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	05/28/2025

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 IN00458155, IN00458168, IN00458641, IN00459777, and IN00459780. Complaint IN00458155 - No deficiencies related to the allegations are cited. Complaint IN00458168 - No deficiencies related to the allegations are cited. Complaint IN00458641 - No deficiencies related to the allegations are cited. Complaint IN00459777 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00459780 - Federal/State deficiencies related to the allegations are cited at F842. Survey dates: May 25, 27, and 28, 2025 Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicaid: 40 Other: 9 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**6-11-2025 ISDHATT: Suzanne WilliamsDirector of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 CCN/Provider Number:155704AIM Number: 1200290450Facility ID: 00423Survey Event ID - Re: Complaint SurveyWaldron Rehabilitation and Health 505 N Main StWaldron, IN.46182 Dear : Suzanne Williams On May 28, 2025 a Complaint Survey E9 1C11 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 compliance.We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 06/11/25. Please feel free to call me with any further questions. 1-765-525-4371. Respectfully submitted,Nicole CherryExecutive Director**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Cherry		06/11/2025

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	05/28/2025

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 0842 SS=D Bldg. 00	Quality review completed on May 30, 2025. 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate, related to care-planned arguing between 2 of 6 residents reviewed for possible abuse allegations and for 1 of 5 residents reviewed for activities programming. (Resident C, Resident D, and Resident H) Findings include. 1. The clinical record of Resident C was reviewed on 5-27-25 at 11:06 a.m. Her most recent Minimum Data Set assessment, dated 4-12-25, indicated she was cognitively intact. An entry in the progress notes, on 5-12-25 at 6:05 p.m., indicated Resident C "had fight with" Resident H during supper, "that brought one of them cussing and walked away." The documentation was unclear regarding what constituted a fight, if it was physical or verbal, who was cursing, the negative impact of the interaction, nor what actions were taken by facility staff during or after the interaction. The clinical record of Resident H was reviewed on 5-28-25 at 10:55 a.m. Her most recent Minimum Data Set assessment, dated 4-15-25, indicated she was cognitively intact. An entry in the progress notes, on 5-12-25 at 6:00 p.m., indicated Resident H "had fight with" Resident C during supper, "that brought one of them cussing and walked away." The documentation was unclear regarding what constituted a fight, if it was physical or verbal, who was cursing, the negative impact of the interaction, nor what actions were taken by	F 0842	**F 842 D RESIDENT RECORDS-IDENTIFIABLE INFORMATION** **The facility respectively requests a desk review 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:**	06/11/2025

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	05/28/2025

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
	facility staff during or after the interaction. During an interview on 5-27-25 at 1:31 p.m. with the Director of Nursing (DON), she indicated the staff member who documented the interaction between Resident C and Resident H was a Registered Nurse (RN) for whom English was not his native language "and his charting and wording and English can be a problem at times." The DON provided an example of a charting problem on a different resident where RN 3 was trying to say the resident was annoyed, but he documented the resident was "annoying." During an interview with the Executive Director (ED) on 5-27-25 at 2:03 p.m., she indicated RN 3 does have "broken English." During a phone interview with RN 3 on 5-28-25 at 11:40 a.m., he indicated English was his second language and sometimes had difficulty with wording in his chart documentation. He indicated on the date in question, the dietary staff had informed him they overheard Resident C and Resident H arguing with each other, as well as these two residents had a history of doing this type of behavior. The management team was aware of this, and it needed to be reported to Social Services. He indicated he sought advice from his co-workers and was informed he needed to report their behaviors to Social Services and document the event in the clinical record. He indicated from what he was aware of with these two residents, the arguing was a common behavior between both residents. During an interview with the DON and the ED on 5-28-25 at 11:40 a.m., the DON indicated she had worked with RN 3 "quite a bit in regards to wording of documentation. For example, I		·Resident C and H care plans were reviewed and updated. ·Nurse was given a teachable moment education for documentation to include but not limited to: documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. ·Resident D plan of care was reviewed to include activities and updated. ·Activity Director in-serviced on documentation accuracy and completion. **2)How the facility identified other residents:** A facility audit was completed 6/4/25 ·Any identified issues were immediately corrected. **3)Measures put into place/ System changes:** Education provided to nursing staff and Activity staff on the requirements of F842 and the provision for documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. **4)How the corrective actions will be monitored:**	

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	05/28/2025

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
	addressed with him using the phrase a resident's actions were annoying to him, when what he meant was the resident had been annoyed. He is normally very good to reach out to me or his co-workers for clarification of terminologies. We review all documentation each morning in our morning meeting to review any care or resident issues... I would say the term, 'fight,' would not be the most accurate word to use for their interaction." The ED indicated both residents were care planned for bickering with one another. She indicated when she spoke with Resident C the next day, Resident C indicated Resident H "was wanting to become verbal, so she [Resident C] chose to just walk away. She did say that she did mumble curse words while she was walking down the hall, but definitely did not yell or curse out loud. There was no physical contact with anyone." In an interview with Resident C on 5-27-25 at 10:30 a.m., she indicated she had no concerns for abuse of any kind. She added there are times that "some people may have words, but then end up being friends again, just like family." In an interview with Resident H on 5-28-25 at 1:50 p.m., she indicated she had no concerns related to any type of abuse at the facility. Resident H indicated there were times that she and a peer have words one day and get upset with each other, "just like with family, but the next day, everything is fine." 2. The clinical record for Resident D was reviewed on 5/27/2025 at 1:45 p.m. The medical diagnoses included major depressive disorder and diabetes. A Quarterly Minimum Data Set assessment, dated 3/7/2025, indicated Resident D was cognitively		The responsible party for this plan of correction is the Executive Director/Director of Nursing/Activity Director who will audit 3 times weekly for documentation in the medical record is objective (not opinionated or speculative), complete and accurate. The results of these audits will be reviewed in QAPI monthly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	05/28/2025

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
	intact and did not reject care. Documented activities for Resident D indicated she did not have documented activities for 7 out of the last 30 days provided. During an interview on 5/27/2025 at 12:01 p.m., Resident D indicated the facility had issues with maintaining activities. Resident D indicated she would attend every activity when it was available. During an interview on 5/28/2025 at 12:15 p.m., the ED indicated the activities staff were responsible for providing and documenting activities to residents. During an interview on 5/28/2025 at 12:45 p.m., the Activities Director indicated residents were provided with passive activities every day and interactive most days. She indicated Resident D comes to almost every activity unless she was out with her family, at an appointment, or not feeling well. It was the responsibility of the activities staff to document activities. A policy entitled, "Charting and Documentation", was provided by the ED on 5/28/2025 at 12:56 p.m. The policy indicated "... Documentation in the medical record will be objective (not opinionated or speculative), completed and accurate..." This citation relates to Complaints IN00459780 and IN00459777. 3.1-50(a)(1) 3.1-50(a)(2)			