STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST 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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 3, 4, 7, 8, and 9, 2024 Facility number: 000423 Provider number: 155704 AIM number: 100290450 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicaid: 35 Other: 12 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 11, 2024.	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 Health 505 N Main St Waldron, IN.46182 Dear Ms. Buroker: On October 3, a recertification and State Licensure Survey 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. Please consider this letter and Plan of Correction to be the facility's credible allegation of paper compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction as of November 8, 2024 Respectfully submitted, Nicole Clapp Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Cherry	HFA	10/25/2024

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to promote residents' dignity by ensuring privacy for a resident during toileting and providing incontinent care in a timely manner for 2 of 2 residents reviewed for dignity. (Resident 23 and Confidential Resident) Findings include: 1. During an observation on 10/8/24 at 12:13 p.m., Qualified Medication Aide (QMA) 1 and Certified Nurse Aide (CNA) 2 assisted Resident 23 to the toilet in the shower room. QMA 1 and CNA 2 indicated they left Resident 23 in the bathroom alone, because the resident preferred privacy. The shower room had hooks for a privacy curtain, but did not have a privacy curtain hanging to provide privacy to the hallway. QMA 1 and CNA 2 did not know what happened to the privacy curtain. The shower room door was opened four times while the resident was using the restroom, exposing the resident to the hallway. During an interview with the Maintenance Director on 10/8/24 at 12:26 p.m., they indicated it was laundry staff's responsibility to ensure the privacy curtains were in place. During an interview with the Maintenance Director on 10/8/24 at 12:32 p.m., they indicated laundry staff had taken the privacy curtains down, on 10/7/24, to wash them and they were putting the curtains back up at that time. During an interview with the Director of Nursing (DON) on 10/9/24 at 1:09 p.m., they indicated	F 0550	F 550 D Resident Rights **The facility requests 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 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.** **1 Immediate actions taken for those residents identified:** Residents # 23 was assessed for incontinence needs and development of toileting plans. Resident# Confidential: Facility wide audit completed. Care plans were reviewed and revised as approp1·iate related to incontinent needs. **2 How the facility identified other residents:** Any resident had the potential to be affected. Audit was conducted to identify those residents that are incontinent. Interviews were	10/28/2024

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	Resident 23 not having the privacy curtain up during toileting 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 bowel and bladder, and dependent on staff for assistance with toileting. The most recently revised care plans, last revised in August of 2024, indicated the resident was incontinent of bladder and was at risk for skin break down related to incontinence. An intervention was to provide the resident with scheduled toileting upon rising, before and after meals, and before bed, as well as incontinence care as needed. 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 confidential resident indicated they "almost always" know when they must relieve their bowel and bladder, but they cannot get assistance to the bathroom 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 "embarrassed".		conducted for proper use of privacy curtains. Issues identified were addressed with re-education. **3 Measures put into place/ System changes:** Education provided to facility staff on resident rights/dignity, incontinent care and proper use of privacy curtains. Care plans were updated as required for those residents identified to be incontinent. **4 How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee with administrative oversight. Use of privacy curtain/ resident rights and dignity audits will be conducted per Director of Nursing/designee 3 times weekly to include all shifts. Interview will be conducted with 3 residents weekly to determine incontinent care is being provided. Identified issues will result in immediate investigation and reeducation. Residents will be assessed quarterly and annually and with significant change to determine appropriate provision of incontinent care. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	During a confidential staff interview conducted during the survey, they indicated they attempt to get everything done, but they cannot always get all the residents toileted and showered due to not having enough "help". A policy entitled, "Resident Rights", was provided by the Director of Nursing on 10/8/2024 at 1:50 p.m. The policy indicated, " ...Residents have the right to a dignified existence ..." and " ...to be treated with considerations, respect, and recognition of their dignity ..." 3.1-3(t)		plan of correction as indicated. **5 Date of compliance:** **10-28-2024**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to hold quarterly care plan meetings for 1 of 3 residents reviewed for care plans. (Resident 8) The clinical record for Resident 8 was reviewed on 10/7/24 at 10:35 a.m. The diagnoses included, but were not limited to, chronic kidney disease, heart failure, and generalized anxiety disorder. During an interview with Resident 8 on 10/4/24 at 11:00 a.m., they indicated they did not have regular care plan meetings. A Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated Resident 8 was cognitively intact for daily decision making. The electronic health record (EHR) indicated Resident 8 had a quarterly care plan meeting, on 8/4/23, a quarterly care plan meeting, on 2/5/24,	F 0657	F657 D Care Timing and Revision 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 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. 1) Immediate actions taken for those residents identified: • Identified resident 8 was assessed, and the care plan meeting was scheduled, and	10/28/2024

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	and another quarterly care plan meeting, on 7/9/24; indicating no care plan meetings were done for six months, then not again for another five months. During an interview with the Social Service Director (SSD) on 10/7/24 at 1:31 p.m., they indicated care plan meetings were to be held quarterly, and she did not know how the quarterly meetings got missed. A Comprehensive Care Plan Policy provided by the Administrator, on 10/8/24 at 10:15 a.m., indicated, "...4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. Participate in the planning process...c. Participate in establishing the expected goals and outcomes of care...5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences...." 3.1-35(d)(2)(B)		representatives were invited. • Care plans were reviewed and revised appropriately. 2) How the facility identified other residents: • Any resident had the potential to be affected, however none were identified to have been negatively impacted. • Care plan meetings will be held in conjunction with assessments. 3) Measures put into place/ System changes: • In-service conducted for the interdisciplinary team to review scheduling and invitations to resident's representatives for participation in the care plan meetings. • Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually. • Notation will be placed in 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: • 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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			• Any issues identified will be immediately addressed. • 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 at which time the IDT can make recommendations to the plan of care. 5) Date of compliance:10+28+2024	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to utilize an assistive device of a gait belt during a transfer resulting in a fall for 1 of 2 residents reviewed for accidents. (Resident 23) Findings include: During an interview with the Director of Nursing (DON) on 10/8/24 at 11:45 a.m., they indicated Resident 23 was an extensive assist of two people for transfers, on 9/20/24, when she fell. The staff were not utilizing a gait belt during the transfer and the resident did not have any medical condition that would prevent a gait belt being used. During an observation on 10/8/24 at 12:13 p.m., Qualified Medication Aide (QMA) 1 and Certified Nurse Aide (CNA) 2 assisted Resident 23 from her wheelchair to the toilet utilizing a gait belt. The	F 0689	F689 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. 1.) What corrective actions will be accomplished for those residents found to have been affected by the practice? • Resident #23 was reviewed by the IDT and the care plan was updated with new interventions. Care will be provided by the staff following the plan of care. 2.) How will other residents having the potential to be affected by the	10/28/2024

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	resident was totally dependent of the two staff and gait belt for the transfer and the resident was bent over at the waist. During an interview with the Therapy Manager on 10/8/24 at 12:34 p.m., they indicated gait belts should be used during transfer and ambulation for all residents unless the resident was independent with ambulation and transfer. The Therapy Manager indicated a gait belt should be used for Resident 23. During an interview with the Therapy Manager on 10/8/24 at 12:40 p.m., they indicated the staff should have been utilizing a gait belt when transferring Resident 23, on 9/20/24, when she fell. Review of the record of Resident 23, on 10/9/24 at 1:27 p.m., indicated the diagnoses included, but were not limited to, vascular dementia, anxiety, weakness, unsteadiness on feet, lack of coordination, muscle wasting, and Alzheimer's disease. The plan of care for Resident 23, dated 6/4/24, indicated the resident was at risk for falls related to impaired safety awareness due to dementia, Alzheimer's disease, hypertension, right rotator cuff strain, incontinence and impaired mobility. The State Optional Minimum Data Set (MDS) assessment for Resident 23, dated 7/12/24, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of two people with transfers and toileting. The initial occurrence note for Resident 23, dated 9/20/24, indicated the resident had a witnessed fall in the bathroom. The resident was lowered down		same practice and what corrective action will be taken: All residents are at risk to be affected by the deficient practice. Review of each resident plan of care and risk for falls will be completed by the IDT on or before 11/8/24. Identified needs for assistive devices required to ensure adequate supervision and to prevent accidents will be reviewed and updates made to plan of care as needed. 3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. • Care Plans will be reviewed to 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 prevention and assistive devices • Identified issues will be addressed through re·education. • Staff educated in components of F689 and the prevention of Accidents and Hazards/ Supervision, to include intervention implementation, gait belt use and care plan updating. • Identified concerns will be addressed with 1•1 education. • Nursing staff will be educated on fall prevention and gait belt use upon hire and at least annually and prn.	

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	to the floor on her knees. There were no injuries. The Interdisciplinary (IDT) note for Resident 23, dated 9/23/24, indicated the resident was lowered to the floor in the restroom. There were no injuries or pain. The resident would be evaluated by therapy. 3.1-45(a)(2)		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. • The DON or designee will audit 5 residents 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 90% compliance or greater is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Correction 10-28-2024	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to have a Registered Nurse (RN) 8 hours a day, 7 days a week, for 5 of 5 months of RN coverage reviewed. This had the potential to affect all 47 residents that resided in the facility. Findings include: Review of the schedules provided by the Administrator, on 10/4/24 at 1:00 p.m., indicated	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 correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	10/28/2024

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	there were no RNs in the facility for seven out of 30 days in April 2024, seven out of 31 days in May 2024, four out of 30 days in June 2024, six out of 30 days in September 2024, and two out of eight days in October 2024. During an interview with the Administrator on 10/8/24 at 2:27 p.m., they verified the facility did not have RN coverage in April, May, June, September, and/or October of 2024. During an interview with the Administrator on 10/8/24 at 2:34 p.m., indicated she was not aware of any residents being affected by the facility not having an RN in the building during those months and there were no incomplete tasks that only an RN could do. The sufficient staffing policy provided by the Director of Nursing (DON), on 10/9/24 at 1:50 p.m., indicated the facility would have a Registered Nurse (RN) at least 8 hours a day, and 7 days a week. 3.1-17(b)(3)		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 1. Immediate actions taken for those residents identified: No residents were identified to have been affected 2. How the facility identified other residents: All residents are at risk to be affected by the deficient practice. 3. Measures put into place/system changes: Staffing will be reviewed daily by the administrator/ director of nursing to determine appropriate staffing/RN coverage 8 hours daily/ 7 days a week The administrator and director of nursing were educated on the 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 plan of correction as indicated.	

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			5 DOC 10-28-2024	
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel Based on observation, interview, and record review, the facility failed to have knowledgeable dietary staff regarding a chemical dishwasher for 6 of 6 dietary employees reviewed for kitchen. (Dietary Manager, Cook 4, Cook 5, Dietary Aid 6, Dietary Aid 7, and Dietary Aid 8) A tour of the kitchen was conducted with Cook 4 on 10/3/24 at 11:15 a.m. Cook 4 indicated she was not sure what the dishwasher strip testing should read. It was observed Cook 4 was using the wrong testing strips to test the chemical dishwasher. She also was unsure of proper temperatures that should be recorded. Cook 4 did not know what the temperatures or readings should be for chemical sanitization parts per million (ppm). During an observation of the chemical dishwasher with the Dietary Manager (DM) on 10/3/24 at 12:00 p.m., she was using the wrong chemical testing strips to test the chemical dishwasher. An incorrect reading was being read and the DM did not know why. During an interview with the DM on 10/3/24 at 12:23 p.m., they indicated high temperature logs were being kept for the chemical dishwasher, but chemical testing was not being logged and monitored. She indicated, we test daily, we just did not start a log for chemical monitoring. During an interview with the Administrator on 10/4/24 at 11:00 a.m., they indicated education on	F 0802	802 E 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 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 F 802 1. Immediate actions taken for those residents identified: No residents were identified to have been affected 2. How the facility identified other residents: All residents are at risk to be affected by the deficient practice. 3. Measures put into place/system changes: The director of food services and all dietary staff were educated on the requirements of F802 All dietary staff were educated on the usage of the dishwasher.	10/28/2024

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	the new chemical dishwasher was provided by the service man when he came to install it, but the Dietary Manager could not find the education that was provided to the employees. The Dietary Policy and Procedure Manual provided by the Administrator, on 10/4/24 at 1:00 p.m., indicated, "...low temperature dishwasher/spray type dish machines using chemicals to sanitize should have wash temperatures of 120 degrees Fahrenheit and final rinse sanitization should read 50 parts per million (ppm) Hypochlorite...." 3.1-20(h)		All new and on coming dietary staff will be checked off on their job duties. 4. How the corrective actions will be monitored: All dietary staff educated on the usage of the dishwasher and checked off on job specific orientation. 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. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. DOC 10-28-2024	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure a chemical dishwasher was tested/monitored three times daily per their expectations and to maintain documentation of such monitoring. This had the potential of affect all 47 residents who resided in the facility. Based on observation, interview, and record review, the facility failed to maintain holding temperatures for pureed foods for 5 of 5 residents receiving pureed foods. (Resident 18, 26, 34, 39, and 40) Findings include:	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/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	10/28/2024

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(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
	1. A tour of the kitchen was conducted, on 10/3/24 at 12:00 p.m., with the Dietary Manager (DM). During an observation of the chemical dishwasher, the only documentation log for monitoring of the dishwasher was obtaining temperatures only for wash and rinse cycles three times a day. The DM indicated the dishwasher was a chemical/low temperature dishwasher and not a high temperature dishwasher. The DM indicated the facility used a chemical solution for the dishwasher. During an interview with the DM on 10/7/24 at 1:17 p.m., they indicated the facility was testing the chemicals daily on the dishwasher before, but they were not recording them. The dishwasher was changed over from a high temperature to a chemical/low temperature a couple months ago and they continued with the temperature logs only and did not add a chemical log. The DM indicated it was the dietary aid who was responsible for the testing of chemical parts per million (ppm) being conducted on the dishwasher. The Dietary Policy and Procedure Manual provided by the Administrator, on 10/4/24 at 1:00 p.m., indicated the following, "... the dishwashing staff will monitor and record dish machine temperatures and Sanitizer PPM to assure proper sanitizing of dishes. The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures and Sanitizer PPM...." 2. A tour of the kitchen was conducted, on 10/3/24 at 11:15 a.m., with Cook 4. During an observation of the pureed food temperatures being obtained, it was noted that pureed mixed vegetables were recorded with a holding temperature of 118		1. Immediate actions taken for those residents identified: No residents were identified to have been affected 2. How the facility identified other residents: . All residents are at risk to be affected by the deficient practice. 3. Measures put into place/system changes: . Temperatures will be reviewed 5 times a week for 4 weeks then 3 times a week for 4 weeks then will reduce down to weekly. The director of food services and all dietary staff were educated on the chemical procedure of the dishwasher. The director of food services and all dietary staff were educated on the hold temperatures of pureed food. All dietary staff educated on the new dishwasher log to be used daily. The director of food services and all dietary staff were educated on the requirements of F812 4. How the corrective actions will be monitored: . Weekly review of audits on the hold temperatures for pureed meals. . Dishwasher log to be completed daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	10/09/2024

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	degrees Fahrenheit. The pureed apple butter pork loin had a holding temperature of 118 degrees Fahrenheit and the pureed mashed potatoes had a holding temperature of 118 degrees Fahrenheit. An observation was noted of pureed food containers being stored in a hot water container. Cook 4 indicated if they did not have room to store food on the serving line, they held the containers in a separate container off the serving line with hot water on the bottom of it to keep the food warm. Cook 4 indicated she would heat the pureed food in the microwave before serving it to the residents. The Dietary Policy and Procedure Manual provided by the Administrator, on 10/4/24 at 1:00 p.m., indicated the following, "... the temperatures of all food items will be taken and properly recorded prior to service of each meal. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit...." 3.1-21(a)(2) 3.1-21(i)(2) 3.1-21(i)(3)		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. . The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. DOC 10-28-2024	