STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	01/07/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00449658 Complaint IN00449658: Federal/State deficiencies related to the allegations are cited at F600. Survey date: January 7, 2025 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicaid: 39 Other: 2 Total: 41 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 13, 2025.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse. A resident was allegedly threatened with physical abuse and then was "smacked" by a staff member in retaliation for the resident striking the staff member during care. (Resident L)	F 0600	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	01/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Brazzell	Administrator	01/24/2025

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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	Finding includes: During a review of state reportable incidents on 1/7/25 at 11:15 A.M., an incident report dated 1/5/25 at 6:50 P.M. indicated Certified Nurse Aide (CNA) 13 reported herself to the nurse after an incident with Resident L. Resident L allegedly hit CNA 13 in the face and CNA 13 then "hit [Resident 13] back in the ribs." During record review on 1/7/25 at 12:00 P.M., Resident L's diagnoses included but were not limited to, hemiplegia affecting left side, anxiety, depression, bipolar disorder, schizoaffective disorder, dementia, traumatic brain injury, and conduct disorder. Resident L's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/12/24, indicated the resident's cognition was moderately impaired. Resident L's care plan included, but was not limited to; Resident has a behavior problem due to traumatic brain injury and being physically/verbally aggressive. Resident hits/punches others (initiated 11/8/23). Interventions included, but were not limited to, caregivers to provide opportunity for positive interaction, approach/speak in a clam manner. Resident L's progress notes included, but were not limited to, an incident note, dated 1/7/25 at 8:32 A.M., that indicated Resident L was re-assessed due to recent incident. Resident asked to point to the area on his right side. Resident touched the upper right rib area. No bruising, swelling or other marks were noted. During review of the facility's investigation into the incident between Resident L and CNA 13, a		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. 1 Immediate action(s) taken for the resident(s) found to have been affected include: *Facility followed Abuse Policy and Procedures. Employee was immediately separated from resident and was instructed to leave the facility. Employee was immediately suspended on (01/05/2025). Resident was assessed for injuries, none noted. Physician and family was notified of the incident on (01/05/2025). Social services interviews with residents indicate no fear or concerns. Resident received a Psych visit on 01/08/2025 Psychosocial visits completed on 01/08/2025.* 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. All interviewable residents were interviewed to make sure no other residents were affected, all residents stated no concerns. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:**	

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	witness statement from Qualified Medication Aide (QMA) 4 indicated that on 1/5/25 at 6:50 P.M., Resident L's call light went off. QMA 4 answered the light and began changing the resident due to an incontinent episode. CNA 13 walked in to Resident L's room to assist with incontinence care. Resident L became very annoyed with the staff during care and began mocking and cursing at the two staff members. Resident L then hit CNA 13 in the face and CNA 13 then smacked him back. An interview signed by the Director of Nurses (DON) with Resident L, dated 1/6/25, indicated that Resident L felt CNA 13 was being too rough during incontinent care. Resident L told CNA 13 that he would hit her and CNA 13 told the resident, "if you hit me, I will hit you back." Resident L indicated that he playfully placed his closed fist on CNA 13's cheek, and she punched him in the side. During an interview on 1/7/25 at 1:50 P.M., CNA 9 indicated that if a resident is being physically or verbally aggressive towards staff, the staff member should remove themselves from the situation and allow the resident to calm down. Staff should re-approach the resident at a later time. The facility's investigation of the incident included an inservice training of the facility's "Procedure for Abuse Prohibition, Reporting, and Investigation policy. The policy indicated, "It is the policy of [Facility] to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion... C. Verbal abuse... can include resident to resident or staff to resident verbal threats of harm..."		*. Facility completed abuse investigation and determined by employee statements that abuse did occur, and employee was terminated* on 01/07/2025. All staff were in-serviced by the Director of Nursing regarding the facility policy for *Abuse.* **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing or designee will complete monthly in-services on abuse prevention and reporting for 12 consecutive months. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 01/26/2025	

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	This citation relates to complaint IN00449658 3.1-27(b)			