

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155388	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2022
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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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E 0000 Bldg. --	<p>A Emergency Preparedness Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/24/22</p> <p>Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790</p> <p>At this Emergency Preparedness survey, Core of Bedford was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73.</p> <p>The facility has 37 certified beds. At the time of the survey, the census was 33.</p> <p>Quality Review completed on 05/31/22</p> <p>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by</p>	E 0000	<p>E-000</p> <p>By submitting the enclosed material, Core of Bedford Nursing and Rehabilitation is not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Core of Bedford Nursing and Rehabilitation requests that the plan of correction be considered our allegation of compliance effective June 12, 2022, to the Emergency Preparedness Recertification and State Licensure Survey that was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Core of Bedford Nursing and Rehabilitation will provide any additional information as requested.</p> <p>Survey Dates: May 24,2022 Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790 Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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E 0036 SS=F Bldg. --	<p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)</p> <p>EP Training and Testing</p> <p>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p>		<p>accomplished corrective action. These do not necessarily chronologically correspond to the date that Core of Bedford Nursing and Rehabilitation is under the opinion that it the requirements of participation or that corrective action was necessary.</p>		

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	<p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and</p>			

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	<p>orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency Preparedness Plan (EPP) on 05/24/22 between 9:30 a.m. and 12:45 p.m. with the Administrator present, there was no documentation available to show the facility had an emergency preparedness training and testing program available. Based on interview at the time of record review, the Administrator said there was no training and testing program available within the EPP.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p>	E 0036	<p>E-036</p> <p>It is the practice of Core of Bedford Nursing and Rehabilitation to assure that it develops *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies, and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient</p>	06/12/2022	

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			<p>practice. Administrator has added a new training and testing program to the Emergency Operations Plan. In compliance with State and Federal Regulations, our facility will conduct initial training on the EOP during the orientation of new staff, and annually to all staff, individuals providing services under contract, and volunteers consistent with their role in the response.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the facilities new training and testing program of the EOP. All staff will be tested on the EOP. All staff will receive a pre-test before being in-serviced on the EOP. After in-service all staff will receive a post-test. All staff will receive individual training on EOP after pre-test, in-service, and post-test. Orientation of EOP will be added to new hire paperwork.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will provide new staff with EOP orientation. HR will monitor new hire paperwork for EOP Orientation. Administrator,</p>	

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E 0037 SS=F Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies</p>		<p>maintenance director, HR, or designee will bring and discuss any issues with the new training and testing of the EOP to QA/PI meeting for review and continued compliance.</p> <p>Date of Compliance: 06/12/2022</p>		

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	<p>and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of 			

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	<p>emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p>			

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	<p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d);](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d);] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p>			

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	<p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>	E 0037	<p>E-037</p> <p>It is the practice of Core of Bedford Nursing and Rehabilitation to assure that it develops *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency</p>	06/12/2022	

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	<p>Based on review of the Emergency Preparedness Plan (EPP) on 05/24/22 between 9:30 a.m. and 12:45 p.m. with the Administrator present, no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of record review, the Administrator confirmed there was no documentation of annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p>		<p>preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Administrator has added a new training program to the Emergency Operations Plan. In compliance with State and Federal Regulations, our facility will conduct initial training on the EOP during the orientation of new staff, and annually to all staff, individuals providing services under contract, and volunteers consistent with their role in the response. What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the facilities new training program of the EOP. All staff will be tested on the EOP. All</p>		

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E 0041 SS=F Bldg. --	<p>482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems.</p>		<p>staff will receive a pre-test before being in-serviced on the EOP. After in-service all staff will receive a post-test. All staff will receive individual training on EOP after pre-test, in-service, and post-test. Orientation of EOP will be added to new hire paperwork.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will provide new staff with EOP orientation. HR will monitor new hire paperwork for EOP Orientation. Administrator, maintenance director, HR, or designee will bring and discuss any issues with the new training and testing of the EOP to QA/PI meeting for review and continued compliance.</p> <p>Date of Compliance: 06/12/2022</p>	

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	<p>The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155388	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING	X3) DATE SURVEY COMPLETED 05/24/2022
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NAME OF PROVIDER OR SUPPLIER CORE OF BEDFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 514 E 16TH ST BEDFORD, IN 47421
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	<p>Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p>			

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	<p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on observation, record review and interview; the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). The facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/24/22 at 9:50 a.m. during the initial tour of the facility with the Administrator, the generator annunciator panel located at the Nurses' Station had the "Horn Switch Off" light (red) illuminated. Furthermore, the system trouble lights for "Low Water Temp", "High Water Temp" and "Low Oil Pressure" (all yellow) were illuminated. The Administrator was able to reset the generator annunciator panel at the time of observation. Based on interview at the time of observation, the Administrator said he exercised the generator the previous day and everything ran normally. He also said this was the first that the annunciator panel has been light up with trouble lights on. Based on review of the emergency generator weekly and monthly test log it was verified that the generator was exercised the previous day by the Administrator.</p> <p>This finding was reviewed with the Administrator</p>	E 0041	<p>E-041</p> <p>It is the practice of Core of Bedford Nursing and Rehabilitation to assure that it has A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No</p>	06/12/2022			

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	during the exit conference.		<p>residents, staff, or visitors were affected by the alleged deficient practice. Administrator placed a workorder with Safecare to check the generator and generator annunciator panel. Safecare found both generator and generator annunciator panel to be in proper working order.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the proper operation of the generator and generator annunciator panel. All staff have been in-serviced to inform maintenance and administrator if the generator annunciation panel horn sounds or any of the system trouble lights become illuminated. All staff have been in-serviced to never turn off the generator annunciator panel horn or reset the system trouble lights that have become illuminated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will monitor generator annunciation panel during daily walking rounds. Administrator, maintenance director, or designee will bring and discuss any issues with the generator annunciator panel to</p>		

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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 05/24/22</p> <p>Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790</p> <p>At this Life Safety Code survey, Core of Bedford was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 37 and had a census of 33 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached shed used for facility storage.</p>	K 0000	<p>QA/PI meeting for review and continued compliance. Date of Compliance: 06/12/2022</p> <p>E-000 By submitting the enclosed material, Core of Bedford Nursing and Rehabilitation is not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Core of Bedford Nursing and Rehabilitation requests that the plan of correction be considered our allegation of compliance effective June 12, 2022, to the Emergency Preparedness Recertification and State Licensure Survey that was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Core of Bedford Nursing and Rehabilitation will provide any additional information as requested. Survey Dates: May 24,2022 Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790 Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for</p>		

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K 0353 SS=F Bldg. 01	<p>Quality Review completed on 05/31/22</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department</p>	K 0353	<p>procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated accomplished corrective action. These do not necessarily chronologically correspond to the date that Core of Bedford Nursing and Rehabilitation is under the opinion that it the requirements of participation or that corrective action was necessary.</p> <p>K-353 It is the practice of Core of Bedford Nursing and Rehabilitation to assure that the fire department connection is in accordance with NFPA 25,</p>	06/12/2022

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	<p>connections to be inspected quarterly to verify the following:</p> <ol style="list-style-type: none"> (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 05/24/22 between 12:45 p.m. and 1:45 p.m. during a tour of the facility with the Administrator, the facility's fire department connection (FDC) was located on the wall outside the sprinkler riser room at the front of the building. There was no signage provided above or around the fire department connection for the responding fire department to easily identify the FDC. Based on interview at the time of observation, this was acknowledged by the Administrator.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p> <p>3.1-19(b)</p>		<p>2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Administrator ordered</p>		

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K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in		<p>FDC sign from local sign shop. Local sign shop made and attached FDC sign to the front of the facility above the fire department connection. Administrator requested, local fire marshal to inspect the new FDC sign for compliance.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the proper installation of the FDC sign. All staff will be advised to inform maintenance if the sign is missing, damaged or unreadable.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will monitor mounted FDC sign during daily walking rounds. Administrator, maintenance director, or designee will bring and discuss any issues with the FDC sign to QA/PI meeting for review and continued compliance.</p> <p>Date of Compliance: 06/12/2022</p>	

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	<p>accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 portable fire extinguishers observed was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect up to 8 residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/24/22 between 12:45 p.m. and 2:45 p.m. during a tour of the facility with the Administrator, there was an ABC portable fire extinguisher mounted on the corridor wall across from room 18 measured at five feet nine inches from the floor to the top of the extinguisher. Based on interview at the time of observation, the Administrator acknowledged the fire extinguisher was mounted to over five feet at the top.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p> <p>3.1-19(b)</p>	K 0355	<p>K-355</p> <p>It is the practice of Core of Bedford Nursing and Rehabilitation to assure that all Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10§483.25(d</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. The ABC portable fire extinguisher mounted on the corridor wall across from room 18 was remounted. The top of the ABC portable fire extinguisher mounted on the corridor wall across from room 18 is now 58 and a half inches from the floor. One and a half inches below the maximum sixty inches high. Maintenance director checked the other six</p>	06/12/2022

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K 0916 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste		<p>ABC portable fire extinguisher mounted in the facility for proper mounted height. All seven mounted ABC portable fire extinguishers in the facility are now in compliance.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the proper installation, minimum and maximum mounting height for an ABC portable fire extinguisher. All staff will be advised to inform maintenance of any ABC portable fire extinguisher found to be non-compliant.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will monitor for improper height of mounted ABC portable fire extinguishers during daily walking rounds. Administrator, maintenance director, or designee will bring and discuss any improperly mounted ABC portable fire extinguisher to QA/PI meeting for review and continued compliance.</p> <p>Date of Compliance: 06/12/2022</p>	

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Bldg. 01	<p>Electrical Systems - Essential Electric System Alarm Annunciator</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.</p> <p>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/24/22 at 9:50 a.m. during the initial tour of the facility with the Administrator, the generator annunciator panel located at the Nurses' Station had the "Horn Switch Off" light (red) illuminated. Furthermore, the system trouble lights for "Low Water Temp", "High Water Temp" and "Low Oil Pressure" (all yellow) were illuminated. The Administrator was able to reset the generator annunciator panel at the time of observation. Based on interview at the time of observation, the Administrator said he exercised the generator the previous day and everything ran normally. He also said this was the first that the annunciator panel has been light up with trouble lights on. Based on review of the emergency generator weekly and monthly test log it was verified that the generator was exercised the previous day by the Administrator.</p>	K 0916	<p>K-916</p> <p>It is the practice of Core of Bedford Nursing and Rehabilitation to assure that it has A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be</p>	06/12/2022			

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	<p>This finding was reviewed with the Administrator during the exit conference.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Administrator placed a workorder with Safecare to check the generator and generator annunciator panel. Safecare found both generator and generator annunciator panel to be in proper working order.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the proper operation of the generator and generator annunciator panel. All staff have been in-serviced to inform maintenance and administrator if the generator annunciation panel horn sounds or any of the system trouble lights become illuminated. All staff have been in-serviced to never turn off the generator annunciator panel horn or reset the system trouble lights that have become illuminated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155388	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/24/2022
NAME OF PROVIDER OR SUPPLIER CORE OF BEDFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 514 E 16TH ST BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
K 0920 SS=E Bldg. 01	<p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord in the Physical</p>	K 0920	<p>will monitor generator annunciation panel during daily walking rounds. Administrator, maintenance director, or designee will bring and discuss any issues with the generator annunciator panel to QA/PI meeting for review and continued compliance. Date of Compliance: 06/12/2022</p> <p>K-920 It is the practice of Core of</p>	06/12/2022	

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	<p>Therapy room was installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect residents' staff and visitors while in the Physical Therapy room.</p> <p>Findings include:</p> <p>Based on observations on 05/24/22 between 12:45 p.m. and 1:45 p.m. during a tour of the facility with the Administrator, there was a power strip in the Physical Therapy room used to power an unknown device. The power strip was not secured and dangling from the wall between two file cabinets. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observation, the Administrator agreed the power strip was dangling and not secured.</p> <p>This finding was reviewed with the Administrator during the exit conference.</p> <p>3.1-19(b)</p>		<p>Bedford Nursing and Rehabilitation to assure that all Power cords and Extension Cords are installed properly and used in a safe manor.</p> <p>NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents, staff, or visitors were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the Physical Therapy room have the potential to be affected by the alleged deficient practice. The administrator moved and secured the power strip to the top of the nearby filing cabinet. Maintenance director checked all other power strips in the facility. All power strips are now mounted</p>		

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			<p>and in compliance.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: All staff will be in-serviced on the proper installation and use of power strips. All staff will be advised to inform maintenance of any power strips found to be non-compliant.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, maintenance director, or designee will monitor for improper use of power strips during daily walking rounds. Administrator, maintenance director, or designee will bring and discuss any improper use of power strips to QA/PI meeting for review and continued compliance.</p> <p>Date of Compliance: 06/12/2022</p>	