

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155388	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/26/2024
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NAME OF PROVIDER OR SUPPLIER  CORE OF BEDFORD	STREET ADDRESS, CITY, STATE, ZIP COD 514 E 16TH ST BEDFORD, IN 47421
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 23, 24, 25, and 26, 2024</p> <p>Facility number: 000370 Provider number: 155388 AIM number: 100290790</p> <p>Census Bed Type: SNF/NF: 33 Total: 33</p> <p>Census Payor Type: Medicare: 2 Medicaid: 26 Other: 5 Total: 33</p> <p>This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed April 29, 2024.</p>	F 0000		
F 0912 SS=D Bldg. 00	<p>483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident</p> <p>§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;</p> <p>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)</p>	F 0912	IT IS THE POLICY OF THE FACILITY TO PROVIDE AT LEAST 80 SQ FEET PER RESIDENT IN MULTABLE RESIDENTS ROOM AND AT LEAST 100 SQ FEET PER	05/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SUSAN JORDAN	hfa	05/14/2024

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

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	<p>Findings include:</p> <p>Room 3, Room 6, and Room 8 were observed on 4/23/24 at 11:00 a.m. The rooms were observed to have the following number of beds:</p> <p>Room 3 - 2 beds Room 6 - 2 beds Room 8 - 2 beds</p> <p>A review of the facility's Rooms Size Certification, received from the Administrator on 4/26/24 at 11:00 a.m., indicated the following:</p> <p>The floor areas of the following multiple resident rooms measured:</p> <p>Room 3 - 2 beds, 153.19 sq. ft., 76.59 sq. ft. per resident, SNF/NF.</p> <p>Room 6 - 2 beds 157.98 sq. ft., 78.99 sq. ft. per resident, SNF/NF.</p> <p>Room 8 - 2 beds 152.97 sq. ft., 76.48 sq. ft. per resident, SNF/NF.</p> <p>During an interview on 4/26/24 at 11:15 a.m., the Administrator indicated Room 3, Room 6, and Room 8 had the room variance waivers. The rooms were licensed for double occupancy and currently had two beds in the room.</p> <p>3.1-19(l)(2)(A)</p>		<p>RESIDENT IN SINGLE RESIDENT ROOM.</p> <p>AFFECTED RESIDENTS: RESIDENT IN ROOM 3, 6, AND 8 WERE FOUND NOT TO MEET THE REQUIREMENT, HOWEVER A WAIVER WAS IN EFFECT FOR THE ROOMS.</p> <p>QUALITY ASSURANCE: A LETTER HAS BEEN SENT TO ISDH REQUESTING A ROOM WAIVER (SEE ATTACHMENT 1A).</p> <p>ALL THREE 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 NEGATIVE OUTCOME DUE TO ROOM SIZE AND VARIANCE IN AN ONGOING CAPACITY SHOULD A NEGATIVE OUTCOME ARISE, THIS WILL BE ADDRESSED IMMEDIATELY IN ACCORDANCE WITH ANY POTENTIAL ISSUES.</p>	

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

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OMB NO. 0938-039

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