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	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldron Rehabilitation and Healthcare Center	505 N Main St Waldron, IN 46182

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to treat residents with dignity and respect for 3 of 6 resident's reviewed for dignity (Residents F, H, and L).Findings include: 1. The clinical record for Resident F was reviewed on 5/13/26 at 10:00 a.m. The resident's diagnosis included, but was not limited to, high blood pressure (elevated above normal range blood pressure). An admission Minimum Data Set (MDS) Assessment, completed 2/7/26, indicated Resident F was cognitively intact. During an interview on 5/13/26 at 10:28 a.m., Resident F indicated on the evening, of 5/8/26, the Director of Nursing (DON) had come to his room to tell him not to curse at the nursing staff. The DON had screamed at him and told him to get the h*ll out. The DON had cursed at him and was disrespectful. The resident had informed the Executive Director (ED) about the incident on Monday 5/11/26. On 5/13/26 at 12:05 p.m., the ED provided a copy of the Reportable Incident Report, dated 5/11/26, indicated Resident F had alleged the DON had screamed at the resident during an interaction. The resident was assessed and had no injuries. A thorough investigation had been initiated. The investigation file for the Reportable Incident included a statement from the DON that indicated on 5/8/26 at around 6:00 p.m., the DON entered Resident F's room to discuss the resident's request for the aides to put his penis in the urinal. When the DON entered the room, the resident was lying in bed. The DON advised the resident to not yell and cuss out (insulting language) the girls (Certified Nursing Assistants) when they offer to help you. The Certified Nursing Assistants were to encourage the resident to do things for himself. During an interview on 5/14/26 at 10:31 a.m., Registered Nurse (RN) 4 indicated she had worked the evening shift on 5/8/26. RN 4 heard the DON and Resident F discussing something in Resident F's room. Both Resident F and the DON's voices had been raised, but the DON had not been screaming. The DON had a voice that carries. RN 4 was unable to hear what was being discussed. During an interview on 5/14/26 at 10:47 a.m., Resident D and Resident J indicated they were outside in the smoking area on 5/8/26 at around 6:00 p.m. Resident D and Resident J had heard Resident F and the DON yelling at each other. Resident F's room was right by the smoking area and Resident F's window had been cracked. Resident D indicated Resident F was hard to get along with sometimes, but the DON should not have yelled at Resident F. During an interview on 5/14/26 at 1:11 p.m., Resident L indicated he was outside in the smoking area on 5/8/26 at around 6:00 p.m. Resident L had heard the DON going off on Resident F. The DON was mad and Resident L had never heard the DON yell like that before. Resident F could push everyone's buttons. During an interview on 5/14/26 at 2:33 p.m., the DON indicated she had a discussion with Resident F on 5/8/26 at around 6:00 p.m., the DON had been firm with Resident F but had not screamed at him during the discussion. Resident F had screamed and cursed at the DON. During an interview on 5/14/26 at 2:33 p.m., the ED indicated that the DON had informed the ED of the interaction between the DON and Resident F on 5/8/26. The DON had been stern with Resident F about his behaviors of cursing at the staff and toileting issues. 2. During an interview on 5/14/26 at 1:11 p.m., Resident L indicated some of the staff were mad at him because he had reported a CNA for being disrespectful to him. The CNA had told Resident L that he had *******[cuss word] peed his pants. Resident L had reported the CNA to the DON about three weeks ago. The CNA that Resident L had reported was not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allowed in his room anymore but would walk by when the resident's call light was on and stare. Since Resident L had reported the CNA, some of the other CNA's would not come into his room to answer his call light. 3. During an interview on 5/13/26 at 1:53 p.m., Resident H indicated he had completed a grievance form earlier in the week because one of the staff had accused the resident that sh*t his pants. Resident H felt that was very disrespectful and it upset the resident. On 5/14/26 at 1:19 p.m., the ED provided the Resident Rights Policy, effective 11/1/2021, that read .Residents have the right to a dignified existence, self-determination, and communication with persons and services inside and outside the facility .Residents have the right to be treated with consideration, respect, and recognition or their dignity and individuality . This citation relates to Intake 3011627 410 IAC (Indiana Administrative Code) 16.3.1-3(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure staff timely reported allegation of abuse to the Executive Director for 1 of 4 residents reviewed for abuse (Resident F). Findings include:The clinical record for Resident F was reviewed on 5/13/26 at 10:00 a.m. The resident's diagnosis included, but was not limited to, high blood pressure (elevated above normal). An admission Minimum Data Set (MDS) Assessment, completed 2/7/26, indicated Resident F was cognitively intact. During an interview on 5/13/26 at 10:28 a.m., Resident F indicated on the evening of 5/8/26, the Director of Nursing (DON) had come to his room to tell him not to curse at the nursing staff. The DON had screamed at him and told him to get the h*ll out. The DON had cursed at him and been very disrespectful. The resident had informed the Executive Director (ED) about the incident on Monday 5/11/26. A confidential interview was conducted during the course of the survey. The confidential interview indicated they had been told by Resident F that the DON had yelled at him. They had not reported it to the ED because Resident F had indicated he had reported it. During an interview on 5/14/26 at 2:33 p.m., the ED indicated she had been at the facility on Saturday 5/9/26. The ED had not heard anyone talking about the incident between Resident F and the DON. The ED had not been informed of the incident by any staff while she was at the facility on Saturday. The ED would have wanted to have known about what was being said about the incident and the staff should have reported it to her. On 5/13/26 at 12:15 p.m., the ED provided the Abuse and Incident Report Policy, dated 4/8/24, that read .The facility will ensure that all alleged violations involving mistreatment or exploitation, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with state and federal regulations. Any incident or accident that meets the requirement of reportable incident as outlined in the policy must be immediately reported to the Administrator or Director of Nursing .Types of Incidents Reportable under Federal and State Regulations: I. ABUSE: a) Staff to Resident Abuse: All allegations of staff to resident abuse must be reported. Staff may receive allegations from any source, including other staff, residents, family members, or otherhealth care providers. Also, each occurrence must be reported. If staff are aware of or witness any abuse that occurs, it must be reported .This citation relates to Intake 3011627.410 IAC (Indiana Administrative Code) 16.3.1-28(c)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to assess pain level prior to administering as needed pain medications and to implement non-pharmacological pain interventions for 1 of 1 resident reviewed for pain (Resident F).Findings include:The clinical record for Resident E was reviewed on 5/13/26 at 10:00 a.m., the resident's diagnosis included, but was not limited to, inguinal hernia (tissue that has protruded through the lower abdominal muscles and caused a bump in the groin). A care plan, initiated 1/27/26, indicated Resident F had chronic conditions and risk for discomfort, complications, or decline. The goal was for him to attain or maintain his highest practicable level of well-being and to minimize risks of complications. The interventions included, but were not limited to, assess for verbal and non-verbal signs and symptoms related to pain such as grimace, guarding, crying, moaning, and increased anxiety. Monitor Resident F for signs and symptoms of discomfort and reports of pain. Attempt non-pharmacological interventions and provide medications, as ordered, if not effective. Offer pharmacological and non-pharmacological interventions to relieve pain as needed. Activity level as tolerated by the residents; encourage rest periods to avoid fatigue. A physician's order, dated 2/5/26, indicated staff were to observe the resident for pain every shift. An admission Minimum Data Set (MDS) assessment, completed 2/7/26, indicated Resident F was cognitively intact, required substantial assistance of staff for toilet hygiene, and had no pain. A nurse's note, dated 4/23/26 at 9:44 p.m., indicated Resident F had returned from an acute care hospital after having his inguinal hernia repaired. The resident had a new physician's order for Ultram (narcotic-like pain medication) 50 milligram (mg) every 8 hours, as needed, for pain. The April 2026 Medication Administration Record (MAR) indicated Resident F had received Ultram 50 mg at the following days and times: on 4/23/26 at 10:45 p.m., for a pain level of 9 (using pain scale of 1 to 10 with 10 being the extreme pain); on 4/24/26 at 8:57 a.m., for a pain level of 10; on 4/27/26 at 9:38 a.m., for a pain level of 6; on 4/28/26 at 8:58 a.m., for a pain level of 8; and on 4/28/26 at 8:22 p.m., for a pain level of 7.The facility Capsus (emergency drug dispensing machine) record indicated four doses of Ultram 50 mg had been obtained for Resident F on 4/24/26 at the following times: 12:28 a.m., 12:45 a.m., 8:58 a.m., and 9:04 a.m. The April 2026 MAR did not include documentation that two of the four doses of Ultram, pulled from the Capsus machine, had been administered to Resident F, what his pain level was upon administration, or if the medication was effective. The clinical record did not include what non-pharmacological interventions had been attempted to assist with Resident F's pain control. A nurse's progress note, dated 4/26/2026 at 1:33 p.m., indicated Resident F had been offered education about the post-surgical period and post-surgical healing. The resident's surgical incision was assessed and was clean, dry, and intact. Resident F was unsatisfied with education and requested to speak to a doctor who can tell me what the h*ll is going on. A Nurse Practitioner Visit Note, dated 4/27/26, indicated Resident F had multiple complaints and indicated he was having a lot of pain from his surgery. He indicated he was unable to do anything for himself due to pain. The resident was unhappy with staff who were trying to force him to get up. The facility staff reported behaviors such as rolling over to the side of the bed to urinate on the floor. The resident indicated he was unable to use the urinal because his testicles were too swollen. The Nurse Practitioner had encouraged the resident to get out of bed for at least for meals. The resident's genitals had mild scrotal edema (swelling). The resident was encouraged to use a urinal to void (urinate). During an interview on 5/13/26 at 10:28 a.m., Resident F indicated he had a lot of pain when he returned from his hernia surgery. The nursing staff did not assist him with controlling his pain. During an interview on 5/14/26 at 1:40 p.m., the Director of Nursing indicated the nursing staff should have documented each dose of Ultram given on the Medication Administration Record and included a pain assessment. The nursing staff should have documented the non-pharmacological pain interventions attempted. On 5/14/26 at 1:33 p.m., the Executive Director provided the Pain Clinical Protocol, revised April 2025, that read .The provider will order appropriate non-pharmacologic and medication interventions to address the individual's pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain, and at least weekly in stable chronic pain. a. Review should include frequency, duration, and intensity of pain, ability to perform activities of daily living [ADLs], sleep pattern, mood, behavior, and participation in activities. b. The staff will evaluate and report on the resident/patient's use of standing and PRN [as needed] analgesics .This citation relates to Intake 3011627.410 IAC (Indiana Administrative Code) 16.3.1-37(a)