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	02/20/2025

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: February 17, 18, 19, and 20, 2025 Facility number: 000370 Provider number: 155388 AIM number: 100290790 Census Bed Type: SNF/NF: 30 Total: 3 Census Payor Type: Medicare: 3 Medicaid: 27 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 26, 2025.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure a resident's choice of code status was documented accurately for 1 of 3 residents reviewed for advanced directives. (Resident 12) Finding includes: On 2/18/25 at 2:37 p.m., Resident 12's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and a history of transient ischemic attack (temporary	F 0578	It is the policy of the facility to ensure a residents code status is documented correctly. Affected resident is #12. Potential to affect all residents, 1 other resident was identified. A chart audit on all residents code status was completed on 02/28/2025, resident #12 code status was verified and entered correctly into	03/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
susan jordan	administrator	03/10/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	blockage of blood flow to the brain, causing stroke like symptoms). The Advanced Directives, a choice of treatment document, dated 9/20/21, was signed by the Resident's POA (power of attorney), and indicated the resident was to be comfort measures only (No CPR to be performed). The Physician's Orders, dated 10/20/23, indicated resident had a current order for CPR (cardiopulmonary resuscitation). A Provider Note, dated 4/10/24, indicated the resident's advanced directive was DNR (do not resuscitate). A Provider Note, dated 8/2/24, indicated the resident's advanced directive was DNR. A Provider Note, dated 9/6/24, indicated the resident's advanced directive was DNR. No additional documentation was in the clinical record to reflect the change in advanced directive. During an interview with the Administrator on 2/19/25 at 11:05 a.m., she indicated she was unsure why the advanced directive was changed. The Administrator indicated there was no documentation noted in the record indicating a request from the POA to change resident's advanced directive from DNR to CPR. During an interview with the DON on 2/20/25 at 11:00 a.m., she indicated that according to resident's medical record and current order, the code status was CPR. She indicated that staff would initiate CPR, if needed (contradictory to the resident's advanced directive).		the electronic medical record along with the other resident that was identified. Systemic changes: The director of nursing educated social services and licensed nurses regarding the documentation procedure for advance directive/code status. A new policy has been made and all nurses will be in serviced. (see attachment #1) Quality assurance: For a period of 6 months, Social service or designee will perform weekly medical record audits on new admissions and those residents on the MDS assessment schedule for consistent documentation of the residents advance directive/code status throughout the electronic medical record. After 6 months the Director of social service will discuss monthly at QA meeting until such time it is determined that substantial compliance is maintained.	

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	On 2/20/25 at 12:00 p.m., the Administrator provided the choice of treatment policy. The policy was undated, the administrator indicated this was a current policy for the facility. The policy indicated "... each resident is afforded the privilege of death with dignity if he/she so desires. In the event the resident is unable to make this determination and the family desires a "NO CODE" this wish shall be carried out..." 3.1-4(f)(5)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure an accurate assessment for 1 of 1 residents reviewed for resident assessment. (Resident 234) Finding includes: On 2/18/25 at 2:04 p.m., Resident 234's clinical record was reviewed. The diagnoses included, but not limited to, schizoaffective disorder (condition that combines symptoms of schizophrenia and a mood disorder) and dementia. Notice of PASARR (Preadmission Screening and Resident Review) Level II Outcome, dated 2/15/23, indicated, "Final Determination By:.. Determination Date: 2/15/23, Level II Outcome: Long Term Approval without Specialized Services." A Significant Change MDS (Minimum Data Set) assessment, dated 9/24/24, did not indicate the resident was a PASARR level II.	F 0641	It is the policy of the facility to ensure accurate assessment data is entered correctly into the MDS. Affected resident #234. Potential to affect all residents with level II. A chart audit was completed on all residents who require a level II to be documented on the MDS and one other was identified. A new comprehensive MDS was completed to correct the errors. Systemic change: Social services has now uploaded all PASSRR level II's on the electronic medical records. Quality Assurance: For a period of 6 months social service or designee will perform weekly audits on all new admissions and those residents that are on the MDS schedule for accuracy of	03/14/2025

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	During an interview with the MDS coordinator on 2/20/25 at 10:10 a.m., she indicated section A1500 on MDS assessment, dated 9/24/24, was marked no in error and indicated it should have been marked yes for PASARR Level II. She indicated they did not have a MDS assessment coding policy, they followed the Resident Assessment Instrument (RAI) manual for coding the MDS assessment. On 2/20/25 at 11:30 a.m., a review of the RAI,Version 3.0 User's Manual, 10/2023, for section A1500 of MDS, "Code 1, yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID [Intellectual disability]/DD [Developmental disability] or related condition..." 3.1-31(d)		A1500 coding. After 6 months social services will discuss monthly at QA meetings until such time it is determined that substantial compliance is maintained.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was labeled with the date for 1 of 3 residents reviewed for respiratory care. (Resident 1) Findings include: On 2/18/25 at 2:40 p.m., Resident 1 was observed sitting in his wheelchair outside his room with oxygen being administered via nasal cannula (N/C) at 4L (liters). There was no date observed on the N/C tubing. On 2/19/25 at 9:55 a.m., Resident 1 was observed sitting in his wheelchair in the dining room with oxygen being administered via N/C at 4L. There was no date observed on the N/C tubing.	F 0695	It is the policy of the facility to ensure the oxygen tubing is labeled with a date. Affected resident #1. Potential to affect all residents with all resident with an order for oxygen. All residents with Oxygen orders was audited to ensure there was orders to change tubing weekly. No other residents were identified. Resident #1 received a new order to change O2 tubing weekly. Systemic change: The director of nursing will in-service all licensed nurses on new policy. (see	03/14/2025

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	On 2/19/25 at 11:43 a.m., Resident 1 was observed sitting in his wheelchair in the dining room with oxygen being administered via N/C at 4L. There was no date observed on the N/C tubing. On 2/20/25 at 2:44 p.m., Resident 1 was observed sitting in his wheelchair inside his room with oxygen being administered via N/C at 4L. There was no date observed on the N/C tubing. On 2/20/25 at 10:42 a.m., Resident 1 was observed laying asleep in bed with oxygen being administered via N/C at 4L. There was no date observed on the N/C tubing. Resident 1's clinical record was reviewed on 2/18/25 at 3:09 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis) and traumatic brain injury. Current physician orders, dated 2/20/25, indicated, "... O2 [oxygen] per nasal cannula at 4 lpm [liters per minute] every shift for low O2 sats [saturations] ..." During an interview on 2/20/25 at 10:20 a.m., the MDS (Minimum Data Set) Coordinator indicated the tubing was changed every Sunday, however, Resident 1 wanted a longer tubing so hospice brought it and must not have marked it with the date. During an interview on 2/20/25 at 10:39 a.m., the MDS Coordinator indicated Resident 1 did not have an order to change the oxygen tubing every Sunday. On 2/20/25 at 12:00 p.m., the Administrator provided the facility policy, "Oxygen		attachment #2) Quality assurance: The director of nursing or designee will audit weekly for 6 months to ensure O2 tubing has been changed and dated weekly as ordered. After 6 months the DON will discuss monthly at the QA meetings until such time it is determined that substantial compliance is maintained.	

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	Concentrator," undated, and indicated it was a policy currently being used. A review of the policy did not indicated putting a date on the oxygen tubing. 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with professional standards for food service safety for 2 of 2 kitchen observations. Findings include: During an initial kitchen tour on 2/17/25 at 10:45 a.m., a large container containing opened bags of rice was observed without a lid in the dry storage area. During a follow-up visit on 2/20/25 at 12:01 p.m., the same rice container was observed uncovered in the dry storage area. During an interview at that time, the Dietary Manager indicated the container should have a lid since there were opened bags of rice in it. On 2/20/25 at 12:40 p.m., the Administrator provided a copy of the facility policy, "Storage of Dry Food and Supplies," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... Use seamless or plastic containers with tight-fitting covers to store products ..." On 2/21/25 at 10:45 a.m., the Indiana State Department of Health, "RETAIL FOOD	F 0812	It is the policy of the facility to ensure food is stored in accordance with professional standards for food service safety. Potential to affect all residents, staff and visitors in the facility. None was affected. Dietary manager discarded the rice and the container with no lid. Dietary assessed all containers to ensure all containers had lids. Systemic change: Dietary manager in-serviced all dietary staff on the policy for storage of dry food and supplies. (see attachment #3). Quality assurance: Dietary manager or designee will audit daily for 6 months to ensure that all containers have lids.	03/14/2025

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	ESTABLISHMENT SANITATION REQUIREMENTS. TITLE 410 IAC 7-24," dated 11/13/04, was reviewed. A review of the rule indicated, "... food shall be protected from contamination by storing the food as follows: ... (2) Where it is not exposed to splash, dust, or other contamination ... (5) In packages, covered containers, or wrappings ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident 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, received from the Administrator on 2/17/25 at 12:50 p.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, Room 6, and Room 8, were observed on 2/19/25 at 2:00 p.m.. The rooms were observed to have the following number of beds two beds in	F 0912	It is the policy of the facility to provide at least 80 square feet (sq. ft.) per resident in multiple resident rooms and at least 100 sq ft in single resident rooms. Affected residents: Resident in room 3, 6, and 8 where found not to meet the requirement, however a waiver was in affect for the rooms. Quality assurance: A letter has been sent to ISDH requesting a room waiver. (see attachment 4a-4d) All 3 rooms are equipped with privacy curtains, comfortable bed environment and adequate space. The method of monitoring any negative outcome do to size of rooms have been negated through placement of only one or two residents in respective rooms. The	03/14/2025

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	each room. During an interview on 2/19/25 at 2:10 p.m., the facility 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. 3.1-19(l)(2)(A)		facility will continue to monitor for any potential negative outcome do to room size and variance in an ongoing compacity. Should a negative outcome arise, this will be addressed immediately in accordance with any potential issues.	