

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

PRINTED: 04/03/2025

FORM APPROVED

OMB NO. 0938-039

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 03/17/2025
--	---	--	---

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

(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
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: 03/17/25</p> <p>Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790</p> <p>At this Emergency Preparedness survey, Core of Bedford was found 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 28.</p> <p>Quality Review completed on 03/20/25</p>	E 0000		
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: 03/17/25</p> <p>Facility Number: 000370 Provider Number: 155388 AIM Number: 100290790</p> <p>At this Life Safety Code survey, Core of Bedford</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
susan jordan	administrator	04/02/2025

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.

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 03/17/2025
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 0291 SS=F Bldg. 01	<p>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 III (211) 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 28 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> <p>Quality Review completed on 03/20/25</p> <p>NFPA 101 Emergency Lighting</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 1 battery backup light was tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery</p>	K 0291	<p>It's the policy of the facility to ensure the battery backup light will be tested annually for 90 minutes.</p> <p>Potential to affect all residents, staff and visitors: None were affected by this alleged practice. Battery back up lighting was ran for 90 minutes 3/31/2025.</p> <p>Systemic change: Maintenance director in-serviced on the new</p>	04/04/2025	

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 03/17/2025
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 0753 SS=E Bldg. 01	<p>powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review at 1:00 p.m. on 03/17/25, documentation of monthly testing of the emergency light at the generator was provided; however, no documentation of an annual 90 minute testing was available for review. Based on interview at 1:05 p.m., the Maintenance Director stated that he tests the emergency light weekly when the weekly generator inspection is conducted, however he has not conducted an annual 90 minute test.</p> <p>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Combustible Decorations</p> <p>Based on observation and interview, the facility failed to ensure 1 of 18 resident room corridor doors was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</p>	K 0753	<p>policy. (see attachment #1)</p> <p>Quality measures: Administrator will audit yearly in march and on going.</p> <p>It is the policy of the facility to ensure resident room corridors are without combustible decorations.</p> <p>Potential to affect all residents, staff and visitors. none were affected. Combustible decorations were removed immediately off the residents room door on 3/17/25.</p> <p>Systemic changes: All staff will be in-serviced on combustible decorations. (see attachment #2)</p>	04/04/2025	

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 03/17/2025
--	---	--	---

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

(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
	<p>(3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source.</p> <p>(4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:</p> <p>(a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).</p> <p>(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.</p> <p>(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>(d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>This deficient practice could affect over 20 residents, staff and visitors in one smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility at 1:44 p.m. on 03/17/24, the corridor door to resident room 6 was covered over 90 percent with decorative wrapping</p>		<p>Quality measures: maintenance director will audit weekly for 4 weeks. Audit records will be reviewed by the QA until such time consistent substantial compliance has been achieved as determined by the committee.</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 03/17/2025
--	---	--	---

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

(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
K 0920 SS=D Bldg. 01	<p>paper. Based on interview with the Maintenance Director at 1:45 p.m., he stated the wrapping paper was not treated with fire retardant material as far as he knew and agreed the surface of the door was covered more than 90 percent and removed the wrapping paper from the corridor door upon observation.</p> <p>This finding was reviewed with the Administrator and Maintenance Director the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity</p>	K 0920	<p>It is the policy of the facility that extension cords including power strips are not used as a substitute for fixed wiring.</p> <p>Potential to effect over all residents, staff and visitors: none were affected. Power strip that was identified was corrected immediately on 3/17/25.</p> <p>Systemic change: maintenance director will be in-serviced on new policy. (see attachment 3a & 3b) Maintenance director has assessed all power strips and electrical outlets in the facility.</p> <p>Quality assurance: Maintenance director will complete an audit of all power strips and electrical outlets monthly and on going.</p>	04/04/2025

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 03/17/2025
--	---	--	---

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
	<p>extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over two residents, staff and visitors in the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility at 2:00 p.m. on 03/17/25, a computer monitor, a wheelchair scale and a floor mounted bike pedal therapy equipment was plugged into a power strip positioned four feet from the bike pedal equipment and scale. The UL listing of the power strip was UL60601-1 and was positioned within the patient care vicinity in the room. Based on interview at 2:02 p.m., the Maintenance Director agreed a power strip was being used in the patient care vicinity that has a mixture of PCREE (Patient Care Related Electrical Equipment) and non-PCREE plugged into it and as a substitute for fixed wiring.</p> <p>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>			