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	12/08/2023

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 the Investigation of Complaints IN00422935 and IN00421548. Complaint IN00422935 - No deficiencies related to the allegations are cited. Complaint IN00421548 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: December 7 and 8, 2023 Facility number: 000423 Provider number: 155704 AIM number: 100290450 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 8 Medicaid: 32 Other: 9 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2023	F 0000		
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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

Nicole Clapp | ED | 12/19/2023

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.

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	12/08/2023

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
	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	12/08/2023

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
	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 4 of 40 residents observed during a random observation. (Residents 14, 31, 35, and 29). Findings include: The clinical record for Resident 14 was reviewed on 12/8/23 at 11:54 a.m. indicated, the resident tested positive for COVID-19 on 12/7/23 and was on contact droplet isolation for 10 days.	F 0880	**F880 E Infection Control** 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	12/20/2023

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	12/08/2023

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
	The clinical record for Resident 31 was reviewed on 12/8/23 at 11:58 a.m. indicated, the resident tested positive for COVID-19 on 12/7/23 and was on contact droplet isolation for 10 days. Resident 14 and Resident 31 were roommates. The clinical record for Resident 35 was reviewed on 12/8/23 and was on strict isolation for contact droplet isolation related to a positive COVID-19 status. Resident 35 was roommates with Resident 29. An interview with ED (Executive Director) conducted on 12/8/23 at 12:25 p.m. indicated, Resident 35 had tested positive for COVID-19 on 12/4/23. She further indicated, Resident 29 had tested negative for COVID-19 on 12/4/23, but refused to leave his room and chose to stay in his room with his roommate, Resident 35. During random observation conducted on 12/8/23 at 10:58 a.m., a meal tray cart had been wheeled onto the hallway. CNA (certified nursing assistant) 2 pulled a tray out of the cart, set it down on the isolation station outside of Residents 14 and 31's room; donned an isolation gown, gloves, and a N95 face mask; picked up the lunch tray; and entered into the residents' room. CNA 2 did not don eye protection prior to entering the room which was clearly marked as a contact droplet isolation room. When entering the room, it was observed that used PPE (personal protective equipment) was hanging just inside the room and next to the door. Upon exiting their room, CNA 2 had the tray in her hand and placed it on top of the isolation station cart outside of the room. She then took a disinfectant wipe and wiped the tray down and placed the tray on the top of the meal cart. CNA 2 did not wipe down the top of the isolation cart after placing the		executed solely because it is required by the provisions of federal and state law. **1 Immediate actions taken for those residents identified:** Resident 14, 31, 35, and 29 was assessed, orders reviewed care plan updated. Residents have had no change of condition since observation of 12/8/23. **2 How the facility identified other residents:** Any resident had the potential to be affected, no resident was identified. **3 Measures put into place/ System changes:** The staff was educated on infection control procedures related to resident care for those residents who are positive for Covid-19. CNA 2 and staff educated on infection control procedures related to meal pass to those residents with isolation precautions along with proper eye wear when entering an isolation room. Styrofoam meal trays purchased for residents on isolation precautions. CNA 3 and staff educated on how to properly wear N95 mask and proper eye protection when entering an isolation room. Isolation carts were	

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	12/08/2023

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
	potentially contaminated meal tray on it. At the same time as the previous observation, CNA 3 had pulled a tray out of the meal cart and placed it on top of the isolation cart in front of Residents 35 and 29's room. CNA 3 donned an isolation gown, gloves, and a N95 mask over her surgical face mask, grabbed the meal tray and entered the room. CNA 3 did not don eye protection prior to entering the room which was clearly marked as a contact droplet isolation room. Upon exiting the residents' room, she had the tray in hand and placed it on top of the isolation station located just outside their room. CNA 3 proceeded to wipe the tray down with a disinfectant wipe and then placed the tray on the top of the meal cart. CNA 3 did not wipe down the top of the isolation cart after placing the potentially contaminated meal tray on it. An interview with ED conducted on 12/8/23 at 11:39 a.m. indicated, the facility should not be re-using any PPE at this time as the supply levels were not in contingency status. The Centers for Disease Control and Prevention (CDC) COVID Data Tracker (https://covid.cdc.gov/covid-data-tracker/#datatracker-home <https://covid.cdc.gov/covid-data-tracker/>), accessed on 12/11/23 indicated the county's hospital admission level was low. The CDC (Centers for Disease and Control) website, accessed on 12/11/23, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Updated May 8, 2023" indicated, "If they are used during the care of patient for which a NIOSH		cleansed with facility disinfectant wipes per guidelines. Facility staff were educated on discarding PPE when leaving an isolation room. Facility staff will be educated upon hire, at least annually and prn on infection control/ PPE. **4 How the corrective actions will be monitored:** The Director of Nursing / designee will be the responsible party for this plan of correction. Observational Audits will be conducted 3 times weekly to include all shifts for proper donning and doffing of PPE. Observational Audit will be conducted 3 times weekly to include all meals for proper infection control process during meal pass. 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. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **Quality Indicator:** **INFECTION CONTROL PATIENT & STAFF SURVEILLANCE** **Threshold:**	

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	12/08/2023

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
	Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned....HCP [healthcare providers]who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).' The CDC (Centers for Disease and Control) website, accessed on 12/11/23,"How to Use Your N95 Respirator" last updated Mar. 16, 2022, indicated, "Your N95 must form a seal to your face to work properly. Your breath must pass through the N95 and not around its edges. Jewelry, glasses, and facial hair can cause gaps between your face and the edge of the mask. The N95 works better if you are clean shaven. Gaps can also occur if your N95 is too big, too small, or it was not put on correctly." An Infection Control Manual, effective date 6/5/2023, was received on 12/8/23 at 11:45 a.m. from ED, indicated, "The PHE[public health emergency] ended on 5/11/23 and this guidance serves as a framework for the facility to continue to implement core infection prevention and control practices to assist in the on-going effort to prevent and contain any COVID-19 outbreaks...Supplies necessary to adhere to hand hygiene or other source control/PPE are readily available in all areas of the facility where care is		**100** % **Recommended Frequency: 3 TIMES WEEKLY** ***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.* **Indicator** **Y** **N** **N/A** **Comments** 1	

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	12/08/2023

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
	being delivered...COVID-19 Positive Facility Case...16. The RED stop sign for Covid-19 will be placed on the Covid-19 positive residents' door to communicate to staff and visitors the required use of PPE. To enter the positive resident's room an N95, gloves, eye protection, and gown are required for every entrance into the room." 3.1-18(b)		Employees are observed using alcohol gel if hands are not visibly soiled or washing hands if visibly soiled before and after resident care and after removing gloves? 2 Staff is using proper hand washing technique? (friction for at least 20 seconds, turn off water with clean paper towel, etc.) 3 N95 mask is donned and doffed correctly when entering and exiting an isolation room? 4 PPE is donned correctly (eye protection, gown, gloves and N95 mask) when entering an isolation room? 5 PPE is doffed and discarded correctly when exiting an isolation room and a surgical mask is donned? 6	

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	12/08/2023

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
			Meals are passed with all disposable products to residents in isolation room? 7 Meals are taken from meal cart straight to isolation room without sitting tray down before entering? 8 Proper PPE (gown, gloves, N95, eye protection) is donned and doffed and discarded after doffing during meal pass when passing meals to a resident in isolation room? 9 10 11 Percentage of Compliance =	

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	12/08/2023

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
			(# of yes responses x 100) = Percentage of Compliance: ____ Total # Responses Threshold Met? Yes No Signature of Assessor Date	