| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155270 | A. BUILDING -- B. WING | 08/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| 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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/29/23<br><br>Facility Number: 000170<br>Provider Number: 155270<br>AIM Number: 100287490<br><br>At this Emergency Preparedness survey, Core of Dale was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 60 certified beds. At the time of the survey, the census was 39.<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:<br><br>Quality Review completed on 09/13/23 | E 0000 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. | |
| E 0006<br>SS=F<br>Bldg. -- | 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)<br>Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Lorri Maples | Administrator | 09/28/2023 |

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.

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| | 155270 | A. BUILDING -- B. WING | 08/29/2023 |

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

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| | §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.<br>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, | | | |

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| | and updated at least annually. The plan must do the following:<br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br>(2) Include strategies for addressing emergency events identified by the risk assessment. | | | |
| | Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance | E 0006 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The risk assessment that was not | 10/20/2023 |

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| | Supervisor present, facility-based and community-based risk hazards were addressed in the plan, however, there was no facility-based and community-based risk assessment utilizing an all-hazards approach available for review. Based on interview at the time of record review, the Administrator said she knows the facility has a risk assessment for the Emergency Preparedness plan but it could not be found.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | available at the time of survey was found and placed back into the Emergency Preparedness binder. It was also updated to include strategies for addressing emergency events identified by the risk assessment.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the facility all hazards risk assessment and the importance thereof.<br>The maintenance staff was in-serviced regarding ensuring all documentation remains in the Emergency Preparedness binder so it's easily accessible when needed.<br>The risk assessment was updated to ensure that hazards were identified, and strategies were addressed.<br><br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Maintenance Director will review and update the hazard assessment annually and as needed to keep the most current information updated. | |

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| | | | The Maintenance Director will bring the Emergency Preparedness binder to quarterly Emergency Preparedness meetings and review with the management team and update the hazard assessment as needed.<br><br>Emergency Preparedness will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |
| E 0009 SS=C Bldg. -- | 403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4)<br>Local, State, Tribal Collaboration Process<br>§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]<br><br>(4) Include a process for cooperation and | | | |

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| | collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. *<br><br>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. | | | |
| | Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Supervisor present, no documentation was available which included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency | E 0009 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The maintenance director contacted the state and local emergency management officials for our district to inquire about meetings and/or community drills etc. A record will be kept of dates and times contact was made or | 10/20/2023 |

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| | preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of review, the Administrator acknowledged there was no cooperation and collaboration process in the Emergency Preparedness plan available for review.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | attempted with emergency officials.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>Maintenance staff were in-serviced regarding the facility policy for updating the emergency planning partners and contacting them periodically to find out about meetings and community drills, as well as planning a collaborative event involving the partners.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will continue to be in contact with the emergency management officials for our district to inquire about meetings and collaborative events.<br>The facility will participate in the collaboration with officials when scheduled.<br>The Administrator will review the record of contact weekly for 6 months to ensure attempts are made to schedule a collaborative event and/or attend trainings/meetings for the local area.<br>The records of phone/emails to emergency management officials | |

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| | | | will be brought to quarterly emergency management meetings to ensure ongoing communications with local, district and state emergency officials. Phone and email records will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |
| E 0025 SS=C Bldg. -- | 403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>*[For Hospices at §418.113(b), PRFTs at | | | |

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| | §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.<br><br>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. | E 0025 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken | 10/20/2023 |

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| | with the Administrator and Maintenance Supervisor present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, the list of facilities have not been updated since 2019. Furthermore, at least one of the facility's on the list has currently changed names and ownership. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be updated.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | for the resident(s) found to have been affected include:<br>The list of providers was updated in the Emergency Preparedness binder and new agreements were signed with the 2 other local nursing homes in the county.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the facility Emergency Preparedness binder and on the agreements with other facilities for transfer.<br>Maintenance staff were in-serviced on keeping the Emergency Preparedness binder updated to current information and will be changed as needed.<br>New agreements were signed with the 2 other local nursing homes in the county to ensure we have updated communication and information.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Maintenance Director will review and update the agreements as needed to keep the most current information updated.<br>The Maintenance Director will | |

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| | | | bring the Emergency Preparedness binder to quarterly Emergency Preparedness meetings and review with the management team and update the agreements as needed.<br>Emergency Preparedness will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |
| E 0026 SS=C Bldg. -- | 403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7)<br>Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the | | | |

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| | [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Supervisor present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Administrator acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | E 0026 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The facility has a new policy establishing roles for providing care during emergencies under blanket or specific 1135 waivers.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put** | 10/20/2023 |

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| | 155270 | A. BUILDING -- B. WING | 08/29/2023 |

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

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| | | | **into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the new facility policy for establishing roles for providing care during emergencies under blanket or specific 1135 waivers.<br><br>The maintenance staff was in-serviced on the new policy for establishing roles for providing care during emergencies under blanket or specific 1135 waivers and keeping the policy updated as needed as roles may change periodically.<br><br>The facility has a new policy establishing roles for providing care during emergencies under blanket or specific 1135 waivers.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Maintenance Director will review and update the Roles under 1135 Waiver as needed to keep the most current information updated.<br>The Maintenance Director will bring the Emergency Preparedness binder to quarterly Emergency Preparedness meetings and review with the management team and update the policy as needed.<br>Emergency Preparedness will be reviewed by the Quality Assurance Committee until such a time | |

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| | | | consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23. | |
| E 0036 SS=F Bldg. -- | 403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)<br>EP Training and Testing<br>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. | | | |

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| | *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and | | | |

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| | updated at every 2 years.<br>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Supervisor present, there was no documentation available to show the facility had an emergency preparedness training and testing program available for review. Based on interview at the time of record review, the Administrator confirmed there is no training and testing program available for review within the Emergency Preparedness plan.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | E 0036 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>A schedule has been developed to complete the testing/training of staff over a period of 1 year, which allows a training/testing to be completed 1 x month. This schedule is based off the updated risk assessment, on hazards indicated.<br>The first training was completed on 9/23/23 with an active shooter scenario.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the facility policy for an active shooter on 9/23/23. | 10/20/2023 |

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| | | | A schedule has been developed to complete the testing/training of staff over a period of 1 year, which allows a training/testing to be completed 1 x month. This schedule is based off the updated risk assessment, on hazards indicated.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Maintenance Director and Administrator will review and update the training/testing program as needed and annually to keep the most current information updated.<br>The Maintenance Director will bring the Emergency Preparedness binder, the completed training or testing and the training/testing program to quarterly Emergency Preparedness meetings and review with the management team and update the program as needed.<br>Emergency Preparedness will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23. | |
| E 0037 SS=F | 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), | | | |

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| Bldg. -- | 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)<br>EP Training Program<br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, | | | |

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| | consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: | | | |

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| | (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. | | | |

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| | (ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. | | | |

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| | *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.<br><br>Findings include:<br><br>Based on review of the Emergency Preparedness plan on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Supervisor present, no documentation of annual Emergency Preparedness training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness plan was available for review. Based on an interview at the time of record review, the Administrator confirmed there was no documentation of annual | E 0037 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>A schedule has been developed to complete the testing/training of staff over a period of 1 year, which allows a training/testing to be completed 1 x month. This schedule is based off the updated risk assessment, on hazards indicated. The schedule will have at least 1 annual emergency preparedness training and documentation to show training was completed and staff | 10/20/2023 |

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| | Emergency Preparedness plan training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness plan was available for review.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | knowledge of emergency procedures.<br>The first monthly training was completed on 9/23/23 with an active shooter scenario.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the facility policy for an active shooter on 9/23/23.<br>A schedule has been developed to complete the testing/training of staff over a period of 1 year, which allows a training/testing to be completed 1 x month. This schedule is based off the updated risk assessment, on hazards indicated. The schedule will have at least 1 annual emergency preparedness training and documentation to show training was completed as well as staff knowledge of emergency procedures.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Maintenance Director and the Administrator will review and update the training/testing program as needed and annually to keep the most current | |

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| | | | information updated. The Maintenance Director and the Administrator will ensure that an annual emergency preparedness training is scheduled and includes staff knowledge of emergency procedures.<br>The Maintenance Director will bring the Emergency Preparedness binder and the training/testing program to quarterly Emergency Preparedness meetings and review with the management team and update the program as needed.<br>Emergency Preparedness will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23. | |
| E 0041 SS=F Bldg. -- | 482.15(e), 483.73(e), 485.625(e)<br>Hospital CAH and LTC Emergency Power<br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155270 | A. BUILDING -- B. WING | 08/29/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| 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 |
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| | The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the | | | |

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| | Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013. | | | |

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| | (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2).<br><br>1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer<br>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.<br>Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility. | E 0041 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The Administrator signed a contract with Cummins Sales and Service to maintain the generators annual/1.5-hour load bank test, the 36 month/4 hour load bank test and annual fuel quality test. The 4-hour load bank test was performed on 9/18/23 and documented.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:** | 10/20/2023 |

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| CORE OF DALE | 510 W MEDCALF ROAD DALE, IN 47523 |

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| | Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Supervisor acknowledged a load bank test for the generator has not occurred within the past 12 month period.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance | | Maintenance staff were in-serviced regarding the facility policy for ensuring that testing the generator, maintaining it properly, and ensuring scheduled vendor performs tests per contract and regulation.<br>The Administrator signed a contract with Cummins Sales and Service to maintain the generators 1.5-hour load bank test, 4-hour load bank test and fuel samples.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will perform and/or ensure vendor will conduct the weekly, monthly, and annual maintenance, fuel, and load tests on the generator. The maintenance director will bring the documentation to the Administrator to review weekly for 6 months to ensure tests are documented and present.<br>Records will be reviewed by the monthly Quality Assurance Committee for 6 months or until such a time consistent substantial compliance has been achieved as determined by the committee.<br>Corrective action completion date: 10/20/23 | |

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| | Supervisor present, there was documentation of an annual generator inspection dated 02/07/23, however, there was no documentation of an annual fuel quality test for the diesel generator available for review during the past 12 month period. The most recent fuel quality test for the diesel generator was dated 08/03/22, which was almost a month past due. Based on interview at the time of record review, the Maintenance Supervisor said she called the generator inspection vendor and was told they would be at the facility by the end of the month and take the fuel sample at that time.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance | | | |

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| CORE OF DALE | 510 W MEDCALF ROAD DALE, IN 47523 |

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| | Supervisor present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record review.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | | |
| K 0000<br><br>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).<br><br>Survey Date: 08/29/23<br><br>Facility Number: 000170<br>Provider Number: 155270<br>AIM Number: 100287490<br><br>At this Life Safety Code survey, Core of Dale 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.<br><br>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping | K 0000 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. | |

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| CORE OF DALE | 510 W MEDCALF ROAD<br>DALE, IN 47523 |

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| | rooms. The facility has a capacity of 60 and had a census of 39 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached laundry building.<br><br>Quality Review completed on 09/13/23 | | | |
| K 0281<br>SS=E<br>Bldg. 02 | NFPA 101<br>Illumination of Means of Egress<br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.<br>18.2.8, 19.2.8<br>Based on observation and interview, the facility failed to ensure the lighting for 2 of 4 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors.<br><br>Findings include:<br><br>Based on observations on 08/29/23 between 1:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Man, there were light fixtures with two bulbs each outside the 100 unit and 200 unit exits. They were both controlled by a switch on the wall inside the door. The Maintenance Supervisor said staff turns these lights on during the evening hours | K 0281 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The 2 lights that were not photocells, have been replaced with automatic dusk to dawn operation lights and the switches have been taken out of service and | 10/20/2023 |

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| | and both light fixtures are connected to the generator. The switch was turned on at the 100 unit exit, but turned off at the 200 unit exit at the time of each observation. The Maintenance Supervisor said she didn't think the light fixtures were equipped with photo cells that would automatically come on when it turns dark outside.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | covered.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>The maintenance staff was in-serviced on ensuring that all the outside lighting is maintained in good working order to ensure that they come on automatically at dusk.<br>2 dusk to dawn lights were purchased and installed to ensure continuous operation.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will complete weekly audits for 12 consecutive weeks to ensure lighting is operational to illuminate the walkways. After 12 weeks, the maintenance director will complete monthly audits for 3 months.<br>The outside lighting will be placed on the preventative maintenance program to ensure continued compliance ongoing.<br>Audit records will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. | |

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| | | | Corrective action completion date: 10/20/23 | |
| K 0374 SS=E Bldg. 02 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would close completely to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on observations on 08/29/23 between 1:30 p.m. and 3:15 p.m. during a tour of the facility with | K 0374 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>Maintenance staff had previously | 10/20/2023 |

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| | the Maintenance Supervisor and Maintenance Man, the set of smoke barrier doors between the 100 Unit and the center corridor did not close completely when tested several times. There was a 1/4 inch to 1/2 inch gap between the entire length of the doors when closed fully. This was acknowledged by the Maintenance Supervisor at the time of observation, who further said this set of smoke barrier doors are going to be replaced when the new smoke barrier doors are delivered.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | identified the problem with the smoke barrier door on the 100 hall and an order for the doors was placed on 8/25/23, prior to survey. The invoice/order was given to surveyor at the time of survey, The facility is still awaiting delivery and installation of the doors as of this plan of correction submission. Calls have been placed for an estimated time of delivery/installation.<br>2 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>Maintenance staff had previously identified the problem with the smoke barrier door on the 100 hall and an order for the doors was placed on 8/25/23, prior to survey. The invoice/order was given to surveyor at the time of survey, The facility is still awaiting delivery and installation of the doors as of this plan of correction submission. Calls have been placed for an estimated time of delivery/installation.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will complete 2 random weekly audits | |

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| | | | for 12 consecutive weeks to ensure all smoke barrier doors are maintained in good condition and working order. Thereafter, maintenance director will complete monthly audits ongoing to ensure doors remain in compliance. Audit records will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |
| K 0712 SS=F Bldg. 02 | NFPA 101<br>Fire Drills<br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 4 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility.<br><br>Findings include: | K 0712 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who | 10/20/2023 |

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

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| | Based on review of the facility's fire drill reports on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, the facility lacked fire drill documentation for the following shifts and quarters:<br>a. First shift (day) of the second quarter (April, May, and June) of 2023, and the third quarter (July, August, and September) of 2022 and so far in 2023<br>b. Third shift (night) of the first quarter (January, February, and March) of 2023, third quarter (July, August, and September) of 2022 and so far in 2023, and fourth quarter (October, November, and December) of 2022.<br>Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of fire drill reports during the previously mentioned shifts and quarters of 2022 and 2023.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>A monthly fire drill is scheduled on September 28th on second shift at 6pm per the new calendar.<br>A calendar was initiated for each month of the year to show what day, shift, and time the fire drill will be conducted. The calendar is placed in the maintenance director's office and te Administrators' office to ensure the drills are performed.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All maintenance staff were in-serviced regarding the facility policy for conducting fire drills monthly, at various times and different shifts.<br>A calendar was initiated for each month of the year to show what day, shift and time the fire drill will be conducted. The calendar is placed in the maintenance director's office and the Administrators' office to ensure | |

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| | | | the drills are performed.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The Administrator will complete monthly audits of the maintenance records to ensure fire drills are conducted per the new calendar initiated. Any noncompliance will result in counseling's up to and including termination.<br>Audit records will be reviewed by the monthly Quality Assurance Committee for one year or until such a time consistent substantial compliance has been achieved as determined by the committee.<br>**10/20/23** | |
| K 0741<br>SS=E<br>Bldg. 02 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. | | | |

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| | (3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 2 area where cigarettes were smoked by residents or staff. This deficient practice could affect at least 5 staff.<br><br>Findings include:<br><br>Based on observations on 08/29/23 between 1:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Man, the staff smoking area outside the center corridor side exit had a large trash can full of paper trash mixed with at least 25 visible cigarette butts. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the paper trash mixed with cigarette butts in the large trash can, furthermore, the Maintenance Man removed the bag within the large trash can at the time of observation.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0741 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>Maintenance disposed of the cigarette butts and trash at time of survey.<br>A sign was placed at the smoke area to remind staff not to dispose of cigarette butts in the trash cans, to use the ash cans.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all | 10/20/2023 |

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| | | | residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff were in-serviced regarding the facility policy for disposing of cigarette butts properly and safely in the ash cans, not the trash cans.<br>Maintenance staff were in-serviced on disposing of the cigarette butts properly when cleaning the smoking areas and not throwing them in the trash.<br>A sign was placed at the smoke area to remind staff not to dispose of cigarette butts in the trash cans, to use the ash cans.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will complete 5 audits per week for 3 months, then 3 audits per week for 3 months of the smoking areas to ensure butts are disposed of properly in the ash cans, not the trash cans.<br><br>Audit records will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |

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| K 0761 SS=C Bldg. 02 | Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and | K 0761 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>Our fire safety vendor has completed the annual inspection and testing the oxygen room fire door and assembly.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>The maintenance staff were in-serviced regarding the facility policy for testing and inspections of all fire doors and ensuring it's completed timely. | 10/20/2023 |

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| | noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, as well as staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly.<br>Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly.<br>Based on observations during a tour of the facility with the Maintenance Supervisor between 1:30 p.m. and 3:15 p.m., there was one oxygen transfilling room fire door assembly noted in the facility in the center corridor near the dining room. | | Any further noncompliance will result in counseling's up to and including termination.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will complete a calendar for inspections/testing so that future inspections are not missed or forgotten. A copy of the calendar will be given to the Administrator to reference it and ensure that it's followed. The Administrator will review the inspection binders with the maintenance director monthly to ensure nothing is missed and documentation is present and available for review.<br>Records of inspections will be reviewed by the monthly Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |

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| | This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | | |
| K 0918<br>SS=F<br>Bldg. 02 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the | | | |

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| | emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer<br>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.<br>Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, the monthly load percentage for the diesel powered generator was documented less than 30% during the past 12 month period. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the | K 0918 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include:<br>The Administrator signed a contract with Cummins Sales and Service to maintain the generators annual/1.5-hour load bank test, the 36 month/4 hour load bank test and annual fuel quality test. The 4-hour load bank test was performed on 9/18/23 and documented.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>Maintenance staff were in-serviced regarding the facility policy for | 10/20/2023 |

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| | generator ran under load on a monthly basis but does not achieve 30% of the name plate rating. Additionally, the Maintenance Supervisor acknowledged a load bank test for the generator has not occurred within the past 12 month period.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, there was documentation of an annual generator inspection dated 02/07/23, however, there was no documentation of an annual fuel quality test for the diesel generator available for review during the past 12 month period. The most recent fuel quality test for the diesel generator was dated 08/03/22, which was | | ensuring that testing the generator, maintaining it properly, and ensuring scheduled vendor performs tests per contract and regulation.<br>The Administrator signed a contract with Cummins Sales and Service to maintain the generators 1.5-hour load bank test, 4-hour load bank test and fuel samples.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will perform and/or ensure vendor will conduct the weekly, monthly, and annual maintenance, fuel, and load tests on the generator. The maintenance director will bring the documentation to the Administrator to review weekly for 6 months to ensure tests are documented and present.<br>Records will be reviewed by the monthly Quality Assurance Committee for 6 months or until such a time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: 10/20/23 | |

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| | almost a month past due. Based on interview at the time of record review, the Maintenance Supervisor said she called the generator inspection vendor and was told they would be at the facility by the end of the month and take the fuel sample at that time.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>3. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.<br><br>Findings include:<br><br>Based on record review on 08/29/23 between 9:30 a.m. and 1:30 p.m. with the Maintenance Supervisor present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record | | | |

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| | review.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | | |
| K 0927<br>SS=F<br>Bldg. 02 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer room was provided with a sign indicating that transferring is occurring and not occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring, and that smoking is the immediate area is not permitted. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on observation and interview on 08/29/23 between 1:30 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Man, the oxygen storage/transfilling | K 0927 | Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.<br>1 Immediate action(s) taken for the resident(s) found to have been affected include: | 10/20/2023 |

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| (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 |
|---|---|---|---|---|
| | room in the center corridor near the dining room, did not have a posted sign indicating when transferring of oxygen occurs in this location and when it is not occurring. Based on interview at the time of observation, the Maintenance Supervisor agreed there was not a sign stating when trans-filling oxygen is occurring and when it was not.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | The oxygen room now has a temporary sign indicating transferring is occurring. A new sign is on order from our vendor to replace the temporary sign when it comes in.<br>2 Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents have the potential to be affected.<br>**3 Actions taken/systems put into place to reduce the risk of future occurrence include:**<br>All staff will be in-serviced regarding the facility policy for using the signage on the oxygen room door when they are filling oxygen tanks.<br>Maintenance staff were in-serviced to ensure signage always remains on the door and to perform weekly audits to ensure signage is being utilized.<br>**4 How the corrective action(s) will be monitored to ensure the practice will not recur:**<br>The maintenance director will complete 5 weekly audits for 3 months then 3 weekly audits to ensure the signage is being utilized.<br>Audit records will be reviewed monthly by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155270 | A. BUILDING 02<br>B. WING | 08/29/2023 |

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

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|---|---|---|---|---|
| | | | Corrective action completion date: 10/20/23 | |