STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155704	A. BUILDING -- B. WING	10/31/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/31/24 Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450 At this Emergency Preparedness survey, Waldron Rehabilitation and Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 71 certified beds. At the time of the survey, the census was 45. Quality Review completed on 11/06/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/31/24 Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450 At this Life Safety Code survey, Waldron	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Cherry	HFA	11/19/2024

Any defiencystatement 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 disclo 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.

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	Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridor and in spaces open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 45 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden garage and wooden shed which were not sprinkled. Quality Review completed on 11/06/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents,	K 0222	**K222** **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	11/15/2024

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	staff and visitors if needing to exit the facility from the back gate. Findings include: Based on observations with the Executive Director and the Senior Maintenance Director during a tour of the facility from 12:25 p.m. to 1:55 p.m. on 10/31/24, the exit door in the facility by resident sleeping Room 35A was marked as a facility exit with an exit sign. The exit door was magnetically locked and could be unlocked by entering a code at a keypad by the door to release the door to open. The correct code to release the door to open was posted at the keypad. The exit discharge for the facility by Room 35A was into a fenced courtyard with one exit gate to the public way in the fenced courtyard. The gate was magnetically locked and could be unlocked by entering a code at a keypad by the door to release the door to open. The incorrect code to release the gate to open was posted at the keypad as the posted code did not release the gate to open. Based on interview at the time of the observations, the Senior Maintenance Director stated he did have the correct code posted but the rain washed it away and agreed the incorrect code was posted at the back gate exit discharge to the public way. These findings were reviewed with the Executive Director and the Senior Maintenance Director during the exit conference. 3.1-19(b)		forth in the statement of deficiencies. The plan of correction is prepped and or executed solely because it is required by the provision of federal and state law. **1 Immediate actions taken for those residents identified:** a No residents were found to be affected by the finding. The correct code not posted at the back gate. **2 How the facility identified other residents:** a Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3 Measures put into place/systems changed** a The correct and current code were updated on the gate. The maintenance director/ designee, have been in serviced. Will complete log to check off the other employee changing codes. **4 How the corrective action will be monitored:** a The maintenance director/designee will present these audits to the QAPI committee during QAPI meetings to ensure completion and compliance. The results of these audits will be reviewed in quality assurance meeting monthly from 6 months or until 100%compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of corrections as	

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			indicated. **5 Date of compliance is: 11/15/24**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to a shutoff switch for 1 of 1 cook tops in the Therapy Room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could affect over 5 residents, staff and visitors in the Therapy Room. Findings include:	K 0324	**K324**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 prepped and or executed solely because it is required by the provision of federal and state law.1 Immediate actions taken for those residents identified: No residents were found to be affected by the finding. The shut off for therapy stove does not have ability to be locked.2 How the facility identified other residents:Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice.3 Measures put into place/systems changedThe maintenance director/ designee and therapy all in serviced.Lock placed on cabinet. Lock to be checked 3 times a week for one month, then 2 times a week for monthly, then monthly there after	11/15/2024

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	Based on observations with the Executive Director and the Senior Maintenance Director during a tour of the facility from 12:25 p.m. to 1:55 p.m. on 10/31/24, there was an electric cooktop in the Therapy Room that was separated from the corridor but there was no lockable switch or a switch located in a restricted location that deactivates the cooktop whenever the kitchen is not under staff supervision. No switch on a timer, not exceeding 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action could be located. Based on interview at the time of the observations, the Senior Maintenance Director stated the electrical shutoff for the oven is two circuit breakers located in an unlocked cabinet above the stove which were not lockable and not on a timer. These findings were reviewed with the Executive Director and the Senior Maintenance Director during the exit conference. 3.1-19(b)		if at 100%. Stove was disconnected with the electrical cord being disassembled rendering it inoperable and no longer in use. 4 How the corrective action will be monitored:The maintenance director/designee will present these audits to the QAPI committee during QAPI meetings to ensure completion and compliance. The results of these audits will be reviewed in quality assurance meeting monthly from 6 months or until 100% compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of corrections as indicated. 5 Date of compliance is: 11/15/24	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the main dining room. Findings include: Based on observations with the Executive Director and the Senior Maintenance Director	K 0363	**K363** **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	11/15/2024

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	during a tour of the facility from 12:25 p.m. to 1:55 p.m. on 10/31/24, the following was noted: a. the corridor door to resident sleeping Room 16 and the corridor door to resident sleeping Room 22 were each propped in the fully open position with a trash can placed on the floor up against the door. b. the corridor door to the kitchen from the main dining room was equipped with a self closing device and latching hardware but the door failed to self close and latch into the door frame when tested to close multiple times due to air flow in the kitchen caused by the operating kitchen range hood fan. When the fan for the kitchen range hood was turned off, the kitchen door self closed and latched into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Senior Maintenance Director agreed the aforementioned three corridor doors each had an impediment to latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director and the Senior Maintenance Director during the exit conference. 3.1-19(b)		deficiencies. The plan of correction is prepped and or executed solely because it is required by the provision of federal and state law. **1 Immediate actions taken for those residents identified:** a No residents were found to be affected by the finding. Trash can used to prop room 16 and 22 corridor doors. The kitchen door to dinning room won't fully self close/latch into door frame with the fan on. **2 How the facility identified other residents:** a Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3 Measures put into place/systems changed** a The maintenance director/ designee, readjusted doors and complete audit for 3 months and then monthly **4 How the corrective action will be monitored:** a The maintenance director/designee will present these audits to the QAPI committee during QAPI meetings to ensure completion and compliance. The results of these audits will be reviewed in quality assurance meeting monthly from 6 months or until 100%compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of corrections as	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. Findings include:	K 0920	**K920** **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 prepped and or executed solely because it is required by the provision of federal and state law. **1 Immediate actions taken for those residents identified:** a No residents were found to be affected by the finding. Power strip usage for PCREE and non-PCREE **2 How the facility identified other residents:** a Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. **3 Measures put into place/systems changed** a Power strips in room 21 and 41 were corrected to the	11/15/2024

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	Based on observations with the Executive Director and the Senior Maintenance Director during a tour of the facility from 12:25 p.m. to 1:55 p.m. on 10/31/24, the following was noted: a. a refrigerator and a lamp were plugged into a power strip placed on the floor under the resident bed nearest the corridor door to resident sleeping Room 21. The UL listing of the power strip could not be determined. b. a nebulizer, a lamp and an operating fan were plugged into a power placed on the floor under the bed nearest the window in resident sleeping Room 41. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Senior Maintenance Director agreed power strips were being used in the patient care vicinity for PCREE and non-PCREE and were also being used as a substitute for fixed wiring in the aforementioned two resident sleeping rooms. These findings were reviewed with the Executive Director and the Senior Maintenance Director during the exit conference. 3.1-19(b)		appropriate outlets. b The maintenance director/ designee, have done a full house audit of power strips and then will audit strips 3 times a week for a month and then twice a week for a month and then monthly there after. **4 How the corrective action will be monitored:** a The maintenance director/designee will present these audits to the QAPI committee during QAPI meetings to ensure completion and compliance. The results of these audits will be reviewed in quality assurance meeting monthly from 6 months or until 100%compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of corrections as indicated. **5 Date of compliance is: 11/15/24**	