STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. BUILDING _____ B. WING _____	R-C 04/04/2023

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

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{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00402634 and IN00401133 completed on 3/7/23. The visit was in conjunction with a PSR to the Investigation of Complaints IN00398997 and IN00399424 completed on 1/19/23. Complaint IN00402634-corrected Complaint IN00401133-corrected Complaint IN00399424-corrected Complaint IN00398997-corrected Unrelated finding. Survey dates: March 3 & 4, 2023 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicare: 1 Medicaid: 33 Other: 3 Total: 37 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2023.	{F 000}		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		4/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 602	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 6 of 7 residents whose medications were reviewed. A staff member tested positive for opioids and oxycodone after signing out residents' narcotic medications without documenting the medications had been administered and after other staff members questioned the staff member's physical and mental state. (Resident F, Resident G, Resident H, Resident J, Resident K, Resident L) Finding includes: Record review on 4/3/23 at 12:00 P.M., a facility reported incident, dated 3/4/23, included that LPN 13 "was not acting right" during their shift at the facility. LPN 13 received a drug screen and tested positive for oxycodone and other opioids. A follow up added 3/10/23 indicated after reviewing residents' medications and the narcotic count book, LPN 13 had signed out 23 narcotic medications but had not documented that they were administered to residents. Two other narcotic medications were unaccounted for in LPN 13's medication cart. LPN 13 was too impaired to provide an explanation regarding the missing medications.	F 602		

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F 602	Continued From page 2	F 602		

1. During record review on 4/3/23 at 1:00 P.M., Resident F's diagnoses included, but were not limited to, chronic pain.
Resident F's physician orders included, but were not limited to, hydrocodone-acetaminophen 10-325 mg (milligrams) 1 tablet by mouth every 4 hours (started 2/20/23).

Resident F's MAR (medication administration record) lacked documentation that hydrocodone-acetaminophen 10-325 mg - 1 tablet was administered as ordered on 3/4/23 at 8:00 A.M., and 12:00 P.M., however, Resident F's narcotic count sheet for hydrocodone-acetaminophen 10-325 mg was signed by LPN 13 at 8:00 A.M. and 11:00 A.M.

2. During record review on 4/3/23 at 1:10 P.M., Resident G's diagnoses included, but were not limited to, pain.

Resident G's physician orders included, but were not limited to, oxycodone 5 mg as needed (started 11/28/22).
Resident G's MAR lacked documentation that oxycodone 5 mg was administered on 3/3/23, however, Resident G's narcotic count sheet for oxycodone 5 mg was signed by LPN 13 on 3/3/23 at 1:00 P.M.

3. During record review on 4/3/23 at 1:15 P.M., Resident H's diagnoses included, but were not limited to, pain.

Resident H's physician orders included, but were not limited to, hydrocodone-acetaminophen 5-325 mg 1 tablet by mouth every 8 hours as needed (started 12/29/21).

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F 602	Continued From page 3	F 602		

Resident H's MAR lacked documentation that hydrocodone-acetaminophen 5-325 mg was administered on 3/3/23 or 3/4/23, however, Resident H's narcotic count sheet for hydrocodone-acetaminophen 5-325 mg was signed by LPN 13 on 3/3/23 at 8:00 A.M. and 3:45 P.M., and 3/4/23 at 8:00 A.M., and 3:00 P.M.

4. During record review on 4/3/23 at 1:20 P.M., Resident J's diagnoses included, but were not limited to, pain.

Resident J's physician orders included, but were not limited to, hydrocodone-acetaminophen 7.5-325 mg 1 tablet by mouth every 4 hours as needed (started 8/3/22).
Resident J's MAR lacked documentation that hydrocodone-acetaminophen 7.5-325 mg was administered on 3/3/23, however, Resident J's narcotic count sheet for hydrocodone-acetaminophen 7.5-325 mg was signed by LPN 13 on 3/3/23 at 8:00 A.M., 10:06 A.M., 2:15 P.M., and 5:45 P.M.

5. During record review on 4/3/23 at 1:25 P.M., Resident K's diagnoses included, but were not limited to, pain.

Resident K's physician orders included, but were not limited to, hydrocodone-acetaminophen 5-325 mg 1 tablet by mouth every 4 hours as needed (started 8/26/22).
Resident K's MAR lacked documentation that hydrocodone-acetaminophen 5-325 mg was administered on 3/3/23 or 3/4/23, however, Resident K's narcotic count sheet for hydrocodone-acetaminophen 5-325 mg was signed by LPN 13 on 3/3/23 at 6:05 A.M., and then again 3 more times on 3/3/23 at

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F 602	Continued From page 4	F 602		

undetermined times. On 3/4/23 LPN 13 signed at 6:00 A.M., 10:00 A.M., and 2:00 P.M.

6. During record review on 4/3/23 at 1:30 P.M., Resident L's diagnoses included, but were not limited to, pain.

Resident L's physician orders included, but were not limited to, hydrocodone-acetaminophen 10-325 mg 1 tablet by mouth every 4 hours (started 7/29/22).
Resident L's MAR lacked documentation that hydrocodone-acetaminophen 10-325 mg was administered as ordered on 3/4/23 at 12:00 P.M., however, Resident L's narcotic count sheet for hydrocodone-acetaminophen 10-325 mg was signed by LPN 13 on 3/4/23 at 11:00 A.M.

An interview on 4/4/23 at 9:15 A.M., Resident L indicated she didn't always receive her routine pain medications, and had to remind the nurses to administer them. One time, she asked the nurse for her medication and the nurse pulled it out of her pocket and then handed it to her.

An interview on 4/3/23 at 12:50 P.M. the DON (Director of Nursing) indicated after receiving a call notifying them that LPN 13 was impaired at work and after reviewing LPN 13's medication cart, several resident medications were missing. The facility replaced the medications. After reviewing the narcotic count sheets and MAR's, it was noticed that count sheets were signed out, but medications were not documented as administered. LPN 13 had signed out medications on a day that she was not working. Two of the missing narcotic medications were ordered routinely and when they asked the residents on 3/4/23, the residents indicated they had not

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F 602	Continued From page 5 received them. Those residents who had orders for "as needed" pain medications denied requesting medication and denied having pain when questioned on 3/4/23. On 4/4/23 at 8:45 A.M., the DON supplied a facility policy, titled Policy and Procedure for Alleged Medication Theft and dated, 1/16/20. The policy included, "...If allegations are made that one Nurse is responsible the Director of Nursing will immediately administer drug screen and suspend the Nurse until investigation is completed.. The Administrator or Director of Nursing will contact local police..." 3.1-28(a)	F 602		