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	11/01/2023

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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/29/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/01/23 Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490 At this PSR to the Emergency Preparedness survey, Core of Dale was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 38. Quality Review completed on 11/02/23	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. **The facility is requesting paper compliance for this tag.**	
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/29/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/01/23 Facility Number: 000170 Provider Number: 155270 AIM Number: 100287490	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Brazzell	Manager	11/23/2023

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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	At this PSR to the Life Safety Code survey, Core of Dale was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of 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 rooms. The facility has a capacity of 60 and had a census of 38 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached laundry building. Quality Review completed on 11/02/23		allegation of compliance. **The facility is requesting paper compliance for this tag.**	
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING 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			

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	provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 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. Findings include: Based on observations on 11/01/23 between 9:30 a.m. and 10:45 a.m. during a tour of the facility with the Maintenance Supervisor, the set of smoke barrier doors between the 100 Unit and the center corridor did not close completely when tested. There was a eight inch gap between the entire length of the doors when closed fully. The north side door was damaged at the top portion on the hinge side of the door. 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, which is supposed to be in mid November. This finding was reviewed with the Maintenance Supervisor during the exit conference. This deficient practice was cited on 08/29/23. The facility failed to implement proper corrective action.	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. **The facility is requesting paper compliance for this tag.** 1 Immediate action(s) taken for the resident(s) found to have been affected include: 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 Life Safety 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 due to the supply chain on materials. Emails were sent for an updated estimated time of delivery/installation which is still currently 11/30/23. Updated smoke Barrier Doors will be repaired on 11/22/2023 with metal	12/27/2023

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	3.1-19(b)		plates so doors close properly. The doors will still be replaced as soon as possible. Estimated to be around 12/27/2023 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. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** 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 the Life Safety 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 due to the supply chain on materials. Emails were sent for an updated estimated time of delivery/installation which is still currently 11/30/23. Updated delivery date 12/27/2023 Lynn Norman of ADA Automated Doors Stated that the factory changed the delivery date again. He also stated that he could repair the existing smoke barrier doors to close properly using metal plates to secure the hinge. He will repair the doors on 11/22/2023 so that they close properly. Fire doors will be replaced as soon as possible.	

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			4 How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance did conduct fire drills daily until fire doors were repaired and functioning properly. Updated ADA Door Systems repaired the Smoke Barrier Doors on 11/22/23 and they are closing properly. The maintenance director will complete 5 audits a week for 2 months to ensure all smoke barrier doors are maintained in good condition and working order. Thereafter, maintenance director will complete 1 weekly audit for 4 months and then one monthly ongoing to ensure doors remain in compliance. *The facility will ensure smoke barrier doors close properly to limit the passage of smoke or flame.* *Ongoing, the Administrator and/or designee will monitor smoke barrier doors to ensure continued 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.* Corrective action completion date: 12/27/23	