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PRINTED: 09/14/2023
FORM APPROVED

09/05/2023

CENTERS FOR	MEDICARE & MEDIC.	AID SERVICES				_	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155704	A. BU B. WI	IILDING NG		COMPL 08/08/		
	PROVIDER OR SUPPLIER	I ON AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, IN 46182					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	Ι		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ļ	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
	REGULATORT OR	LISC IDENTIFTING INFORMATION		IAG			DATE	
E 0000 Bldg E 0031 SS=C Bldg	An Emergency Preponducted by the In accordance with 42 Survey Date: 08/08 Facility Number: 0 Provider Number: AIM Number: 1002 At this Emergency Rehabilitation and In not in compliance with Requirements for Marticipating Provides 483.73. The facility census of 53 at the total Quality Review conductive Complex (2), 482 483.73(c)(2), 484 485.68(c)(2), 485 486.360(c)(2), 485 486.360(c)(2), 497 Emergency Official §403.748(c)(2), §441.184(c)(2), §441.184	paredness Survey was diana Department of Health in CFR 483.73. 2/23 200423 290450 Preparedness survey, Waldron Healthcare Center was found with Emergency Preparedness Iedicare and Medicaid Iters and Suppliers, 42 CFR has a capacity of 79 and had a time of this survey. 2.15(c)(2), 418.113(c)(2), 2.15(c)(2), 483.475(c)(2), 102(c)(2), 485.625(c)(2), 727(c)(2), 485.920(c)(2), 1.12(c)(2), 494.62(c)(2) Its Contact Information It6.54(c)(2), §418.113(c)(2), It6.54(c)(2), §482.15(c)(2), It60.84(c)(2), It60.84(c)(2)	E 00		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision of federal and state law.	of n of not f or he d use		
	§483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated							
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	E	TITLE		(X6) DATE	

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 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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CENTERS FO	OR MEDICARE & MEDIC				OMB NO. 0938-039			
STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED			
		155704	B. WING		08/08/2023			
NAME OF PROVIDER OR SUPPLIER WALDRON REHABILITATION AND HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			505 N I	STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, IN 46182 ID PROVIDER'S PLAN OF CORRECTION (X5)				
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE			
	facilities]. The con include all of the five contact inform (i) Federal, State, emergency prepa (ii) Other sources *[For LTC Facilities Contact information (i) Federal, State, emergency prepa (ii) The State Lice Agency. (iii) The Office of the Ombudsman. (iv) Other sources *[For ICF/IIDs at § information for the (i) Federal, State, emergency prepa (ii) Other sources (iii) The State Lice Agency. (iv) The State Pro Agency.	nation for the following: tribal, regional, and local redness staff. of assistance. es at §483.73(c):] (2) on for the following: tribal, regional, and local redness staff. nsing and Certification the State Long-Term Care of assistance. §483.475(c):] (2) Contact of following: tribal, regional, and local redness staff. of assistance. ensing and Certification tection and Advocacy						
	Based on record rev failed to ensure the communication pla	view and interview, the facility emergency preparedness in included all applicable e. This deficient practice appants.	E 0031	E031 Emergency Officials Contact Information The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.				
	Administrator and t	view and interview with the he Maintenance Director on 0:20 a.m. and 11:56 a.m.,		Preparation and/or execution this plan of correction does a constitute admission or				

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Event ID:

documentation of the communication plan part of

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Facility ID: 000423

agreement by the provider of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/08/2023	
	PROVIDER OR SUPPLIE ON REHABILITATION	R ON AND HEALTHCARE CENTER	505 N	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, IN 46182	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
IAG	the facility's emerg did not include spe including telephone State Long Term C Administrator agre communication pla include specific coro of the State Long T emergency operation contained much inflaforementioned coro Long Term Care O in the plan at the time. This finding was ac Administrator and the time of discovered	ency operations plan reviewed cific contact information, enumber, for notification of the dare Ombudsman. The end documentation for the enter part of the program did not entact information for the office form Care Ombudsman. The consideration, however the entact information for the State entact i	IAG	the truth of the facts alleg conclusions set forth in the statement of deficiencies. plan of correction is prepared and/or executed solely be it is required by the provise of federal and state law. 1)Immediate actions taken those residents identified State Long term Care Ombudsman specific containformation was added to the Emergency Operations Plate 2)How the facility identified other residents: All residents that reside at the community have the potent be affected by the alleged of practice. 3) Measures put into place System changes: Facility has reviewed and units Emergency Preparedness with staff to include specific contact information for the Long-Term Care State Ombudsman. Facility staff been re-in serviced on the updated. 4)How the corrective action will be monitored: The Maintenance Director/designee will present monthly to the QAPI Community QAPI Meetings to encompletion of any new necoupdates and compliance. The report will be reviewed in Qaping Resulting monthly to the reviewed in Qaping Meeting monthly to th	ed or ne The ared cause sions for ct ne n d he ial to deficient e/ pdated ss Plan f have ent the Plan nittee nsure essary he uality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 08/08/2023	
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER	505 N	FADDRESS, CITY, STATE, ZIP COD MAIN ST DRON, 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 CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
ing	REGULATORY	ESC IDENTIFICATION	ind	months or until 100% con is achieved. The QA Cor will identify any trends or and make recommendation revise the plan of correction indicated. 5) Date of compliance: 08/26/2023.	nmittee patterns ons to	BATE
E 0037 SS=F Bldg	441.184(d)(1), 482 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 49 EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §48	am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)				
	Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training in policies and proce existing staff, indivunder arrangemer consistent with the (ii) Provide emergat least every 2 years.	a emergency preparedness dures to all new and viduals providing services at, and volunteers, eir expected roles. ency preparedness training ears. ementation of all emergency and staff knowledge of				

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	F OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155704		UILDING	NSTRUCTION	(X3) DATE COMPL 08/08/	ETED	
	ROVIDER OR SUPPLIER N REHABILITATIO	ON AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, IN 46182					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOTE DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	and procedures a	cy preparedness policies re significantly updated, the duct training on the and procedures.						
	The hospice must (i) Initial training ir policies and proce existing hospice e providing services consistent with the (ii) Demonstrate s emergency proced (iii) Provide emergat least every 2 ye (iv) Periodically reemergency preparemployees (including with special emphasis the procedures nearly others. (v) Maintain docur preparedness train (vi) If the emerger and procedures and p	taff knowledge of dures. gency preparedness training ears. view and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out ecessary to protect patients mentation of all emergency ning. ncy preparedness policies re significantly updated, the duct training on the						
	program. The PR following: (i) Initial training in policies and proceexisting staff, individual arrangement consistent with the (ii) After initial train							

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPL		
		155704	B. W	ING		08/08/	2023	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD MAIN ST			
WALDRO	ON REHABILITATIO	ON AND HEALTHCARE CENTER	<u>.</u>		ON, IN 46182			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	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	
	` '	staff knowledge of						
	emergency procedures. (iv) Maintain documentation of all emergency							
	preparedness trai							
		icy preparedness policies						
	, ,	re significantly updated, the						
	· ·	uct training on the updated						
	policies and proce	- ·						
	ponoiso and prossuance.							
	-	60.84(d):] (1) The PACE						
	organization must do all of the following: (i) Initial training in emergency preparedness							
	policies and procedures to all new and							
		viduals providing on-site						
		rangement, contractors,						
		volunteers, consistent with						
	their expected role	es. Jency preparedness training						
	at least every 2 ye							
		staff knowledge of						
	' '	dures, including informing						
		at to do, where to go, and						
		n case of an emergency.						
	(iv) Maintain docu	mentation of all training.						
	(v) If the emerger	ncy preparedness policies						
		re significantly updated, the						
		uct training on the updated						
	policies and proce	edures.						
	*IFor LTC Facilitie	es at §483.73(d):] (1)						
	_	. The LTC facility must do all						
	of the following:	- ,						
	_	n emergency preparedness						
	policies and procedures to all new and							
	existing staff, individuals providing services							
	under arrangement, and volunteers,							
	consistent with their expected role.							
		ency preparedness training						
	at least annually.							
	(iii) Maintain documentation of all emergency							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/08/2023		
		ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		505 N M	DDRESS, CITY, STATE, ZIP COD IAIN ST ON, IN 46182		
	(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		preparedness trail (iv) Demonstrate s emergency proces	staff knowledge of					
		CORF must do all (i) Provide initial tr preparedness poli new and existing s services under arr consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docur (iv) Demonstrate s emergency proced must be oriented a responsibilities rec emergency plan w workday. The train instruction in the le systems and signal equipment. (v) If the emerge and procedures an CORF must condu- policies and proced *[For CAHs at §48 program. The CAH	raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. eency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting ency preparedness policies re significantly updated, the uct training on the updated					
		following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers,						

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155704	1	ILDING NG	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/08/2023	
	OF PROVIDER OR SUPPLIEF	ON AND HEALTHCARE CENTER		505 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, 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	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(ii) Provide emerg at least every 2 ye (iii) Maintain docu (iv) Demonstrate semergency proceed (v) If the emerge and procedures a CAH must conduct policies and procedures and procedures and procedures and procedures to all individuals providical arrangement, and their expected roled documentation of must demonstrate emergency procedures to all individuals providically provided and their expected roled documentation of must demonstrate emergency procedures trail Based on record revisible facility must do all training in emergency procedures to all neindividuals providical and volunteers, con roles; (ii) Provide etraining at least and documentation of a training; (iv) Demolemergency procedures described and training; (iv) Demolemergency procedures and training; (iv) Demolemergency procedures and training; (iv) Demolemergency procedures and training at least and documentation of a training; (iv) Demolemergency procedures and training at least and documentation of a training; (iv) Demolemergency procedures and training at least and documentation of a training; (iv) Demolemergency procedures and training at least and documentation of a training at least and documentation	mentation of the training. staff knowledge of dures. ncy preparedness policies re significantly updated, the et training on the updated edures. 485.920(d):] (1) Training. provide initial training in redness policies and new and existing staff, ng services under volunteers, consistent with es, and maintain the training. The CMHC e staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. view and interview, the facility mual training for the edness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and ew and existing staff, ng services under arrangement, sistent with their expected mergency preparedness nually; (iii) Maintain Il emergency preparedness nistrate staff knowledge of cres in accordance with 42 CFR deficient practice could affect	E 00)37	E037 EP Training Program The facility requests paper compliance for this citation. This Plan of Correction is th center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. T plan of correction is prepare and/or executed solely beca it is required by the provision	n of not f or The ed use	08/28/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155704	B. WI	NG		08/08	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			MAIN ST		
WALDRO	ON REHABILITATIO	ON AND HEALTHCARE CENTER			RON, 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					of federal and state law.		
		view and interview with the			1)Immediate actions taken fo	or	
		he Maintenance Director on			those residents identified		
		0:20 a.m. and 11:56 a.m., there			Facility Staff were re- in service	ed	
	was no documentation of EPP training; and no documentation to show staff could demonstrate				on the Facility Emergency		
					Preparedness Plan.		
	_	PP. Based on an interview at			2)How the facility identified		
		review, the Administrator and			other residents:		
		rector stated that after			All residents that reside in the		
	-	HR department a limited staff			community have the potential		
	EPP training was completed however they were				be affected by the alleged defi	icient	
	not tested for knowledge of the EPP. The facilities				practice.		
		l program does provide for this			3) Measures put into place/		
	-	ver the Administrator stated			System changes:		
		HR that the option was not			The Facility Emergency		
		ram, and they would get that			Preparedness plan will be		
	changed.				reviewed with all new staff in		
	751 ' C' 1'				orientation and annually and/c	or	
	This finding was ac				when updates occur per the		
		he Maintenance Director at			regulation. The Maintenance		
		ry and again at the exit			Director or designee will cond		
		Administrator and the			tabletop exercises & in-persor		
	Maintenance Direct	tor present.			training/unannounced random		
					drills with the staff as required	-	
					the guidelines to ensure staff		
					demonstrate knowledge of the		
					emergency preparedness plar		
					4)How the corrective actions	i	
					will be monitored:		
					The Maintenance	tha	
					Director/designee will present		
					Emergency Preparedness Pla		
					training of new staff monthly a		
					annual training of staff annual	•	
					the QAPI Committee during Q		
					Meetings to ensure compliance	e.	
					The report will be reviewed in		
					Quality Assurance Meeting		
					monthly for 6 months or until		
					I IIIIVA COMPIIANCA IS ACRIOVAD		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/08/2023	
		155704	B. WI			08/08/	2023
	PROVIDER OR SUPPLIER DN REHABILITATIO	ON AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, 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
IX 0000					The QA Committee will identify any trends or patterns and ma recommendations to revise the plan of correction as indicated 5) Date of compliance: 08/28/2023.	ke e	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 08/08 Facility Number: 00 Provider Number: 1002 At this Life Safety C Rehabilitation and I not in compliance w Participation in Mec Subpart 483.90(a), I 2012 edition of the I Association (NFPA) Chapter 19, Existing 410 IAC 16.2. This one-story facilit Type V (111) constr The facility has a fin detection in the corr corridor. The facility detectors in all resid	200423 200450 Code survey, Waldron Healthcare Center was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and fully sprinkled. The alarm system with smoke ridor and in spaces open to the ty has battery operated smoke lent sleeping rooms. The ty of 79 and had a census of	K 0	000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision of federal and state law.	of n of not f or he d use	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155.704		r í	JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/08/2023		
		155704	В. W.	_		00/08/	2023
	PROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		505 N N	ADDRESS, CITY, STATE, ZIP COD MAIN ST RON, 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)	TE	(X5) COMPLETION DATE
	All areas where resi were sprinkled and services were sprink	dents have customary access all areas providing facility cled. The facility has a d storage shed which were not					
K 0000							
Bldg. 02	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: 08/08/23 Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450 At this Life Safety Code survey, Waldron 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		K 0	000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision of federal and state law.	of n of not f or the od use	
	detection in the corr corridor. The facilit detectors in all resid	re alarm system with smoke ridor and in spaces open to the y has battery operated smoke lent sleeping rooms. The ty of 79 and had a census of s visit.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155704		(X2) MULTIPLE C A. BUILDING B. WING	construction 02	COMI	(X3) DATE SURVEY COMPLETED 08/08/2023	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	505 N	ADDRESS, CITY, STATE, ZIP CO MAIN ST RON, IN 46182)D	
(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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 02	were sprinkled and services were sprink	dents have customary access all areas providing facility kled. The facility has a distorage shed which were not appleted on 08/09/23				
	Doors protecting of than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible material hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or complying to a covering is not exceed to room the covering is not exceed to room the door closed with a control of the door closed with a control of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be laterial frames shall be laterial to residue the control of the door release shall be laterial to the control of the door release when the permitted and the control of the door release when the permitted and the control of the door release when the permitted and the control of the door release when the permitted and the control of the control of the door release when the permitted and the control of t	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
155704			B. WING 08/08/2023				/2023
NAME OF PROVIDER OR SUPPLIER WALDRON REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 505 N MAIN ST WALDRON, IN 46182				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)	DATE	
	unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 1 of impediment to closi frame and would residents. Findings include: Based on observation to the facility with Maintenance Direct p.m. and 2:20 p.m., Therapy Area failed into the door frame a self-closing device when tested 3 times stated that the door when tested. This finding was ac Administrator and the time of discovery	compartment is fire window assemblies are a sprinklered compartments ctions in area or fire s or frames in window Parts 403, 418, 460, 482, S details of doors such as angs, automatics closing on and interview, the facility f over 30 corridor doors had no ang and latching into the door sist the passage of smoke. ice could affect 4 staff and 6 ons and interview during a with the Administrator and for on 08/08/23 between 12:05 the corridor door to the d to close and latch positively This door was equipped with the but failed to latch positively The Maintenance Director worked the previous day knowledged by the the Maintenance Director at ry and again at the exit Administrator and the	K 03		K363 Corridor Doors The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely because it is required by the provision of federal and state law. 1) Immediate actions taken for those residents identified. The corridor door to the Thera area was repaired to ensure the latches and closes properly. 2) How the facility identified other residents: All residents that reside in the	of n of not f or he d use ns or	08/26/2023
				community have the notential	notential to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) E) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02		02	COMPLETED			
155704			B. WING			08/08/2023			
			<u> </u>						
NAME OF P	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD						
			505 N MAIN ST						
WALDRON REHABILITATION AND HEALTHCARE CENTER				WALDRON, IN 46182					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION					DATE		
			be		be affected by the alleged deficient				
				practice.					
				3) Measures put int		place/			
				System changes:					
				An audit of all facility corri					
					doors was completed to ensur	·e			
				each close and latch correc					
				Any concerns noted were					
				immediately corrected.					
					4)How the corrective actions	;			
					will be monitored:				
					The Maintenance				
					Director/designee will audit all				
					corridor doors for proper closis				
					and latching monthly. Any	.9			
					concern will be immediately				
					addressed and corrected. Th	ie.			
					report will be reviewed in Qua				
					Assurance Meeting monthly for	•			
				months or until 100% compliance					
					is achieved. The QA Committ				
					will identify any trends or patte				
					and make recommendations to				
					revise the plan of correction as	5			
					indicated.				
					5) Date of compliance:				
					08/26/2023.				
			l						

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