STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Core of Dale	510 W Medcalf Road Dale, IN 47523

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39130 Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse. A resident was allegedly threatened with physical abuse and then was smacked by a staff member in retaliation for the resident striking the staff member during care. (Resident L) Finding includes: During a review of state reportable incidents on 1/7/25 at 11:15 A.M., an incident report dated 1/5/25 at 6:50 P.M. indicated Certified Nurse Aide (CNA) 13 reported herself to the nurse after an incident with Resident L. Resident L allegedly hit CNA 13 in the face and CNA 13 then hit [Resident 13] back in the ribs. During record review on 1/7/25 at 12:00 P.M., Resident L's diagnoses included but were not limited to, hemiplegia affecting left side, anxiety, depression, bipolar disorder, schizoaffective disorder, dementia, traumatic brain injury, and conduct disorder. Resident L's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/12/24, indicated the resident's cognition was moderately impaired. Resident L's care plan included, but was not limited to; Resident has a behavior problem due to traumatic brain injury and being physically/verbally aggressive. Resident hits/punches others (initiated 11/8/23). Interventions included, but were not limited to, caregivers to provide opportunity for positive interaction, approach/speak in a clam manner. Resident L's progress notes included, but were not limited to, an incident note, dated 1/7/25 at 8:32 A.M., that indicated Resident L was re-assessed due to recent incident. Resident asked to point to the area on his right side. Resident touched the upper right rib area. No bruising, swelling or other marks were noted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's investigation into the incident between Resident L and CNA 13, a witness statement from Qualified Medication Aide (QMA) 4 indicated that on 1/5/25 at 6:50 P.M., Resident L's call light went off. QMA 4 answered the light and began changing the resident due to an incontinent episode. CNA 13 walked in to Resident L's room to assist with incontinence care. Resident L became very annoyed with the staff during care and began mocking and cursing at the two staff members. Resident L then hit CNA 13 in the face and CNA 13 then smacked him back. An interview signed by the Director of Nurses (DON) with Resident L, dated 1/6/25, indicated that Resident L felt CNA 13 was being too rough during incontinent care. Resident L told CNA 13 that he would hit her and CNA 13 told the resident, if you hit me, I will hit you back. Resident L indicated that he playfully placed his closed fist on CNA 13's cheek, and she punched him in the side. During an interview on 1/7/25 at 1:50 P.M., CNA 9 indicated that if a resident is being physically or verbally aggressive towards staff, the staff member should remove themselves from the situation and allow the resident to calm down. Staff should re-approach the resident at a later time. The facility's investigation of the incident included an inservice training of the facility's Procedure for Abuse Prohibition, Reporting, and Investigation policy. The policy indicated, It is the policy of [Facility] to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion . C. Verbal abuse . can include resident to resident or staff to resident verbal threats of harm . This citation relates to complaint IN00449658 3.1-27(b)