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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00440376, IN00440284, and IN00437718. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00440284- Federal/State deficiencies related to the allegations are cited at F 689. Complaint IN00440376- Federal/State deficiencies related to the allegations are cited at F 689. Complaint IN00437718- No deficiencies rlated to the allegations are cited. Survey dates: August 13, 14, 15, 16, 19, 20, 21, 2024 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicaid: 37 Other: 2 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2024.	F 0000	It is the policy of this facility to ensure that all Exit doors are functioning properly to prevent residents with the potential to wander and or identified as an Elopement Risk. 1 Immediate action(s) taken for the resident(s) found to have been affected include: Resident A was assessed for injuries and placed on 1:1 for 2 hours and 15minute checks for 72 hours. Facility head count was performed per Elopement policy. Facility immediately called SafeCare to the facility on 08/04/2024 and started a fire watch until they arrived. The code was changed on the door and was not used again until Automated Doors & Access arrived at 11:30 am on 08/05/2024 and made all the repairs needed for the front door to function properly. Resident B was assessed for injuries and placed on 1:1 for 2 hours and 15minute checks for 72 hours. Facility head count was performed per Elopement policy. Facility called SafeCare to check the side door and they made repairs needed for door & alarms to function properly. 2 Identification of other	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles Brazzell	Administrator	09/11/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			residents having the potential to be affected was accomplished by: The MDS Coordinator reviewed all Care plans and found that it had a potential to affect 9 residents. 2 residents were affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All staff in serviced on the new facility policies for Wandering Residents, Alarms and Elopements. See Attachment: **A** All residents had their Wandering/Elopement Risk Assessment reviewed and updated to reflect the current Wandering and Elopement Risk Policy. . All staff were in-serviced on new Exit Door Policy. See Attachment: **B** Facility added a new Daily Maintenance Checklist that includes checking all the Exterior Doors daily. See Attachment: **C** The new Wandering Residents, Alarms and Elopement Policy was added to the new hire packet. Missing Resident Action Plan was added to Nursing Duty Binders at each nurse's station. Agency Staffing any training not completed, will be expected to be completed prior to working the shift that is located in the training binder labeled Agency Staffing. **4 How the corrective**	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			action(s) will be monitored to ensure the practice will not recur: The Administrator will audit the new Daily Maintenance Checklist weekly x 26 consecutive weeks. The facility will in-service all staff on Wandering Residents, Alarms and Elopement Policy monthly for 12 months and annually thereafter. The IDT management team will review new incident reports 5 x weekly, ongoing to ensure appropriate interventions are implemented and the plan of care is complete. The Director of Nursing Services (DON), or designee, will complete random weekly chart audits on current residents & new admissions ongoing for elopement risk assessments and appropriate care plans for 26 consecutive weeks. This plan of correction will be monitored at the Quarterly Quality Assurance meeting until such a time consistent substantial compliance has been met. // Corrective action completion date: 08/15/2014. Facility had SafeCare install new Code Alert System on three exterior doors, completed on 09/09/2024	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to clarify a Resident's code status for 1 of 2 residents reviewed for advanced directives. A Resident's current Physician Orders did not match the signed DNR (Do Not Resuscitate) form. (Resident 41) Finding includes: On 8/16/24 at 9:34 A.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/11/24, indicated Resident 41 was cognitively intact. Current Physician's Orders included, but was not limited to, full code status, dated 7/3/24. Current care plans included, but was not limited to, "Advanced Directives...Code Status: CPR [Cardiopulmonary resuscitation]..." dated 7/11/24 A current State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order form was signed by Resident 41 and Nurse Practitioner 43 on 7/23/24. During an interview on 8/16/24 at 9:53 A.M., Resident 41 indicated he wanted to be a DNR. During an interview on 8/16/24 at 10:40 A.M., RN (Registered Nurse) 25 indicated Resident 41 is a full code and CPR would be performed if he was not responsive. During an interview on 8/16/24 at 10:46 A.M., the DON (Director of Nursing) indicated Resident 41 should be a DNR and all nursing staff is responsible for updating resident's code status	F 0578	It is the policy of this facility to clarify the residents code status matches the physician orders. 1. Immediate Action taken: The code status of Resident #41 was verified and entered consistently into all relevant locations within the electronic record. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence /absence of Advance Directives is required for all residents. Had the potential to affect all residents. 3. Actions taken/systems put into place to reduce the risk of further occurrence include: Communication of Code Status policy reviewed/revised. The Director of Nursing Services educated Social Services staff regarding the documentation procedures for Advance Directives/Code status. A chart audit of all residents was completed on 08/16/2024. Discrepant findings were addressed immediately, all corrective actions were completed on 08/16/2024.	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and it should immediately be updated when the code status is changed. On 8/21/24 at 8:45 A.M., the DON provided an undated Advance Directive Policy that indicated "...To provide services to our residents that will recognize and respect their dignity as individuals for freedom of choice related to healthcare...The copy of the Advance Directive will become a permanent part of the medical record..." 3.1-4(5)		4. How the corrective actions will be monitored to ensure the practice will not recur: The Social Services Director or designee will perform weekly medical record audits of new admissions and residents on the MDS assessment schedule for accurate documentation of the residents Advance Directives/Code Status throughout the electronic medical record for a period of 13 weeks. The Social Services Director or designee will perform random medical record audits of at least 3 medical records for accurate documentation for a period of 4 weeks: then 2 residents weekly for 4 weeks; then 1 resident weekly for 5 weeks Results of the audits will be discussed at the quarterly QA meetings until such a time its determined that substantial compliance is maintained.	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalizations. There was no documentation of a resident or representative receiving a notice of transfer or discharge at the time of hospitalization. (Resident	F 0623	It is the policy of this facility to ensure notice of transfer discharge is given to residents or residents representatives. 1. Immediate actions taken for the residents found to have been	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12, Resident 33, Resident 6, Resident 18, Resident 7) Findings include: 1. On 8/15/24 at 1:07 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and dementia without behaviors. Resident 12 was admitted from the facility to the hospital on 4/28/24 and returned back to the facility from the hospital on 5/6/24. Resident 12's records lacked a notice of transfer/discharge given to the resident or a representative at the time of the transfer. During an interview on 8/20/24 at 10:52 A.M., the DON (Director of Nursing) indicated the facility did not have documentation of Resident 12 or Resident 12's representative receiving a notice of transfer or discharge on 4/28/24 but they should have. 2. On 8/15/24 at 11:50 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and dementia with behaviors. Resident 33 was admitted from the facility to the hospital on 7/21/24 and returned back to the facility from the hospital on 7/22/24. Resident 33's records lacked a notice of transfer/discharge given to the resident or a representative at the time of the transfer. During an interview on 8/20/24 at 10:52 A.M., the DON indicated the facility did not have documentation of Resident 33 or Resident 33's representative receiving a notice of transfer or discharge on 7/21/24 but they should have.		affected: Social Services mailed out notices to the residents representatives or had residents sign. 2. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing completed an audit and identified 5 residents had the potential to be affected in August. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. **3.Actions taken/systems put into place to reduce the risk of future occurrence include:** An Audit was performed for the month of August for residents who were discharged or transferred out of the facility to ensure notice of transfer was completed. Any discrepancies were corrected. The State Ombudsman was notified of all August discharges/transfers Review/revise the transfer and discharge notice policy **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Transfer/Discharge Notice policy reviewed/revised. Nurses and Social Services will be educated on the Transfer/Discharge notice policy The Director of Nursing, or	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. On 8/15/24 at 8:21 A.M., Resident 18's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/30/23, 5/2/24, and 5/25/24. Resident 18's records lacked a notice of transfer/discharge given to the resident or a representative at the time of each transfer. During an interview on 8/19/24 12:07 P.M., the DON (Director of Nursing) indicated the facility did not have a Record of Resident 18 or Resident 18's representative receiving a notice of transfer or discharge on the hospitalizations on 11/30/23, 5/2/24, and 5/25/24. 4. On 8/15/24 at 9:28 A.M., Resident 6's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 12/2/24. Resident 6's records lacked a notice of transfer/discharge given to the resident or a representative at the time of the transfer. During an interview on 8/19/24 12:07 P.M., the DON indicated the facility did not have a record of Resident 6 or Resident 6's representative receiving a notice of transfer or discharge on 12/2/24. 5. On 8/20/24 at 1:10 p.m. Resident 7's clinical record was reviewed regarding hospitalization on 8/8/24. Resident 7's clinical record lacked documentation of Resident or Resident representative being given transfer discharge paperwork for hospitalization on 8/8/24. The Director of Nursing indicated, on 8/21/24 at 11:16 a.m., that their policy was to follow the		designee, utilizing the 24-hour report, will conduct an audit to ensure residents transferred or discharged from the facility received the transfer/discharge notice. If there is no evidence of the notice being given, the DON, Social Service Director (SSD), or designee will ensure that they have received a transfer/discharge notice written in a language that they can understand. This will be an on-going audit. A transfer/discharge list will be sent to the State Ombudsman Office monthly via fax or email. SSD will keep records of transfer/discharge notices, either in the EHR or paper form. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 20, 2023	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfer discharge form. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalizations. There was no documentation of a resident or representative receiving a bed hold policy at the time of hospitalization. (Resident 12, Resident 33, Resident 6, Resident 18, Resident 7) Findings include: 1. On 8/15/24 at 1:07 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and dementia without behaviors. Resident 12 was admitted from the facility to the hospital on 4/28/24 and returned back to the facility from the hospital on 5/6/24. Resident 12's records lacked documentation a bed hold policy was given to the resident or a representative at the time of the transfer. During an interview on 8/20/24 at 10:52 A.M., the DON (Director of Nursing) indicated the facility did not have documentation of Resident 12 or Resident 12's representative receiving a bed hold policy on 4/28/24 but they should have. 2. On 8/15/24 at 11:50 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and dementia with	F 0625	1 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. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** The Director of Nursing completed an audit and identified 5 residents had the potential to be affected in August. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. **3** An Audit was performed for the month of August for residents who were discharged or transferred out of the facility to ensure notice of bed hold policy. Any discrepancies were corrected. The State Ombudsman was notified of all August discharges/transfers Review Bed Hold policy Review/Revise Bed Hold Policy notice upon transfer/discharge. Staff education on the reviewed/revised policies.	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	behaviors. Resident 33 was admitted from the facility to the hospital on 7/21/24 and returned back to the facility from the hospital on 7/22/24. Resident 33's records lacked documentation a bed hold policy was given to the resident or a representative at the time of the transfer. During an interview on 8/20/24 at 10:52 A.M., the DON indicated the facility did not have documentation of Resident 33 or Resident 33's representative receiving a bed hold policy on 7/21/24 but they should have. 3. On 8/15/24 at 8:21 A.M., Resident 18's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/30/23, 5/2/24, and 5/25/24. Resident 18's records lacked a bed hold policy given to the resident or a representative at the time of each transfer. During an interview on 8/19/24 12:07 P.M., the DON (Director of Nursing) indicated the facility did not have a record of Resident 18 or Resident 18's representative receiving a bed hold policy on 11/30/23, 5/2/24, and 5/25/24. 4. On 8/15/24 at 9:28 A.M., Resident 6's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 12/2/24. Resident 6's records lacked a bed hold policy given to the resident or a representative at the time of the transfer. During an interview on 8/19/24 12:07 P.M., the DON indicated the facility did not have a record of Resident 6 or Resident 6's representative receiving		**4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing, or designee, utilizing the 24-hour report, will conduct an audit to ensure residents transferred or discharged from the facility received notice bed hold. If there is no evidence of the notice being given, the DON, Social Service Director (SSD), or designee will ensure that they have received a notice written in a language that they can understand. This will be an on-going audit. The State Ombudsman will be notified of all transfer/discharges monthly via fax or email. SSD will keep records of notice of bed hold, either in the EHR or paper form. This plan of correction will be monitored at the Quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 20, 2024.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a bed hold policy on 12/2/24. 5. On 8/20/24 at 1:10 p.m. Resident 7's clinical record was reviewed regarding hospitalization on 8/8/24. Resident 7's record lacked documentation of Resident or Resident representative being given a bed hold policy for hospitalization on 8/8/24. On 8/21/24 at 8:45 A.M., the DON provided a current bed hold/bed reservation policy, dated August 28, 2012, that indicated prior to discharge, or as soon as possible if discharge is on emergency basis a written reservation agreement will be completed. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure accuracy of MDS (Minimum Data Set) Assessments for 3 of 17 resident assessments reviewed. A resident's traumatic brain injury, a resident's history of CVA (Cerebrovascular Accident), and a resident's antiplatelet use were not marked on the MDS Assessments. (Resident 5, Resident 14, Resident B) Findings include: 1. On 8/15/24 at 11:59 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to history of CVA. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/11/24, indicated cognition status could not be assessed. CVA was not	F 0641	It is the policy of this facility to ensure accuracy of the MDS (Minimum Data Set) Assessments. 1 Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents are at risk and have the potential to be affected. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** Implement a new policy for Conducting an Accurate Resident Assessment.	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	marked as a diagnoses. On 8/20/24 at 12:37 P.M., the MDS Coordinator indicated CVA should have been marked on the 5/11/24 MDS and was an oversight. 2. On 8/15/24 at 1:09 P.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, cerebral infarction. The most recent Annual MDS Assessment, dated 7/6/24, indicated a moderate cognitive impairment. The MDS indicated Resident 14 had taken an anticoagulant, but antiplatelet was not marked. Current physician orders included, but were not limited to: Clopidogrel Bisulfate Oral Tablet (an antiplatelet) 75 MG (milligrams) 1 tablet by mouth in the evening related to cerebral infarction, dated 7/1/24. Physician orders lacked an order for an anticoagulant. Resident 14's MAR (Medication Administration Record) for July 2024 indicated Clopidogrel was administered during the assessment period for the 7/6/24 MDS. The MAR indicated an anticoagulant was not ordered or administered during the assessment period. On 8/20/24 at 12:37 P.M., the MDS Coordinator indicated Clopidogrel had been coded on Resident 14's 7/6/24 MDS Assessment as an anticoagulant instead of an antiplatelet. 3. On 8/13/24 at 8:30 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, traumatic brain injury (TBI), and schizoaffective disorder.		All staff entering data in the resident assessment in serviced on the new implementation for Conducting an Accurate Resident Assessment. **3 How the corrective action(s) will be monitored to ensure the practice will not recur:** The MDS Coordinator, or designee, will conduct a random audit of five 5 residents per week for 4 consecutive weeks; then 3 residents per week for 4 consecutive weeks; then 2 resident per week for 4 consecutive weeks; then 1 resident per week for 3 months. These residents and their medical records will be assessed to ensure appropriate documentation of diagnoses and/or medications are identified on the MDS assessment if present during assessment observation period. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 20, 2024.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The most recent Annual MDS (Minimum Data Set) Assessment, dated 8/3/24, indicated resident B's cognition was severely impaired and supervision of staff for bed mobility, transfers, toileting, and did not have a TBI. During an interview on 8/20/24 at 12:37 P.M., the MDS Coordinator indicated TBI should have been included as an active diagnosis for Resident B but was missed. At that time, the MDS Coordinator indicated they did not have a policy for doing MDS Assessments, but they use the Resident Assessment Instrument (RAI) manual.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview and record review, the facility failed to develop a care plan for 3 of 5 residents reviewed for Unnecessary Medications. Three residents did not have a care plan for antiplatelets while receiving an antiplatelet. (Resident C, Resident 3, Resident 10) Findings include: 1. On 8/13/24 at 9:00 A.M., Resident C's clinical records were reviewed. Diagnosis included, but were not limited to rheumatoid arthritis, paroxysmal atrial fibrillation, unspecified dementia, hallucinations and anxiety disorder. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 5/18/24, indicated Resident C had moderate cognitive impairment, required supervision of one for bed mobility, supervision with set up assist for transfers, eating, and limited assistance of one for toilet use. Medications included antipsychotic,	F 0656	It is the policy of this facility to ensure residents receiving antiplatelet have a care plan while receiving antiplatelet. 1 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. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** Reviewed/revised policies and procedure for Comprehensive Care Plans and Care Plan Revisions upon status change. All interdisciplinary care plan team members responsible for writing care plans will be	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	antidepressant, diuretic and antiplatelet. Physician orders included, but were not limited to the following: Aspirin Oral Capsule 81 MG (Milligram) Give 1 capsule by mouth in the morning related to paroxysmal atrial fibrillation, dated 2/9/24 The clinical records lacked a care plan for antiplatelet use. 2. On 8/16/24 at 12:02 p.m. Resident 3's clinical record was reviewed. The Resident had diagnosis including but not limited to, peripheral vascular disease (a disorder affecting blood circulation in the body). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/8/24 indicated the Resident is not cognitively intact. Current Physician Orders included, but were not limited to: Aspirin 81mg (milligrams), by mouth, daily. Order was active starting 10/11/23. Resident 3's clinical record lacked an antiplatelet care plan. 3. On 8/16/24 at 10:57 A.M., Resident 10's clinical records were reviewed. Diagnosis included, but were not limited to traumatic brain injury, anxiety disorder, and depression The most current Quarterly MDS (Minimum Data Set) Assessment, dated 6/15/24, indicated Resident 10 had moderate cognitive impairment. Medications included, but were not limited to, an antiplatelet. Physician orders included, but were not limited to the following:		educated/re-educated on the facility's policy and procedure for developing Comprehensive Care Plans and the accuracy of the assessments. **3 How the corrective action will be monitored to ensure the practice will not recur:** Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing (DON), or designee, will complete a random audit of care plans 5 times weekly for 4 consecutive weeks; then 3 times weekly for 4 consecutive weeks; then 2 times weekly for 4 consecutive weeks; then 1 time weekly for 3 months. Random audits will be completed to ensure that comprehensive care plans are developed and accurate for residents. 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. Audit results will be shared with the Resident/Family Group Council for comments and suggestions. Corrective action completion date: September 20, 2024	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Clopidogrel Bisulfate Tablet (antiplatelet) 75mg (milligrams): Give 1 tablet for stroke prevention in the evening. The clinical records lacked a care plan for antiplatelet use. During an interview on 8/20/24 at 9:55 A.M., the MDS Coordinator indicated she put in care plans for antianxiety, antidepressant, anticoagulant, diuretic and antipsychotic medication use. She usually puts the antiplatelet with the anticoagulant care plan. She indicated she had not put in an antiplatelet care plan for Resident C, Resident 3, or Resident 10 but should have. On 8/21/24 at 8:45 A.M., the DON (Director of Nursing) provided a current, undated Comprehensive Care Plans policy that indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident..." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to revise care plans and physician orders to reflect the current status of residents for 2 of 17 resident care plans reviewed. A resident's physician order for a pre-op diet was not removed after the procedure, a care plan for respiratory illness was not removed when the resident recovered from the illness, and a resident with current antianxiety and anticoagulant care plans was not receiving either medication. (Resident 14, Resident 10)	F 0657	It is the policy of this facility to revise care plans and physician orders to reflect the current status of the residents. 1 Immediate actions taken for the residents found to have been affected include: MDS coordinator updated the care plans for Resident #s 10, 14. Director of Nursing reviewed and	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. On 8/15/24 at 1:09 P.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and depression. The most recent Annual MDS (Minimum Data Set) Assessment, dated 7/6/24, indicated a moderate cognitive impairment. Current physician orders included, but were not limited to: On 6-22-24 stop all NSAIDS, iron pills, and all foods that contain skins, hulls, seeds, nuts (peanuts, popcorn, grapes, green beans, peels of apples, potatoes), dated 3/27/24. Resident 14 had a current care plan for a respiratory illness, dated 6/24/24. A progress note on 6/23/24 indicated Resident 14 had received a new order for an antibiotic due to a sore throat and white patches to the back of the throat (the antibiotic was completed on 7/3/24). On 8/16/24 at 8:35 A.M., the Kitchen Manager indicated Resident 14 had been on an order to restrict certain foods back in June, but the order was only supposed to be for a few days, and was unable to locate her paperwork as to why. She indicated Resident had a procedure following the few days of a restricted diet, and after that had resumed with a normal diet. On 8/20/24 at 9:58 A.M., the Director of Nursing (DON) indicated Resident 14 had a procedure done and the restrictive diet order was placed 5 days prior to the procedure but an end date should have been put in at that time. She further indicated Resident 14 did not currently have a respiratory illness, and the care plan for that		consulted with the providers to update orders accordingly for Resident #s 10, 14 2 Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** Reviewing/revising/implementation of a policy for care plan revision All interdisciplinary care plan team members responsible for writing care plans will be educated/re-educated on the facility's policy and procedure for care plan revision. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing (DON), or designee, will complete a random audit of care plans and physician orders 5 times weekly for 4 consecutive weeks; then 3 times weekly for 4 consecutive weeks; then 2 times weekly for 4 consecutive weeks; then 1 time weekly for 3 months. Random audits will be completed to ensure	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should have been resolved. 2. On 8/16/24 at 10:57 A.M., Resident 10's clinical record was reviewed. Diagnoses included, but were not limited to traumatic brain injury, anxiety, and depression. The most resent Quarterly MDS (Minimum Data Set) Assessment, dated 6/15/24, indicataed a moderate cognitive impairment. Resident 10's clinical record lacked a current order for an antianxiety medication. Resident 10's clinical record lacked a current order for an anticoagulant medication. Resident 10 had a current care plan for an antianxiety medication, revised 7/8/24. Resident 10 had a current care plan for an anticoagulant medication, revised 7/8/24. During an interview on 8/20/24 at 11:13 A.M., the DON (Director of Nursing) indicated the antianxiety and anticoagulant care plan should have been removed after Resident 10 discontinued the medication. On 8/21/24 at 8:45 A.M., the DON provided an undated, current Care Plan Revisions Upon Status Change policy that indicated, "...The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change..." 3.1-35(d)(2)(B)		that physician orders and care plans are consistent. 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: September 20, 2024	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices A. Based on interview and record review, the facility failed to ensure supervision of two	F 0689	It is the policy of this facility to ensure that all Exit doors are	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cognitively impaired residents; and failed to follow the facility elopement policy resulting in elopements for 2 of 2 residents reviewed for accidents. Resident B exited the facility by a side door and walked 0.5 miles to a gas station. An hour later, the resident's brother notified the facility that Resident B had left the facility. Resident C exited the facility by the front door after being returned to the facility by the son after an overnight stay. Twenty minutes later the resident was found outside the facility walking in the grass away from the facility next to the road, Highway 62. (Resident B, Resident C) This deficient practice resulted in an Immediate Jeopardy. This Immediate Jeopardy began on August 4, 2024, when the facility failed to ensure a cognitively impaired resident was adequately supervised and was allowed to leave the facility by the front door. On August 5, 2024, another cognitively impaired resident left the facility by the side door. The second resident had a history of wandering and was not adequately monitored for these behaviors. The Administrator was notified of the Immediate Jeopardy on August 13, 2024 at 2:29 P.M. The Immediate Jeopardy was removed on 8/15/24 at approximately 3:30 P.M., but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on observation, record review, and interview, the facility failed to develop and implement interventions to reduce the risk of falls, fall risk assessments were failed to be completed after falls, and neurological checks were not completed after unwitnessed falls for 2 of 7 residents reviewed for accidents, (Resident 18, Resident 33).		functioning properly to prevent residents with the potential to wander and or identified as an Elopement Risk. 1 Immediate action(s) taken for the resident(s) found to have been affected include: Resident A was assessed for injuries and placed on 1:1 for 2 hours and 15minute checks for 72 hours. Facility head count was performed per Elopement policy. Facility immediately called SafeCare to the facility on 08/04/2024 and started a fire watch until they arrived. The code was changed on the door and was not used again until Automated Doors & Access arrived at 11:30 am on 08/05/2024 and made all the repairs needed for the front door to function properly. Resident B was assessed for injuries and placed on 1:1 for 2 hours and 15minute checks for 72 hours. Facility head count was performed per Elopement policy. Facility called SafeCare to check the side door and they made repairs needed for door & alarms to function properly. 2 Identification of other residents having the potential to be affected was accomplished by: The MDS Coordinator reviewed all Care plans and found that it had a potential to affect 9 residents.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: A 1. On 8/13/24 at 9:15 A.M., the Indiana Department of Health (IDOH) incident reports were reviewed and indicated on 8/5/24 at 4:51 P.M., "Charge nurse called stated that resident called his brother and said I'm at a gas station come pick me up. Brother called facility and staff immediately went and picked him up." On 8/13/24 at 9:30 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury, epilepsy with status epilepticus, unsteadiness on feet, rheumatoid arthritis, dementia with behavioral disturbance, schizoaffective disorder, bipolar disorder, unspecified mood (affective) disorder, conversion disorder with seizures, anxiety, and unspecified psychosis. The most recent Annual MDS (Minimum Data Set) Assessment, dated 8/3/24, indicated Resident B's cognition was severely impaired, supervision of 1 staff with set up for bed mobility, transfers, eating, and toileting, did not have behaviors of wandering or exit seeking, and wore a WanderGuard (device worn to prevent elopement) daily. The physician orders, dated, 10/11/23, (prior to 8/5/24 when Resident B eloped), indicated facility staff should monitor Resident B for behaviors including, but not limited to, elopement, wandering, and to check placement and function of the WanderGuard every shift. A plan of care for history of elopement, dated 7/28/24, included, but were not limited to, interventions for staff to use distraction techniques, structured and individual activities,		2 residents were affected. **3 Actions taken/systems put into place to reduce the risk of future occurrence include:** All staff in serviced on the new facility policies for Wandering Residents, Alarms and Elopements. See Attachment: **A** All residents had their Wandering/Elopement Risk Assessment reviewed and updated to reflect the current Wandering and Elopement Risk Policy. . All staff were in-serviced on new Exit Door Policy. See Attachment: **B** Facility added a new Daily Maintenance Checklist that includes checking all the Exterior Doors daily. See Attachment: **C** The new Wandering Residents, Alarms and Elopement Policy was added to the new hire packet. Missing Resident Action Plan was added to Nursing Duty Binders at each nurse's station. Agency Staffing any training not completed, will be expected to be completed prior to working the shift that is located in the training binder labeled Agency Staffing. **4 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Administrator will audit the new Daily Maintenance Checklist	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	music, Activities of Daily Living (ADL) care, and a WanderGuard to prevent further elopement attempts. The care plan did not include documentation to show the plan was revised with interventions to prevent another elopement. A plan of care for Psycho-Social Distress Risk, dated 11/3/23, included but were not limited to, intervention to monitor behavior episodes, attempt to determine underlying cause, and to document behavior and potential causes. An elopement risk evaluation, dated 7/30/24, indicated the resident did not have a history of elopement, did not wander, and was not at risk for elopement. The progress notes were reviewed from 8/1/24 through 8/13/24 and lacked documentation of exit seeking behavior. A nursing progress note, dated 8/5/24 6:00 P.M., indicated one-to one (continuous) supervision was provided for two hours followed by 15-minute checks per facility protocol that ended on 8/6/24 at 10:15 A.M. The August 2024 MAR (Medication Administration Record), dated 8/1/24 through 8/12/24, indicated Resident B demonstrated behavior of exit seeking on the evening shift of 8/5/24. The facility's investigation of Resident B's elopement on 8/5/24 included the following: Resident B approached LPN (Licensed Practical Nurse) 5 at approximately 4:48 P.M. and asked where he could get a meal. The report indicated LPN 5 told Resident B supper would be served in 10 minutes, but did not include documentation to determine interventions to prevent elopement were implemented in accordance with the plan of		weekly x 26 consecutive weeks. The facility will in-service all staff on Wandering Residents, Alarms and Elopement Policy monthly for 12 months and annually thereafter. The IDT management team will review new incident reports 5 x weekly, ongoing to ensure appropriate interventions are implemented and the plan of care is complete. The Director of Nursing Services (DON), or designee, will complete random weekly chart audits on current residents & new admissions ongoing for elopement risk assessments and appropriate care plans for 26 consecutive weeks. This plan of correction will be monitored at the Quarterly Quality Assurance meeting until such a time consistent substantial compliance has been met. // Corrective action completion date: 08/15/2014. Facility installed new Code Alert System on three exterior doors on 09/09/2024 Part B. 1 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. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:**	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care. At approximately 5:45 P.M., LPN 5 answered the phone and the resident's brother said he got a phone call from Resident B telling him he was outside the facility at a gas station and he wanted to be picked up. A (Name of Door Repair Company) technician reported on 8/5/24 (time unknown) the hinges on the side door (employee entrance) were adjusted to so the door would close properly. Maintenance Employee 7 indicated on 8/5/24 (exact time unknown but after door repair company was there that day) inspected the side door and noticed the door was still not closing properly against the alarm sensor. A (Name of Door Repair Company) technician report about the side door dated 8/6/24 at 1:30 P.M., indicated upon arrival, maintenance stated that from time to time the Maglock would not engage when the door closed and the alarm would not sound when door was left ajar as expected. The technician identified a wiring problem that prevented the alarm equipment from functioning properly. During an interview on 8/13/24 at 9:49 A.M., LPN 5 indicated Resident B needed some supervision, had behavior of wandering up and down the halls, wore a WanderGuard, and had a very poor short term memory. At that time, she indicated he had eloped before but not for at least a year and was not exit seeking or voicing that he wanted to leave the facility. She indicated they do not document random wandering in his clinical record. It's only documented if he's intrusive to other residents. At that time, LPN 5 indicated the Elopement Risk Evaluation, dated 7/30/24, was filled out incorrectly.		Fall assessments are complete and interventions currently in place are appropriate for all residents. All staff will be in serviced on the updated facility policy for Accidents and Supervision. Review/Revise Post Fall Protocol Policy; nursing staff will be educated on policy All resident falls/accidents will be reviewed daily by IDT to ensure appropriate implementation of safety interventions including updating the plan of care . **3 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DON), or designee, will complete random weekly chart audits to review fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions, 5 times a week for 4 consecutive weeks; then 3 times a week for 4 weeks; then 2 times a week for 4 weeks; the 1 time weekly for 3 months. and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions. Audited records will be reviewed by the Risk Management/Quality	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/13/24 at 9:57 A.M., CNA (Certified Nurse Aide) 6 indicated Resident B was mainly independent, did wander in the halls, and staff only had to check on him every now and then. She indicated he had not eloped before that she knew of and she was not working the day he eloped but was told that Resident B wanted turkey for an evening meal and went to get one for himself. During an interview on 8/13/24 at 10:08 A.M., the SSD (Social Services Director) indicated Resident B had a history of elopement and vocalization that he did not want or need to be in the facility and he wanted to leave, but nothing recently. He had not been exhibiting exit seeking behavior prior to the elopement. He had a thought in his head at that minute, found a way out, and then left the facility to get what he wanted. At that time, she indicated he did wander, but they were not tracking wandering behaviors because it was considered his normal activity. During an interview on 8/13/24 at 10:16 A.M., the Administrator indicated Resident B has had exit seeking/wandering and aggressive behavior in the past but not recently. To keep the resident safe, they use a WanderGuard but it does not sound an alarm at any of the 3 exterior doors as you would expect. It only sounds when those residents enter and exit through the double doors from the dining room. During mealtimes and activities, the facility disables that alarm because so many residents pass through the doors at those times. At that time, he indicated on 8/5/24 he got a call from a nurse that Resident B went to the nurse's station and asked for a sandwich. Resident B was told to follow the CNA's to the dining room. Resident B went to the dining room, knocked on the kitchen door, asked for a turkey sandwich, and was told it		Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: September 20, 2024.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	would be on his meal tray. At that time, the resident sat down at a table, got up and walked down the hall, and went out of the side door near the dining room. The nurse was contacted at 5:45 P.M. by the resident's brother and notified that the resident had left the facility and was at a gas station. The staff only documented Resident B's behaviors if they were accelerated and since wandering was his normal, they don't document that. The Administrator indicated he would expect staff to provide interventions to prevent elopement in accordance with the care plan for a cognitively impaired resident at risk for elopement. During an interview on 8/13/24 at 10:35 A.M., the Maintenance Director indicated maintenance staff was not expected to randomly check the doors of the facility to make sure they were functioning properly. They were only checked when maintenance staff were alerted to a problem with them and staff did not keep any documentation about it. During an interview on 8/13/24 at 2:01 P.M., CNA 4 indicated he was working at the time Resident B eloped and was working on the West Hall where Resident B's room was. CNA 4 indicated Resident B had a history of eloping from the facility. CNA 4 indicated when he went to pick up the resident from the gas station after they were notified Resident B was missing, the resident was confused and didn't know where he was but said he went to (name of restaurant) across the street from the gas station and got himself a drink and a sandwich. According to the Iphone map application, the restaurant where the resident went was 0.5 miles away from the facility and would take 11 minutes to walk there. The resident had to cross Indiana			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Highway 62 and Washington Street twice to get to the restaurant and then to the gas station where he was picked up by staff. A 2. On 8/13/24 at 9:15 A.M., an Indiana Department of Health Incident Report, dated 8/4/24, indicated Resident C was found walking up the road by a staff member. Facility was investigating how she got out. It was reported that a nurse left for lunch and resident may have followed the nurse out the front entrance door. Resident C was immediately returned to facility and placed on 1:1 for 2 hours and 15 minute checks for 72 hours. Facility immediately notified maintenance to check the doors and called (Name of Door Repair Company #1) to come and inspect the doors. On 8/13/24 at 9:30 A.M., Resident C's medical records were reviewed. Admission date was 2/8/24. Diagnosis included, but were not limited to rheumatoid arthritis, coronary artery disease, hypertension, non-Alzheimer's dementia, seizure disorder, anxiety disorder, asthma, and hallucinations. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 5/8/24, indicated Resident C was moderately cognitively impaired, needed supervision of one for bed mobility, supervision with set up for transfers and eating and limited assistance of one for toilet use. Resident had no behavior of wandering, no hallucinations, no delusions, no physical or verbal behavioral symptoms, and used a wander/elopement alarm daily. Current physician orders, dated 7/25/24, indicated facility staff should monitor Resident C for behaviors including, but not limited to elopement and check placement and function of the			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	WanderGuard every shift. A plan of care for risk of elopement/wandering, dated 7/8/24, included, but were not limited to, interventions for staff to use distraction techniques, structured and individual activities, music, quiet time, identify patterns of wandering, and a WanderGuard to prevent further elopement attempts. Care plan interventions were not updated after Resident C eloped on 8/4/24. Progress Notes included, but were not limited to the following: 7/18/24 5:46 A.M. Health Status Note Note Text: "Resident pacing from room to lobby multiple times. c/o [complained of] being cold. Resident given a jacket and went back to room." 7/18/24 8:38 A.M. Health Status Note Note Text: "Resident pacing from room to lobby. Snack given, went back to room." 7/20/24 12:20 P.M. Behavior Progress Note Note Text: "Resident restless, walking up and down hallway, standing next to nursing cart, and following nurse from room to room. Resident laid down at noon for a nap." 7/25/2024 12:50 P.M. Behavior Progress Note Note Text:" Resident has been pacing today and standing at the nurses [sic] station multiple times today. Resident is not causing any issues. Resident has brought some of her greeting cards from her room to the nurses [sic] station and has read them repeatedly to whomever is there at the nurses [sic] station to listen, otherwise resident stands there quietly. Resident has been asked if			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	there are any unmet needs. Resident denies and unmet needs." 7/26/24 5:13 A.M. Health Status Note Note Text: Resident restless and pacing early in shift between 6 P.M. to 8 P.M. Once resident was assisted with getting ready for bed, rested well with C-Pap on. 8/4/2024 1:48 A.M. Health Status Note Note Text: "OOF [out of facility]- Family went out with resident and to be returned to facility 5pm [sic] per report given. RSD [resident] has not been returned to facility at this time. Calls made to family via phone. Pending response back." 8/4/2024 1:33 P.M. Health Status Note Note Text:" Resident has returned to facility at this time with son." 8/4/2024 2:29 P.M. Incident Note Note Text: "This nurse received a phone call from employee who was leaving on lunch break that this resident was walking outside facility and he was assisting her back to front door. This nurse and CNAs [Certified Nurses Aides] ran to front door and assisted resident back into the facility where she was assessed. Temp [Temperature] 96.5, Resp [Respirations] 16, HR [Heart Rate] 99, BP [Blood Pressure] 120/95, 93% RA [Room Air]. Resident had just returned from overnight stay with son and stated that she was trying to get home to her son. Resident is currently on 1 on 1 supervision for 2 hours. Administrator, DON [Director of Nursing], PCP [Primary Care Provider], andfamily [sic] notified." 8/4/2024 4:41 P.M. Elopement Evaluation done by LPN 5 had an Elopement Score of 3 which indicated Resident C was an elopement risk and			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wandered. A progress note dated 8/5/24 8:38 A.M. indicated Resident C was on 15 minute checks for 72 hours. A Fifteen Minute Checks Form was completed every 15 minutes starting on 8/4/24 at 4:30 P.M. through 8/7/24 at 11:45 P.M. A progress note by Social Services, dated 8/5/24 3:55 P.M., indicated Social Services met with Resident C in her room and talked about the weekend. Resident C talked about other things not related to the elopement. No exit seeking had been reported. A progress note, dated 8/5/24 8:13 P.M., indicated Resident C had no exit seeking. She stayed in her room or stood at the nurse's desk. She went to the dining room for supper. She refused to wear bipap and had to be put to bed 4 (four) times. She will be monitored. A progress note, dated 8/7/24 5:19 P.M., indicated Resident C was very confused, wandering on the unit, almost blocked another resident's doorway. The other resident raised their voice to get her to move. Both residents were redirected successfully. A progress note, dated 8/11/24 11:48 A.M., indicated Resident C was seen wandering by the front door several times, pushing on the double doors by the front door. Alarm was applied to front door and Resident C was monitored for safety. The most recent Core Behavior Risk Assessment completed on 4/25/24 indicated Resident C was on psychotropic medications, was cognitively			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	impaired, had no history of mental illness and no aggressive behaviors in the last 3 months. The August 2024 Medication Administration Record (MAR), dated from 8/1/24 through 8/13/24, indicated Resident C had no behaviors on any shift and the WanderGuard was checked for placement and function every shift, except for the evening of 8/3/24, which was blank. A handwritten note signed by LPN 5 indicated on 8/4/24 when she went to the front door to get Resident C from Dietary Aide 3, she noticed the front entrance door was not latched and the alarm was not sounding. A typed note by LPN 12, dated 8/4/24, indicated she went out the front entrance door to put belongings in her car. She heard the front entrance door slam. She helped Resident c through the second set of double doors by the entrance after explaining to the resident that her son had left. After Resident C was in the hallway, LPN 12 went to the West Hall. Since the door had slammed LPN 12 assumed it closed. When she left the facility, LPN 12 noticed the front entrance door was not closing all the way and was staying open. The door had to be pushed on to close it when leaving. A typed note, dated 8/4/24, by Maintenance Tech 26, indicated he was called by the Maintenance Supervisor that the front door was malfunctioning. He was unable to repair the door due to multiple damages. He let his supervisor know and the (Name of Door Repair Company #1) was contacted. Fire Watches were conducted every 15 minutes (from 6:40 P.M. through 7:10 P.M.) until (Name of Door Repair Company #1) arrived. (Name of Door Repair Company #1) was			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unable to repair the front entrance door due to multiple damages and recommended the code to enter and exit the front entrance door be changed for safety measures. The code was changed. A typed note by the Maintenance Supervisor, dated 8/4/24, indicated nothing was reported to her that the front entrance door had any problems. She was called about the door malfunctioning. When (Name of Door Repair Company #1) indicated they were unable to fix the door, she called the Administrator and he called (Name of Door Repair Company #2) to come and repair the front entrance door. Review of the (Name of Door Repair Company #1) invoice dated 8/4/24 indicated "Technician called facility to inform of arrival time. Apon [sic] arrival technician met with facility and began troubleshooting front door. With nothing on door, door swings open 8 inches due to the bottom hinge rotting out. Technician tried to adjust two door closers to hold door shut for maglock to engage. Door closers do not have enough force to keep door from moving back out of range for maglock to engage. Technician spaced out bottom hinge to realign door. Spacing was unsuccessful and if we step up the spacing anymore it will blow the door out of what is remaining for the bottom hinge. The side and top of the door frame moves and shifts with the door. The bottom threshold has soft wood under it. Door is locked down until further work is done." Review of the (Name of Door Repair Company #2) work order, dated 8/5/24, indicated "the front entrance door was not shutting all the way. Bottom pivot was busted and moving around. Replaced the bad pivots with a continuous hinge. We fabricated a brace for hinge side jams/top of			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	frame. We also made a door stop for the bottom of the door. Door is short on width. Note: It was reported a resident busted out of the door and did some damage." During an interview 8/13/24 at 9:58 A.M., the DON (Director of Nursing) indicated Resident C was checked every two hours for check and change since she was incontinent. She was not followed by staff when ambulating in the hall since it was a locked building. The DON indicated Resident C wandered but did not have a history of exit seeking. From the time Resident C was admitted, she wandered the halls looking out the front double doors for her son's car in the parking lot but didn't try to go out the doors. She had a WanderGuard on, and staff redirected her away from the doors. She liked to hang out with the nurses. She was a jailer on night shift all her life and liked making rounds with the nurses. The DON indicated the son picked Resident C up on Saturday for an overnight stay and brought her back on Sunday. The son did take her to her room. The son indicated that he turned around to make sure the door was shut. The DON indicated that there were no problems with the alarm system on 8/4/24 and maintenance checked the doors and alarms routinely. Wander Guard would not trigger if a resident went out the front door. During an interview on 8/13/24 at 11:02 A.M., CNA (Certified Nurse Aide) 6 indicated Resident C did not have a history of elopement. Her son had dropped her off and she told CNA 6 after the elopement that she was going to whoop his butt because she was not done staying at home. Thirty minutes after Resident C was returned the elopement happened. CNA 6 heard the alarm but did not respond because she was on the end of the hall with a resident. Resident C was in the			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	parking lot and had already been out there at that point. During an interview on 8/13/24 at 11:32 A.M., LPN (Licensed Practical Nurse) 5 indicated she usually worked on the West Hall but had worked with Resident C on 8/4/24. Resident C needed limited to extensive assistance with care, depending on what it is. She required her meat to be cut but could ambulate on her own. Elopement assessments were done quarterly and could be seen under assessments in the medical records. Resident C did not have a history of exit seeking but she wandered and wore a WanderGuard. At the time of the elopement on 8/4/24, LPN 5 indicated she was doing charting at the desk at the opposite end of the East Hall, not in view of the front entrance door. The son brought Resident C back at 1:30 P.M. About 1:50 P.M., kitchen employee called and said resident was walking outside. LPN 5 indicated she did not see Resident C go out the front door. When she got outside Resident C was in parking lot. She brought her inside and kept her at the nurse's desk for 1:1 for 2 hours. Resident C did go to the dining room for supper and had no further behaviors. LPN 5 indicated Resident C has had no other attempts of exiting the building. LPN 5 indicated the alarm at the front door went off anytime someone went in or out of the building. Each nurse's desk had box on the wall that indicated where the alarm was going off. Any employee could check an alarm to see if a resident was setting it off. During an interview on 8/13/24 at 2:01 P.M., CNA 4 indicated he was working the day Resident C eloped. He indicated the alarm would sound, but he always had to press the front entrance door back because you didn't know if it would stay			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	closed. He indicated Resident C was warm when she came back into the facility. They had to put cool cloths on her and make sure her air conditioner unit was turned up in her room. During an interview on 8/13/24 at 2:12 P.M., Dietary Aide 3 indicated he went out the back door going on lunch break around 2:00 P.M. He indicated he was leaving the parking lot when he saw Resident C standing in the grass next to the facility sign facing Indiana Highway 62. He called the nurse to notify her the resident was outside and turned around as soon as possible. He parked his Jeep in the parking lot, called Resident C's name and she walked to him. He assisted her to the front door where staff was waiting. During an interview on 8/14/24 at 8:59 A.M., Resident C indicated her son brought her back to the facility on 8/4/24 because he had to mow the yard. She indicated her son's truck was broke down and didn't want her to have to deal with that as well. Resident C could not recall any specifics about the elopement incident. During an interview on 8/14/24 at 9:44 A.M., the DON indicated that care plans might be updated by MDS (Minimum Data Set) Coordinator, Social Services or Activities depending on what the care plan entails. As far as when care plans were to be updated, the DON indicated that usually that was done with quarterly MDS assessments, or if there was something that arose such as infection, injury, or something of an acute nature. On 8/14/24 at 11:55 A.M., the weather report for 8/4/24 at 1:53 P.M. to 2:53 P.M. found on TimeandDate.com/weather indicated the temperature was 91 degrees and the humidity was 52%.			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/14/24 at 8:33 A.M., the DON provided an undated Elopement Policy and Procedure that indicated, " ...The facility team will assess the environment to identify potential risks associated with elopement and/or hazards associated with elopement. Elopement is defined as follows: When a cognitively impaired resident leaves the physical structure of the facility unattended and without staff knowledge and displays exit seeking behavior. [name of company] will implement individualized interventions to strive to prevent elopement ...Complete Elopement Plan of Care as applicable...Review and evaluate assessments and risk factor data and make a determination of risk for elopement...Review and revise plan of care as needed ...Review and correct deficiencies in practice as they relate to the following, including, ...response to alarms, testing alarms ...Validate that the resident is wearing an electronic/alarm device as indicated and check that electronic/alarms systems are functioning according to manufacturer recommendations. Record residents at risk for elopement on patient care guide/assignment sheets ...If in the event a resident is found to be missing or suspected to be missing a FULL FACILITY head count will be completed and the "Missing Resident Action Plan" will be initiated ...The interdisciplinary team will re-evaluate cognitively impaired residents who have attempted (unsuccessfully or successful) to elope from the facility. Individualized interventions will be developed and initiated to manage the elopement behavior ...Review and update plan of care and evaluate risk factors identified ..." On 8/14/24 at 11:37 A.M., the DON indicated that the missing resident action plan was not completed after the incident, as per policy, as staff			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was not aware of where the forms were located, but she would expect the form to be completed in the event a resident was missing. On 8/14/24 at 8:33 A.M., the DON provided a Behavior Management Policy, dated 3/11/24, that indicated, "A Behavior Risk Assessment will be completed on all residents upon admission, quarterly, and when new or worsening behavior occurs. All residents who score 3 or above on the behavior risk assessment may be deemed high risk for behaviors and may require a review of the current care plan by the IDT (Inter-disciplinary Team) and/or the medical provider. All residents will be monitored for behaviors every shift. If an identified behavior occurs, it will be documented in the medical record ... " On 8/14/24 at 11:37 A.M., the DON indicated that the missing resident action plan was not completed for Resident B and Resident C as staff was not aware of where the forms were located to complete it. The Immediate Jeopardy, that began on 8/4/24, was removed on 8/15/24 when the facility in-serviced facility staff on exterior door policy, revised elopement policy and identification, missing person action plan, use of Wanderguard system, additional updates to exterior doors, and wandering behaviors but the noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. B 1. On 8/14/24 at 9:55 A.M., Resident 18 was observed sleeping in bed with a fall mat placed on the ground.			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/15/24 at 12:09 P.M., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to: non-traumatic brain dysfunction, seizure disorder, and depression. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 6/21/24, indicated Resident 18 was an extensive assistance of two or more persons for: bed mobility, transfers, and toileting. The MDS indicated he had two or more falls since admission or the prior assessment. Care plans included, but were not limited to, "I am at risk for falls r/t [related to] Psychoactive drug use, dementia, tremors, repeated falls, lack of coordination, unsteadiness on feet, restless leg syndrome, degenerative disease of nervous system, anemia, uses a wheelchair and uses walker at times for ambulation..." revised 7/1/24. Resident 18's fall history included, but was not limited to: Fall 1: On 7/19/24 Resident 18 fell in the bathroom after breakfast. Resident 18's clinical record lacked an update to his care plan after that fall. Fall 2: On 7/24/24 "resident was sitting in chair enjoying his activity and when he was done he just jumped up and started to try to walk across the floor. legs were weak and he fell to floor on buttock . did not hit his head. and received no injuries..." Resident 18's clinical record lacked an update to his care plan and notification to his family and doctor. Fall 3: On 7/26/24 Resident 18 was leaning to his left side			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and fell when he tried to stand up. His clinical record lacked an update to his care plan after that fall. Fall 4: On 7/28/24 Resident 18 was found kneeling on his fall mat. His clinical record lacked a notification to his family. During an interview on 8/16/24 at 1:29 P.M., the MDS Coordinator indicated the care plan was not updated after every fall and the interdisciplinary team should update the care plans after a fall and family and the physician should be notified after a fall by the nurse on duty. B 2. On 8/19/24 at 10:57 A.M., Resident 33 was observed awake and in bed with both feet hanging off the right side of the bed and the wheelchair was placed by the bathroom door. The resident indicated he "wanted to get up". The resident was asked to use his call light, but it was wrapped around the bed rail, hanging down, and stuck between the bedrail and mattress. The resident attempted twice but was not able to pull it out to use it. At that time, there was not a sign to "call and don't fall" observed in Resident 33's room. On 8/20/24 at 8:32 A.M., Resident 33 was asleep in his bed and the wheelchair was by the closet door. On 8/15/24 at 11:50 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, dementia with behaviors, and schizophrenia. The most recent Admission MDS Assessment, dated 6/12/24, indicated Resident 33 was			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, and toileting. A current Risk for Falls Care Plan, dated 6/19/24, included, but was not limited to, the following interventions: Be sure the resident's call light is within reach, initiated 6/19/24 Follow facility fall protocol, initiated 6/19/24 Staff to ensure wheelchair is at bedside for self-transfers, initiated 7/15/24 Vision sign call don't fall for reminder, initiated 7/30/24 The following were the only Fall Risk Assessments documented in Resident 33's clinical record: 6/9/24 indicated resident was not a high risk to fall. 8/12/24 indicated resident was not a high risk to fall. On 8/19/24 at 9:36 A.M., the DON (Director of Nursing) provided the following Fall reports on Resident 33 that included, but were not limited to, the following falls: 7/11/24 at 6:40 P.M., Resident 33 was observed on the floor next to his bed on both knees and indicated he was trying to get to bed. A post Fall Risk Assessment was not documented in the clinical record. 7/21/24 at 7:30 P.M., CNA (Certified Nurse Aide) reported to nurse that Resident 33 fell in his room and was observed laying on his right side close to his bed. Resident 33 indicated that he hit his head on the wall and felt dizzy. The fall report indicated he slid on food crumbs he dropped accidentally on the floor while having supper. Resident 33 was tra			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nsferred to the emergency room for further assessment. Upon his return to the facility on 7/22/24, the clinical record lacked documentation that neurological checks were completed. A post Fall Risk Assessment was not documented in the clinical record. During an interview on 8/19/24 at 11:09 A.M., CNA18 and LPN (Licensed Practical Nurse) 5 indicated they were not sure if there should be a "call don't fall" sign in Resident 33's room but observed that there was not one. CNA 18 indicated he did transfer himself at times but she wasn't sure if the wheelchair was supposed to be kept at bedside, but they did keep his call light in reach because he can use it.During an interview on 8/19/24 at 11:18 A.M., the DON (Director of Nursing) indicated Resident 33 should have a sign in his room and indicated the staff did find a sign under his bed and weren't sure how long it had been there. At that time, the DON indicated there should not be any food crumbs or debris on the resident's floor, but he was always snacking and got up on his own so it's possible there could have been at the time of his 7/21/24 fall. She could not remember.During an interview on 8/19/24 at 2:03 P.M., the DON indicated a Fall Risk Assessment should be completed on a resident at admission, every quarter, and after a fall and if the fall is unwitnessed,			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	neurological checks should be completed per protocol.On 8/21/24 at 8:45 A.M., the DON (Director of Nursing) provided a current Incidents and Accidents policy, revised November 2017, that indicated, "...The nurse will contact the resident's practitioner to inform them of the incident/ accident...In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet...The resident's family or representative will be notified of the incident/accident and any orders obtained...Documentation should included date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions...FILL OUT FALL ASSESSMENT..."This citation relates to Complaints IN00440284 and IN00440376.3.1-45(a)3.1-45(a)(2)			
F 0741 SS=D Bldg. 00	483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs Based on observation, interview, and record review, the facility failed to ensure resident's safety by sufficiently tracking behaviors and assessing residents that were at risk for behaviors according to their plan of care for 2 of 2 residents reviewed for behavior monitoring. The behavior tracking system used by the facility staff was inconsistent and ineffective for monitoring behaviors to keep residents safe for 2 of 2 residents. (Resident B, Resident 4)	F 0741	It is the policy of this facility to ensure resident safety by sufficiently tracking behaviors. 1 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	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. On 8/13/24 at 9:03 A.M., Resident B was observed asleep in his bed. On 8/13/24 at 8:30 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury, epilepsy with status epilepticus, unsteadiness on feet, rheumatoid arthritis, dementia with behavioral disturbance, insomnia, schizoaffective disorder The most recent Annual MDS (Minimum Data Set) Assessment, dated 8/3/24, indicated Resident B's cognition was severely impaired, supervision of 1 staff with set up for bed mobility, transfers, eating, and toileting, did not have behaviors of wandering or exit seeking, had insomnia, and wore a WanderGuard (device worn to prevent elopement) daily. Current Physician's Orders included, but were not limited to, monitoring for the following behaviors and side effects of medications: restlessness, increase in complaints, elopement, refusal of care, fatigue, and trouble sleeping. A current Risk for Psycho-Social Distress Care Plan, dated 11/3/23, included, but was not limited to, the following intervention: Monitor behavior episodes and attempt to determine underlying cause. Document behavior, potential causes, and interventions tried, initiated 11/3/23 Progress Notes were reviewed from 5/1/24 through 8/20/24, and included the following behavior documentation: 5/17/24 resident refused shower		affected. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** Behavior risk assessments were completed on all residents. Social Services, MDS nurse, and floor nurses in-serviced regarding the facility policy for Behavior management. Administration is working with Point Click Care representatives to update the behavior tracking/monitoring module to make the process more consistent. Staff to be in serviced once the new PCC modules are updated. **3 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Social Services Director or designee will complete random weekly audits for new admissions and residents with new or worsening behaviors to ensure that behavior risk assessments are completed on an ongoing basis. IDT will meet daily to discuss any behaviors, and update care plans as needed. 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.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/21/24 resident refused shower 6/10/24 resident awake all night 7/2/24 resident refused shower 8/5/24 resident eloped 8/7/24 resident complained he was tired 8/8/2024 resident reported feeling tired 8/9/24 resident restless this shift pacing floors 8/12/24 resident pacing hallway 8/14/24 resident up off and on tonight The MAR was reviewed from 5/1/24 through 8/20/24 and indicated no wandering, fatigue, or trouble sleeping noted except for the evening shift of 8/5/24 when the resident eloped from the facility. Under the tasks section of the electronic medical record, reviewed from 5/1/24 through 8/20/24 included behavior monitoring of insomnia, refusals, restlessness, and wandering. The tasks lacked documentation of those behaviors when they occurred. The SSD (Social Services Director) provided a current Behavior Tracking Binder that staff kept of all residents behaviors on handwritten forms, and it lacked documentation of any behaviors for Resident B, except a shower refusal on 7/2/24. The most recent Behavior Risk Assessment, dated 5/12/24, indicated Resident B was high risk for behaviors. During an interview on 8/13/24 at 10:08 A.M., the SSD indicated until the resident successfully eloped on 8/5/24, he was not exhibiting any exit seeking behaviors. Resident B had a history of eloping in the past and that was why he wore the WanderGuard. At that time, she indicated he did wander, but they were not tracking wandering			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	behaviors because it was considered his normal activity and insomnia was the most recent concern with him. She indicated she started at the facility in March of 2024 and no one was looking at behaviors at that time. She indicated she started reviewing and monitoring behaviors, making sure they were addressed, and care plans were updated. She was still in the process of trying to implement a tracking system because there was not one. They do track behaviors on EHR (Electronic Health Record) in CNA tasks, the MAR, and the progress notes, but it's inconsistent and there wasn't one place to look for behavior monitoring. That was the reason she kept the Behavior Binder as well and staff were supposed to mark any behavior that happens including wandering on the form in her office. The resident should also be having Behavior Risk Assessments completed when a major escalation in behavior happened (a Behavior Risk Assessment was not completed for the residents 8/5/24 elopement). During an interview on 8/21/24 at 9:01 A.M., RN (Registered Nurse) 32 indicated Resident B liked to sleep until noon every day. At that time, she indicated she was not sure if the resident had insomnia and no one from the night shift said anything about him not sleeping or trouble sleeping at night during the verbal report on Resident B at each shift change.2. On 8/15/24 at 10:08 A.M., Resident 4's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease, seizures, anxiety, depression, and Bipolar Disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/25/24, indicated a severe cognitive impairment, and behaviors directed at others and rejection of care 1-3 days during the 7 day assessment period.			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Current physician orders included, but were not limited to: Monitor for behaviors and document in progress notes specific behaviors if observed, dated 10/7/23. Resident 4's MAR (Medication Administration Record) from May 2024 through August 2024 indicated the following dates with behaviors: 5/10/24 5/22/24 6/19/24 7/20/24 Behavior progress notes indicated behaviors on the following dates from May 2024 through August 2024: 5/22/24 5/23/24 5/24/24 5/29/24 5/30/24 6/16/24 6/19/24 6/23/24 6/28/24 6/29/24 7/20/24 7/21/24 7/22/24 8/4/24 8/8/24 8/12/24 Behavior tracking on the "task" portion of the clinical record indicated behaviors on the following dates from May 2024 through August 2024: 5/30/24			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/20/24 6/21/24 6/22/24 6/25/24 7/22/24 On 8/20/24 at 9:38 A.M., Licensed Practical Nurse (LPN) 21 indicated the nurses charted behaviors in a progress note, and also notified the Social Services Director (SSD). Any additional charting would go in the progress notes. She further indicated when providing a physician of behaviors, nurses would give the information that was documented in progress notes only. On 8/20/24 at 10:04 A.M., the Director of Nursing (DON) indicated behaviors were reviewed in morning meeting from the previous day. She indicated a 24-hour report for behaviors and clinical information was pulled to review, and the SSD kept all behavior reports. She indicated the 24-hour report pulled information from progress notes, assessments, and only from the MAR if an order prompted the nurse to put in a progress note. She indicated the 24-hour report did not pull from the "task" section of the clinical record. On 8/20/24 at 10:08 A.M., the SSD indicated she was working on tracking behaviors, but had not started tracking for Resident 4. She indicated the information for tracking was obtained from 24-hour reports and what is documented and logged from the aides. She indicated behaviors documented on the MAR, progress notes, and the "task" portion of the clinical record should all match. At that time, a behavior tracking binder was reviewed that the SSD indicated she had used prior to starting her new system. The binder indicated the following dates Resident 4 had behaviors from May 2024 through August 2024:			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/1/24 5/9/24 5/10/24 5/19/24 5/22/24 5/23/24 5/29/24 5/30/24 6/19/24 6/22/24 6/28/24 On 8/21/24 at 8:45 A.M., the DON provided a current Behavior Management policy, dated 3/11/24, that indicated "All residents will be monitored for behaviors every shift ... If an identified behavior occurs, it will be documented in the medical record ... The behavior monitoring report will be reviewed on a minimum of a monthly basis"			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure accurate documentation for 2 of 7 residents reviewed for accidents. A resident's fall risk assessments, MD notes, and evaluations did not accurately reflect the resident's current status, and a resident's clinical record reflected him as present in the facility while hospitalized. (Resident 4, Resident 5) Findings include: 1. On 8/15/24 at 10:08 A.M., Resident 4's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease, seizures, anxiety, depression, and history of Cerebrovascular Accident (CVA). The most	F 0842	It is the policy of this facility to ensure accurate documentation for residents reviewed for accidents. 1 Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** All residents have fall assessments updated, and care plans updated accordingly.	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/25/24, indicated a severe cognitive impairment. Resident 4 was hospitalized from 7/2/24 through 7/19/24. Progress notes from 7/2/24 through 7/19/24 included, but were not limited to: 7/2/24 at 11:02 P.M. Nurse indicated resident was transferred to a behavioral health center. 7/3/24 at 3:32 P.M. An activity participation note indicated the resident had participated in several activities that day with no behaviors noted. 7/6/24 at 8:36 A.M. A nursing note indicated "He with family" 7/19/24 at 9:07 P.M. A nursing note indicated resident returned from the behavioral health center at approximately 8:30 P.M. Resident 4's July 2024 Medication Administration Record (MAR) indicated the following was performed during the resident's hospitalization from 7/2/24 through 7/19/24: Wanderguard was checked to ensure functionality twice on 7/8/24. Side effects of antidepressant medications marked as "NO" (monitored and not observed) on 7/9/24, 7/10/24, 7/12/24, and 7/16/24. Side effects of anticonvulsant medications marked as "NO" (monitored and not observed) on 7/9/24, 7/10/24, 7/12/24, and 7/16/24. Side effects of antianxiety medications marked as "NO" (monitored and not observed) on 7/9/24, 7/10/24, 7/12/24, and 7/16/24.		Nurses educated on revised Post Fall Protocol policy and proper documentation Nurses were educated on Documentation in Medical Record Policy and the importance of accurate documentation. **3 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing (DON), or designee, will complete a random chart audits 5 times weekly for 4 consecutive weeks; then 3 times weekly for 4 consecutive weeks; then 2 times weekly for 4 consecutive weeks; then 1 time weekly for 3 months. Random chart audits will be completed to ensure that assessments, MD notes, and nursing documentation are accurate for residents. This plan of correction will be monitored at the Quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 20, 2024.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Side effects of antipsychotic medications marked as "NO" (monitored and not observed) on 7/9/24, 7/12/24, and 7/16/24. Behaviors marked as "NO" (monitored and not observed) on 7/9/24 and 7/16/24. Weekly nursing assessment completed on 7/5/24 and 7/12/24. On 8/20/24 at 9:55 A.M., the Activities Director indicated the activities note for Resident 4 on 7/3/24 was an oversight. She indicated she must have marked the wrong person on her log. On 8/21/24 at 10:19 A.M., the Director of Nursing (SON) indicated Resident 4 should have been marked "out of facility" instead of marking "NO" as that meant the resident was monitored. Marking "out of facility" would have prompted the nurse to mark a code as to where the resident was and would not have marked "NO" on the MAR. 2. On 8/15/24 at 11:59 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, aphasia, depression, and psychotic disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/11/24, indicated cognition status could not be assessed, and one fall without injury since the prior assessment. Resident 5 required supervision with setup for bed mobility and eating, and supervision of one for transfers and toileting. Resident 5 had experienced one fall in the previous 12 months on 4/6/24 with no injury. A Physician Narrative Progress Note, dated			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/6/24, indicated resident had a history of stroke, and occasionally fell due to weakness. A Physician Narrative Progress Note, dated 7/18/24, indicated resident had a history of stroke, and occasionally fell due to weakness. A Long Term Care Evaluation, dated 4/11/24, indicated resident experienced no falls since the previous evaluation on 4/4/24. A fall risk assessment, dated 2/13/24, indicated Resident 5 was ambulatory, use of a walker was not checked, and the resident did not have any predisposing diseases. A fall risk assessment, dated 4/6/24, indicated Resident 5 had experienced 3 or more falls in the past 3 months, and did not have any predisposing diseases. A fall risk assessment, dated 5/11/24, indicated Resident 5 had no falls in the past 3 months, and had no predisposing diseases. A fall risk assessment, dated 8/7/24, indicated Resident 5 was ambulatory and did not have any predisposing diseases. On 8/15/24 at 12:50 P.M., the Director of Nursing (DON) provided a copy of a blank fall risk assessment form that explained what predisposing diseases should have been included on the forms. The list included seizures and CVA. On 8/16/24 at 12:30 P.M., the DON indicated Resident 5 had only fallen on 4/6/24 and did not have a problem falling, that it was a one-time thing. The electronic medical record went back to November 2023, and she did not remember the			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident falling prior to that. She indicated Resident 5 had only been independent with ambulation a "long while ago", and had been chairbound for a long time. She indicated the fall risk assessments were not filled out correctly, and all staff filling them out should be held to the same protocol. On 8/21/24 at 8:45 A.M., the DON provided a current Documentation in Medical Record policy, dated 3/5/24, that indicated "Documentation shall be factual, objective, and resident centered ... False information shall not be documented ... Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care" 3.1-50(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure infection control practices were in place for 4 of 4 residents during incontinence care and 1 of 1 resident during wound care. Staff failed to sanitize hands and change gloves between dirty to clean tasks. Staff failed to lather for at least 20 seconds when washing hands. (Resident 2, Resident 12, Resident 15, Resident 31, Resident 35) Findings include: 1. On 8/21/24 at 9:38 A.M., Registered Nurse (RN) 25 was observed to change a dressing for Resident 35. RN 25 entered the room with supplies, and did not wash or sanitize hands prior to putting on gloves. With gloved hands, RN 25 removed the dressing from the resident's left shin,	F 0880	It is the policy of this facility to ensure that infection control practices are in place during incontinence care and during wound care. 1 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. **2 Actions taken/systems put into place to reduce the risk of future occurrence include:** All personnel will be in-serviced on the facility's policy for hand	09/20/2024

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	retrieved the garbage can from beside the bed touching the side of the bed and nightstand and placed it by the resident who was sitting in a wheelchair, and threw away the old dressing. Without changing gloves, RN 25 placed a piece of gauze in her palm, and sprayed it with wound cleanser. That gauze was then used to rub the wound area. The area was then dried, ointment placed, and a new clean border bandage was placed while RN 25 touched the inside of the bandage prior to placing with her gloved hand. Gloves were not changed during the dressing change, and hands were not sanitized. RN 25 removed the gloves, and washed hands with a 12 second lather. 2. On 8/21/24 at 10:05 A.M., the Infection Preventionist (IP) indicated staff did not use an infection assessment tool or management algorithm for infections. She indicated she had not used anything like that since she had taken the position in February 2024. She indicated instead of using an assessment tool, it was nursing judgement or the nurses brought their concerns to her to address. 3. During an observation on 8/20/24 at 10:39 A.M., incontinence care on Resident 2 was performed by CNA (Certified Nurse Aide) 6 and CNA 24. Both CNAs put on gloves without sanitizing their hands after getting the resident into the shower room. Both CNAs locked his wheelchair, told resident to grab the handrail, assisted resident to stand and pivot to sit on the toilet. CNA 6 took off the soiled incontinence pad and with the same gloves, grabbed a wash cloth, turned on the water faucet, wet the cloth, turned off the faucet, grabbed the bottle of peri wash sitting on the sink and sprayed it onto the wet wash cloth. CNA 6 wiped the resident's backside, folded the wash cloth, wiped again, then using the same wash		hygiene. In-service training includes random observation of personnel performing hand hygiene procedures according to facility policy. Findings are reviewed with all personnel. Corrective action provided as needed. All nursing staff will be in-serviced on the facility's policy for peri-care. In-service training includes random observation of personnel performing peri-care on residents. Findings are reviewed with nursing staff. Corrective action provided as needed Review/revised Clean Dressing Change policy; Nursing staff who provide wound care in-serviced on policy. **3 How the corrective action(s) will be monitored to ensure the practice will not recur:** The Infection Preventionist (IP), or designee, will complete random audits of personnel and the timing and technique of hand hygiene procedure. To ensure personnel are performing the procedure in accordance with the facility's hand hygiene policy, random monitoring will occur each week for 26 weeks. The IP, or designee, will complete random audits of nursing staff performing resident peri-care. To ensure nursing staff are performing	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cloth, wiped the front of the resident. CNA 24 asked the resident to grab the handrail again, and CNA 6 assisted resident to stand by grabbing his shirt, then grabbed the back of the new incontinence pad to pull it up and helped CNA 24 fasten it still wearing the same gloves. CNA 6 pulled on the wheelchair armrest with her gloved hand to get it closer to Resident 2 and assisted the resident to stand, discarded the soiled wash cloth, and pushed the wheelchair towards CNA 24. Both CNA 6 and CNA 24 took off their gloves and washed their hands, CNA 6 with a 5 second lather and CNA 24 with a 10 second lather. Then CNA 24 left the room with Resident 2 without asking resident if he wanted to wash his hands. 4. During an observation on 8/20/24 at 8:39 A.M., CNA (Certified Nurse Aide) 6 and CNA 24 provided incontinence care on Resident 12. CNA 6 removed a bedpan that had stool in it, wiped Resident 12's buttocks with 3 washrag's, and then placed a clean brief under Resident 12. CNA 6 failed to perform hand hygiene and change gloves between dirty and clean tasks. 5. On 8/20/24 at 2:19 p.m. CNA's (Certified Nursing Aides) 22 and 24 observed while Resident 15 was assisted to the bathroom. Both CNA's 22 and 24 did not wash hands or use hand sanitizer before care was started. After the soiled brief was removed, both CNA'S 22 and 24, kept soiled gloves on throughout the rest of incontinence care, including when a clean brief was put on Resident. 6. During an observation on 8/19/24 at 12:11 P.M., CNA 28 and CNA 22 performed incontinence care on Resident 31. CNA 28 and CNA 22 put on PPE (Personal Protective Equipment) for Enhanced Barrier Precautions. CNA 28 went into the bathroom to wet a wash cloth while CNA 22 unfastened and pushed the brief down. CNA 22 used the wet wash cloth to clean the front perineal		the procedure in accordance with the facility's peri-care policy random monitoring will occur each week for 26 weeks. To ensure staff are performing wound care in accordance to the facility's policy to prevent infection, the IP, or designee, will complete random audits of wound treatments 5 times a week for 4 weeks; then 3 times a week for 4 weeks; then 2 times a week for 4 weeks; then 1 time a week for 3 months. This plan of correction will be monitored at the Quarterly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: September 20, 2024.	

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	area, placed the dirty wash cloth in a plastic bag. CNA 28 assisted Resident 31 to turn to the left side. CNA 22 used the brief to remove stool from the buttocks, rolled up brief and put in trash bag. CNA 28 went into the bathroom to get two wet wash cloths. CNA 22 washed the resident's buttocks with a wet wash cloth, put it in a plastic bag, used another wet wash cloth to wash the buttocks again and put the wash cloth in a plastic bag, CNA 22 did not change gloves and worked to remove the resident's shirt while he had a tight grip on it. After removing the shirt, CNA 22 assisted the resident to turn to the right side. CNA 28 put a clean brief under the resident, turned him to his back and fastened the brief. CNA 28 put sweat pants on resident and assisted resident to turn to left side. CNA 22 placed the lift pad under the resident and turned resident to the right side. CNA 28 pulled the lift pad through. CNA 22 placed the lift over the bed and both CNAs fastened the lift pad to the lift. CNA 22 lifted the resident off the bed while CNA 28 positioned the high-back wheelchair closer to the lift and guided the resident over the chair. CNA 22 lowered the resident into the chair. CNA 28 put a shirt over the residents head and CNA 22 raised the chair to sitting. CNA 22 leaned the resident forward while CNA 28 pulled the resident's shirt down in the back. CNA 28 put the dirty linens in the plastic bag and removed trash bag with dirty brief, tying both. Neither CNAs changed gloves or cleaned hands during the process. Both CNAs removed PPE and put in tall, black trash can in room. CNA 22 cleaned her hands with sanitizer and pushed the resident to the dining room. CNA 28 carried the bags to the dirty linen room. On 8/21/24 at 10:38 A.M., the Infection Preventionist (IP) provided an undated Hand Hygiene policy which indicated "1. Staff will			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice...5. Hand hygiene technique when using soap and water: a. Wet hands with water...b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use clean towel to turn off the faucet...6. a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves..." On 8/21/24 at 10:38 A.M., the Infection Preventionist (IP) provided an undated Perineal Care policy which indicated "...6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate...9. a. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes...16. Remove gloves and discard. Perform hand hygiene..." On 8/21/24 at 10:38 A.M., the Infection Preventionist (IP) provided an undated Infection Control Tips policy which indicated " 1. Do not touch anything with gloves other than pericare items with gloves on before performing pericare...4. Once you have touched wet or soiled objects, such as clothing, briefs, linens, etc...you cannot touch any other surfaces in the room without performing hand hygiene. You must remove your gloves, clean hands and reglove, before touching anything...5. Always clean the residents hands. Either give them a soapy washcloth and then a clean one to rinse or assist them to the sink. This needs to be done with incontinence care..."			

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	08/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/21/24 at 10:38 A.M., the Infection Preventionist (IP) provided an undated How to Safely Remove Personal Protective Equipment (PPE) which indicated "...5. Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE..." 3.1-18(b) 3.1-18(l)			