

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155270</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/24/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CORE OF DALE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 W MEDCALF ROAD</b> <b>DALE, IN 47523</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  This visit was for the Investigation of Complaint IN00445210.  This visit was in conjunction with for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 21, 2024. This visit included PSR to Complaints IN00440284 and IN00440376 completed on August 21, 2024.  Complaint IN00445210-- No deficiencies related to the allegations are cited.  Complaint IN00440284-corrected  Complaint IN00440376-Corrected  Survey dates: October 23, 24, 2024  Facility number: 000170 Provider number: 155270 AIM number: 100287490  Census Bed Type: SNF/NF: 40 Total: 40  Census Payor Type: Medicaid: 37 Other: 3 Total: 40  Core of Dale was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Complaint IN00445210 survey.			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/24/2024
NAME OF PROVIDER OR SUPPLIER  CORE OF DALE			STREET ADDRESS, CITY, STATE, ZIP CODE  510 W MEDCALF ROAD DALE, IN 47523		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1  Quality review completed on October 29, 2024.	F 000			