on job specific orientation. The results of these audits with reviewed in the monthly quality assurance meeting for 6 monor until 100% is achieved x3 consecutive months. The QA committee will identify any trends or patterns and material recommendations to revise the plan of correction as indicated 5. DOC 10-28-2024	will he II be ty ths
F 0812 SS=F Bldg. 00	Based on observation review, the facility of dishwasher was test daily per their expediocumentation of suppotential of affect at the facility. Based on observation review, the facility temperatures for put	e/Prepare/Serve-Sanitary on, interview, and record failed to ensure a chemical ed/monitored three times etations and to maintain uch monitoring. This had the ll 47 residents who resided in on, interview, and record failed to maintain holding reed foods for 5 of 5 residents ods. (Resident 18, 26, 34, 39,	F 0812	F 812F The facility request paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/execution of this plan of corredoes not constitute admission agreement by the provider of 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 required by the provisions of federal and state law	for section or the sec it

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIF A. BUILDIN B. WING		nstruction <u>00</u>	(X3) DATE COMPL 10/09/	ETED	
	PROVIDER OR SUPPLIEI DN REHABILITATIO	N AND HEALTHCARE CENTER	50	5 N M	DDRESS, CITY, STATE, ZIP COD IAIN ST ON, IN 46182		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	ΊΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	1. A tour of the kit 10/3/24 at 12:00 p.s (DM). During an old dishwasher, the onl monitoring of the demperatures only fitimes a day. The Diwas a chemical/low not a high temperature.	chen was conducted, on m., with the Dietary Manager observation of the chemical y documentation log for ishwasher was obtaining for wash and rinse cycles three M indicated the dishwasher we temperature dishwasher and ure dishwasher. The DM y used a chemical solution for	IA	u	1. Immediate actions taken for those residents identified: No residents were identified thave been affected 2. How the facility identified of residents: All residents are at risk to be affected by the deficient praction. 3. Measures put into	o her	DATE
	1:17 p.m., they indithe chemicals daily they were not recor was changed over for chemical/low temp and they continued only and did not ad indicated it was the responsible for the million (ppm) being The Dietary Policy provided by the Adp.m., indicated the staff will monitor a temperatures and S	with the DM on 10/7/24 at cated the facility was testing on the dishwasher before, but ding them. The dishwasher from a high temperature to a cerature a couple months ago with the temperature logs d a chemical log. The DM dietary aid who was testing of chemical parts per g conducted on the dishwasher. and Procedure Manual ministrator, on 10/4/24 at 1:00 following, " the dishwashing and record dish machine antizer PPM to assure proper. The director of food and			place/system changes: . Temperatures will be reviewed times a week for 4 weeks ther times a week for 4 weeks ther reduce down to weekly. The director of food services all dietary staff were educated the chemical procedure of the dishwasher. The director of food services all dietary staff were educated the hold temperatures of pure food. All dietary staff educated on the new dishwasher log to be use daily. The director of food services all dietary staff were educated all dietary staff were educated all dietary staff were educated.	n 3 n will and l on and l on ed he d	
	nutrition services w machine for the sta and Sanitizer PPM. 2. A tour of the kite at 11:15 a.m., with of the pureed food was noted that pure	rill post a log near the dish ff to document temperatures			the requirements of F812 4. How the corrective actions to be monitored: . Weekly review of audits on the hold temperatures for pureed meals. . Dishwasher log to be completedaily	will ne	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> C			3) DATE SURVEY COMPLETED	
		155704	B. WING		10/09	/2024
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	505 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST PRON, IN 46182		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	_	. The pureed apple butter pork		The results of these audits w		
	_	emperature of 118 degrees		reviewed in the monthly qualit	-	
	· ·	pureed mashed potatoes had a		assurance meeting for 6 month	ths	
	holding temperatur	e of 118 degrees Fahrenheit.		or until 100% is achieved x3		
	A14:	s noted of pureed food		consecutive months.	:c .	
		ored in a hot water container.		. The QA committee will ident any trends or patterns and ma	•	
		they did not have room to		recommendations to revise th		
		erving line, they held the		plan of correction as indicated		
		arate container off the serving		plan of correction as indicated	4.	
	_	on the bottom of it to keep the		5. DOC 10-28-2024		
		indicated she would heat the		0.000 10 20 2021		
		microwave before serving it to				
	the residents.	C				
	provided by the Ad p.m., indicated the of all food items wi recorded prior to se food items must be	and Procedure Manual ministrator, on 10/4/24 at 1:00 following, " the temperatures ill be taken and properly ervice of each meal. All hot cooked to appropriate internal and served at a temperature of s Fahrenheit"				
	3.1-21(i)(3)					

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