STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155388	A. BUILDING 00 B. WING	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF BEDFORD	514 E 16TH ST BEDFORD, IN 47421

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 14, 15, 16, and 17, 2023 Facility number: 000370 Provider number: 155388 AIM number: 100290790 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 3 Medicaid: 30 Other: 1 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 21, 2023.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan m Jordan	hfa	04/14/2023

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 1 residents	F 0656	It is the policy of the facility to develop a comprehensive care plan related to colostomies.	05/15/2023

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	reviewed for a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). (Resident 6) Findings include: On 3/17/23 at 11:00 a.m., Resident 6 was observed to have a colostomy bag attached to his side. During an interview on 3/17/23 at 11:02 a.m., the resident indicated he usually changed the colostomy bag when needed. Nursing staff assisted him when he needed assistance. During an interview on 3/17/23 at 11:20 a.m., LPN 1 indicated the resident frequently changed his colostomy bag, and sometimes required nursing staff assistance with this task. During an interview on 3/17/23 at 11:54 a.m., the DON indicated there was no care plan in place in reference to the resident's colostomy care. On 3/17/23 at 12:10 p.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, paraplegia and diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident had an ostomy (an ostomy is surgery to create an opening from an area inside the body to the outside). A physician's order, dated 6/7/22 through 3/31/23 indicated, colostomy change as needed. The Resident Care Plan Conference document, dated 3/2/23, indicated the resident had an ostomy.		Affected resident: Resident # 6. Resident #6 is now receiving assistance from charge nurse with colostomy care weekly and as needed. Potential to affect 2 residents: 2 residents were affected. Systemic changes: A new order has been received for resident #6 to receive assistance with colostomy care weekly and as needed. This will be documented on the treatment record. The other resident identified is also receiving colostomy care by the charge nurse weekly and as needed. Care plans have been updated for both residents identified. All charge nurses will be in-service on colostomy care policy (see attachment 1). Quality assurance: DON or designee will perform random audits weekly times 6 months (see attachment 1b).	

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	The resident's clinical record lacked a care plan regarding the care of the resident's colostomy. 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to provide services to maintain the residents highest practicable quality of care for 1 of 1 residents reviewed for positioning. A resident was not provided positioning assistance. (Resident 8) Finding includes: On 3/16/23 at 11:15 a.m., Resident 8 was observed self-propelling down the hallway in a wheelchair. She was observed slouching down and to the right side in her wheelchair without any positioning aides. On 3/17/23 at 10:00 a.m., Resident 8 was observed self-propelling down the hallway in a wheelchair. She was observed slouching to the right side in her wheelchair without any positioning aides. On 3/17/23 at 12:31 p.m., Resident 8 was eating lunch in the main dining room. She was observed	F 0684	It is the policy of the facility to maintain positioning of a resident while up in wheelchair. Affected resident was #8. Resident #8 now has interventions added to her care plan. The resident is now utilizing a side wedge cushion to the right side of her wheelchair. Potential to affect 20 residents: No other residents were identified. Systemic changes: Facility had OT to assess resident and per his recommendations the Facility has ordered a new high back reclining wheelchair (see attachment 2). Quality assurance: All staff will be	05/15/2023

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	slouching to the right side in her wheelchair without any positioning aides. During an interview, at that time, the resident indicated she would like a pillow on her right side to help with positioning. During an interview on 3/17/23 at 1:00 p.m., CNA 4 indicated she tried to put a pillow under the resident's affected (right) arm to help with positioning and prevent her from getting any scratches on her elbow. On 3/17/23 at 1:07 p.m., Resident 8's clinical record was reviewed. The diagnoses included, but were not limited to, stroke and hemiplegia (paralysis) and hemiparesis (weakness). A Quarterly Minimum Data Set (MDS) assessment, dated 2/9/23, indicated the resident had moderately impaired cognition and had one-sided impairment in her upper and lower extremities. A review of the resident's care plans indicated no care plans were implemented to address the resident's positioning. A review of the resident's record indicated no occupational therapy notes. A review of the March, 2023, physician's orders indicated there were no orders which addressed the resident's positioning. During an interview on 3/17/23 at 2:51 p.m. the MDS Coordinator indicated she did not have any clinical documentation related to the staff addressing the resident's positioning. She further indicated the facility did not have a policy in regard to positioning.		in-serviced on wheelchair positioning, charge nurse will monitor this every shift ongoing.	

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	3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide services for a pressure ulcer for 1 of 2 residents reviewed. A wound care referral was not completed and the weekly wound assessments were not completed. (Resident 4) Findings include: During an interview on 3/14/23 at 2:51 p.m., Resident 4 indicated he had a black-colored pressure ulcer on the bottom on his left foot for the last 3-4 months. He has not had any wound care from anyone outside of the facility. He had his right foot amputated and did not want to have the same thing happen to his left foot. At that time, during an observation, Resident 4 was observed to be wearing a pressure relieving device to his left foot and had a below the knee	F 0686	It is the policy of the facility to provide services for pressure ulcers. Affected resident: Resident #4. Resident #4 refused to go out to wound care referral. Resident #4 had a wound consult in house by zoom in-house from AMT on 04/07/2023. resident is satisfied with this service and will continue to receive this service monthly until wound is healed. Resident #4 is now having wounds measured weekly. Potential to affect 2 residents: No other residents were identified.	05/15/2023

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	amputation of his right foot. During an observation on 3/16/23 at 10:23 a.m., Resident 4 was observed to be sitting in his wheelchair participating in therapy with his pressure relieving device on his left foot. During an observation on 3/17/23 at 12:54 p.m., Resident 4 was observed to be sitting in his wheelchair his pressure relieving device on his left foot. On 3/16/23 at 10:45 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, below the knee amputation, diabetes mellitus, osteomyelitis (infection of the bone), and arteriosclerosis (hardening of the walls of the arteries). The care plan, dated 1/2/23 and current through 4/2/23, indicated Resident 4 had a pressure area to his left heel. His interventions were to measure the area weekly, document the measurements and the appearance of the wound; the wound team to assess the area weekly; change treatment per wound team and physician recommendations; and a pressure relieving device to the left foot. The Nurse's Notes indicated the following: - On 1/14/23 at 2:00 p.m., Resident 4's left heel had a moderate amount of pink drainage. The area of deep tissue injury became open during his shower. - On 1/24/23 at 11:00 a.m., Resident 4 received an order for referral of wound care. The Physician's Progress notes, dated 1/24/23, indicated Resident 4 had a heel wound. Resident 4 indicated he had a painful heel ulcer and was		Systemic change: All residents with pressure injuries will be measured weekly and all nurses will be in-serviced on pressure prevention policy. (see attachment 3). Quality assurance: DON or designee will monitor weekly for completion of wound measurements for 6 months (see attachment 4).	

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	interested in starting with wound care. The physician ordered wound care for further evaluation and management. The March 2023 Physician's Order indicated the following: - Cleanse left heel with normal saline; pat dry; paint with iodine; cover with dressing and secure with tape daily (start date 1/14/23). - Referral of wound care (start date 1/24/23). - Pressure relieving device to left foot (start date 2/7/23) The Weekly Wound Assessment and Summary indicated the following: - On 1/3/23, Resident 4's left heel unstageable pressure injury measurements were 4.5 centimeter (cm) length and 6.5 cm width. - On 1/12/23, Resident 4's left heel unstageable pressure injury measurements were 4.0 cm length and 7.0 cm width. - On 1/19/23, Resident 4's left heel unstageable pressure injury measurements were 4.0 cm length and 7.0 cm width. - On 1/26/23, Resident 4's left heel unstageable pressure injury measurements were 4.2 cm length and 7.0 cm width. - On 2/2/23, Resident 4's left heel unstageable pressure injury measurements were 4.4 cm length and 7.0 cm width. - On 2/9/23, Resident 4's left heel unstageable pressure injury measurements were 4.5 cm length and 6.8 cm width.			

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	- On 2/16/23, Resident 4's left heel unstageable pressure injury measurements were 4.7 cm length and 6.7 cm width. - On 2/23/23, the weekly wound assessment and summary lacked documentation of wound measurements or assessment. - On 3/2/23, the weekly wound assessment and summary lacked documentation of wound measurements or assessment. - On 3/9/23, Resident 4's left heel unstageable pressure injury measurements were 4.0 cm length and 2.5 cm width. The clinical record lacked documentation of Resident 4 refusing a wound care referral or wound care assessment. The targeted behaviors symptoms lacked documentation of refusal of care. During an interview on 3/16/23 at 11:34 a.m., the Director of Nursing (DON) indicated Resident 4 refused to have referral for wound care. She indicated the clinical record lacked documentation of Resident 4 refusing wound referral. During an interview on 3/17/23 at 11:07 a.m., the DON indicated pressure ulcers are measured and assessed weekly and documented on the Weekly Wound Assessment and Summary. If the resident refused to have pressure ulcer assessed or measured, the nurse would document the refusal on wound summary or nurses notes. During an interview on 3/17/23 at 11:25 a.m., the DON indicated Resident 4's Weekly Wound Assessment and Summary lacked documentation			

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	on 2/23/23 and 3/2/23. On 3/17/23 at 2:20 p.m., the MDS nurse provided the facility policy, "Pressure Injury Prevention," dated 11/1/22 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."8. Each resident who has a skin issue that has been identified (pressure or non-pressure) will be kept in the wound book and measure weekly..." 3.1-40(a)(2)			
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to implement infection control measures to prevent the spread of infections for 34 of 34 residents residing in the building. A water management program was not implemented to prevent water borne pathogens and gloves were not worn while obtaining a blood glucose level. (Resident 4, RN 1) Findings include: 1. On 3/17/23 at 12:00 p.m., the Administrator (ADM) presented the Water Management Binder. The binder contained the Water Borne Pathogen Prevention Policy which indicated the facility would implement a water management program which follows a preventative guide. The binder lacked documentation of monthly, semi-annually, and annually preventative maintenance. On 3/17/23 at 12:36 p.m., the ADM indicated the Water Management binder lacked documentation of any completed preventative maintenance. On 3/17/23 at 12:50 p.m., the ADM provided the facility policy, "Water Borne Pathogen Prevention Policy," dated 11/2017 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."1. The facility will conduct risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system....2. The facility will implement a water management program which follow the preventative maintenance guide...: MONTHLY:	F 0880	It is the policy of the facility to implement infection control measures to prevent the spread of infections. Affected residents: Resident #4. Potential to affect 34 residents. No other residents were identified. Systemic changes: All nurses will be in-serviced on blood glucose policy (see attachment 5). maintenance director has been in-serviced on the requirements to maintain a water management program. water borne pathogen policy has been updated (see attachment 6a). the facility has ordered legionella test kits (see attachment 6b). Quality Assurance: DON or designee will do random audits weekly for 6 months on wearing gloves while doing blood sugars (see attachment 7). Administrator will monitor the water management program every month for 6 months (see attachment 6c).	05/15/2023

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	CENTRAL BATHING....SEMI-ANNUALLY: RESIDENT ROOMS...ANNUALLY: DOMESTIC WATER SYSTEMS..."2. On 3/16/23 at 11:05 a.m., Registered Nurse (RN) 1 was observed to obtain a blood glucose level for Resident 4 by pricking the finger with a lancet (small, sharp needle) and obtaining a small amount of blood. No gloves were observed to be worn during the procedure. During an interview on 3/16/23 at 11:20 a.m., RN 1 indicated she should have worn gloves during the blood glucose check for Resident 4. On 3/17/23 at 12:47 p.m., the Minimum Data Set (MDS) Coordinator provided the policy, "Blood Glucose Meters Cleaning and Disinfecting," and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Procedure: 1. Gloves should be worn for all blood glucose monitoring checks and hands washed after removal of gloves ..." 3.1-18(b)(1)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in multiple occupancy resident rooms for 3 of 18 resident rooms in the facility. (Room 3, Room 6, Room 8) Findings include: Review of the facility's Rooms Size Certification,	F 0912	It is the policy of the facility to provide at least 80 sq ft per resident in multiple resident rooms and at least 100 sq ft in single resident rooms. Affected residents: Residents in room 3, 6, and 8 were found not to meet the requirement, however a waiver was in affect for the rooms.	05/15/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF BEDFORD	514 E 16TH ST BEDFORD, IN 47421

(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
	received from the Administrator on 3/17/23 at 12:50 a.m., indicated the following: The floor areas of the following multiple resident rooms measured: Room 3: 2 beds, 153.19 sq. ft., 76.59 sq. ft. per resident, SNF/NF. Room 6: 2 beds 157.98 sq. ft., 78.99 sq. ft. per resident, SNF/NF. Room 8: 2 beds 152.97 sq. ft., 76.48 sq. ft. per resident, SNF/NF. Room 3, 6, and 8, rooms with the variances, were observed on 3/15/23. The rooms were observed to have the following number of beds: Room 3 - 2 beds Room 6 - 2 beds Room 8 - 2 beds During an interview on 3/17/23 at 12:50 p.m., the facility Administrator indicated Rooms 3, 6, and 8 had the room variance waivers. The rooms were licensed for double occupancy and currently had two beds in the room. 3.1-19(l)(2)(A)		Quality assurance: A letter has been sent to ISDH requesting a room waiver (see attachment 8a-e). All 3 rooms are equipped with privacy curtains, comfortable bed environment and adequate space. the method of monitoring any negative outcome due to size of rooms has been negated through placement of only one or two residents in respective rooms. The facility will continue to monitor for any potential negative outcome due to room size and variance in an ongoing compacity. should a negative outcome arise, this will be addressed immediately in accordance with any potential issue.	