STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

(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 Complaint IN00424882. IN00424882: No defeciencies related to the allegations are cited. Unrelated deficiency cited. Survey date: January 31, 2024 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicaid: 32 Other: 4 Total: 36 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2024.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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

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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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 2 of 4 allegations of abuse. A staff member threatened to hit a resident while providing care, and a staff member was overheard talking down to a resident while administering medication, and then referred to the resident as "lazy." (Resident C, Resident D) Findings include: 1. During a review of facility reported incidents on 1/30/2 at 11:15 A.M., an incident, dated 12/29/23, included that Resident C shook their fist at CNA 13 and told CNA 13 that she was going to hit her. CNA 13 then told Resident C that she would hit her back. During record review on 1/30/24 at 10:30 A.M., Resident C's diagnoses included, but were not limited to bipolar disorder, mild intellectual disabilities, anxiety, chronic pain, and post-traumatic stress disorder (PTSD). Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 12/22/23, indicated the resident's cognition was severely impaired and the resident demonstrated verbal behaviors towards others during 1 to 3 days of a 7-day review period.	F 0600	We would like to request paper compliance. It is the policy of this facility to prevent all types of Abuse by in-servicing, investigating and reporting Abuse. Immediate Actions: An investigation was conducted immediately into the allegations. The agency Nurse and Aid were put on the DNR (Do Not Return) from the facility agency pool. A report was made to the ISDH and the Agency the nurse and aid worked for, regarding the allegations and the outcome. Residents C and D met with SSD to ensure psycho/social needs are met and allowing residents to talk about any fear or concerns they may have. Affected Residents: Had the potential to affect all residents.	02/09/2024

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	Resident C's care plan included, but was not limited to resident has a diagnosis of intellectual disability with behaviors of yelling, screaming outburst, cursing, and aggression toward staff and other residents. Interventions included; if behavior during care, assure resident's safety, and re-approach with different staff, and re-assure resident with calming measures and converse with resident (revised 12/3/23). During an interview on 1/30/24 at 12:40 P.M., Resident C indicated the facility gets staff to come in that are unfamiliar with the resident's disposition and they try to "overrule" her. Resident C indicated that CNA 13 had threatened to hit her and that the facility had terminated that staff member's employment. During a review of the facility's investigation of the incident between Resident C and CNA 13 on 1/30/24 at 1:00 P.M., an undated written statement from CNA 13 included, "...While changing [Resident C] she shook her fist at me and told me she was going to hit me. I told her I would hit her back..." A typed statement from the Social Service Director (SSD), dated 12/29/23, included, "[CNA 13] came to the social service office to tell us what had just happened because she was afraid the resident (Resident C) might say something... [CNA 13] stated, [Resident C] was screaming and throwing her arms like she was going to hit [CNA 13]. [CNA 13] said to resident, if you hit me, I swear, I will hit you back. I don't care if I get in trouble, I will quit my job." 2. During a review of facility reported incidents on 1/30/2 at 11:15 A.M., an incident, dated 12/29/23, included that Maintenance 4 overheard RN 31 tell		Actions taken: All staff including agency staff on duty were in-serviced regarding the facility policy for abuse on Feb 9, 2024. Ongoing bi-weekly in-services will be conducted for all staff for the next 6 months. The nurse`s stations binder, that includes the facility abuse policy were updated to include quick, bullet points reminder of what to do and who to call if there`s an allegation of abuse. A copy has been posted in every department as well as the break room for reminders. The facility also had signs made that read (Warning we report Abuse to the ISDH) these signs will be posted at the front entrance of the facility and at each nurse`s station. How corrective actions will be Monitored: The director of Nursing and/or designee will complete a review of the agency staff prior to working any shifts to ensure they have had Abuse training on record. If they have had the training they will be allowed to pick up shifts as needed at the facility. If they have	

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	Resident D that he was lazy and could put his medications into his mouth himself. During record review on 1/30/24 at 11:30 A.M., Resident D's diagnoses included but was not to chronic pain, major depressive disorder, anxiety, history of traumatic brain injury, alcohol induced persisting dementia, mood disorder, personality disorders, and mental disorder. Resident D's most recent quarterly MDS assessment, dated 1/10/24, included that the resident had moderately impaired cognition. Resident D's care plan included, but was not limited to resident has a behavior problem. Interventions included; caregivers to provided opportunity for positive interaction, attention (Revised 11/8/23). During a review of the facility's investigation of the incident between Resident D and RN 31 on 1/30/24 at 1:20 P.M., an undated written statement from Maintenance 4 included, "I was standing on West Hall with a contractor when the nurse ask [sic] resident (if the resident wanted a pain medication)... (Resident D) asked (RN 31) to put (the medication) in his mouth. [RN 31] told him he was lazy and he could do it himself. Then (RN 31) ask [sic] resident who told him he could chew in the building. I told her that I let him. [RN 31] look [sic] at [Resident D] an [sic] said well if he was not so lazy he could have went with the other smoker's outside..." During an interview on 1/30/24 1:30 P.M. Maintenance 4 indicated she was near Resident D's room and could hear RN 31 talking with Resident D. Resident D had a decline and was about to have a procedure on his arm. Resident D		not the facility will ensure they have been educated on abuse prior to working any shifts. The SSD will interview residents weekly from the MDS and care plan schedule for abuse. Any allegations will be reported immediately to the Administrator for investigating and reporting. In-services of all staff will be conducted on abuse bi-weekly for 6 months. The Director of Nursing and/or designee will complete the attached monitoring tool to ensure agency staff have abuse training before working any shifts. IDR: The facility is being punished for training staff to identify abuse and to protect residents from abuse by reporting abuse. Facilities will lose reimbursement and/or noncompliance for surveys will continue and extending the fines, increasing the CMP. The facility would request that this be changed to substantiated without findings. We are trying to prevent abuse before it happens.	

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	was taking pain medication and was not fully alert. RN 31 was overheard telling the resident he could do things for himself and that he was being lazy. Maintenance 4 indicated that she felt RN 31 was verbally abusive and she reported the nurse immediately. On 1/30/24 at 2:00 P.M., the DON supplied a facility policy titled, Abuse Policy and Procedures, dated 9/15/17. The policy included, "It is the policy of [Facility] to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion... C. Verbal abuse is oral, written, and/or gestured language that includes disparaging and/or derogatory terms to resident or their families... It can include resident to resident or staff to resident verbal threats of harm..." 3.1-27(b)			