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	09/25/2025

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure specific, comprehensive care plans were revised for 4 of 4 reviewed for behaviors related to sexual offenders. Care plans were not revised to include specific behaviors, restrictions, and interventions. (Resident B, Resident C, Resident D, Resident F)Findings include:On 9/24/25 at 9:55 A.M., a binder was provided by the Director of Nursing (DON) with a list of registered sexual offenders that were currently residents or had previously been a resident at the facility.The Sex Offender Registry list on the [NAME] County Sheriff's Department website was retrieved on 9/24/25 at 2:20 P.M. The list included registered sex offenders who have been convicted of a sexual offense and were mandated to register as a sexual offender annually and were within a one mile radius of the facility address (510 [NAME] St Dale, Indiana 47523). The registry included 16 residents currently residing at the facility. It included the type of offense, but lacked specific details about the resident's conviction and restrictions. Resident B was listed as a sex offender (a general category for individuals convicted of sex offenses). Resident C and Resident D were listed as a sexually violent predators (a specific designation for offenders deemed a high risk to re-offend and a threat to the public).1. On 9/25/25 at 11:51 A.M., Resident B was observed sitting in a wheelchair in the dining room.On 9/25/25 at 9:33 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis.The most recent quarterly MDS assessment, dated 7/29/25, indicated a moderate cognitive impairment.A current Behavior Care Plan, (last reviewed date unknown), indicated Resident D had the potential for sexually inappropriate behavior related to sexual offender history. Interventions included the following:Monitor for inappropriate sexual behaviorsInvolve resident in activitiesEncourage appropriate communication and socializationNotify SSD if behaviors occurExplain to the resident why behaviors were inappropriate1:1 (staff to resident watch) as needed15 minute checks (staff to observe resident every 15 minutes) as neededPsychology services as neededChildren present under age [AGE] to remain supervised by an adult.The care plan lacked resident specific sexual offender history and behaviors, restrictions, and interventions.2. On 9/16/25 at 12:58 P.M., Resident C was observed sitting in his bed.On 9/19/25 at 12:30 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure, diabetes mellitus type II, anxiety disorder, and depression.The most recent quarterly MDS assessment, dated 9/6/25, indicated Resident C was cognitively intact. A current Behavior Care Plan, initiated 6/11/25 and last reviewed on 9/7/25, indicated Resident D had the potential for behaviors that included sexually inappropriate behavior related to sex offender history, verbal aggression (yelling, cursing), and refusing medications. Interventions, initiated on 6/11/25, included the following:Monitor for inappropriate sexual behaviorsInvolve resident in activitiesEncourage appropriate communication and socializationNotify SSD if behaviors occurExplain to the resident why behaviors were inappropriate1:1 (staff to resident watch) as needed15 minute checks (staff to observe resident every 15 minutes) as neededPsychology services as neededChildren present under age [AGE] to remain supervised by an adultThe care plan lacked resident specific sexual offender history and behaviors, restrictions, and interventions.3. On 9/24/25 at 9:08 A.M., Resident D was observed in his motorized wheelchair telling a nurse that he was leaving the facility to go to church.On 9/18/25 at 12:51 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, psychoactive substance abuse, unspecified sexually transmitted disease, and noncompliance with other medical treatment and regimen.The most recent annual MDS assessment, dated 8/2/25, indicated a moderate cognitive impairment.A current Behavior Care Plan, initiated on 5/19/25 and revised on 5/27/25, indicated Resident D had the potential to be physically aggressive. Interventions, initiated on 5/19/25, included the following:The resident's triggers for physical aggression were not getting what he wants when he wants it. The resident's behaviors were de-escalated by promptly assisting resident as soon as possibleAdminister medications as ordered and monitor/document for side effects and effectivenessAnalyze and document time of day, places, circumstances, triggers, contributing sensory deficits and what de-escalated behaviorAssess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.Provide physical and verbal cues to alleviate anxietyGive positive feedbackAssist with verbalization of source of agitationAssist to set goals for more pleasant behaviorEncourage seeking out of staff member when agitatedGive the resident as many choices as possible about care and activitiesModify environment: Adjust room temperature to comfortable level, Reduce noise, dim lights, place familiar objects in room, keep door closed, etcMonitor and

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure services provided by the facility met professional standards for 1 of 2 residents reviewed for nutrition. A resident's weights were not transferred into the clinical record, the medical provider and family were not notified of weight loss, the dietitian's recommended orders were not put into place, and the resident continued to have weight loss. (Resident G)Finding includes:On 9/19/25 at 12:06 P.M., Resident G was observed sitting in a Broda chair in the dining room while staff fed him.On 9/18/25 at 12:48 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/12/25, indicated Resident G's cognitive status could not be assessed and was dependent on staff for eating, showering, toileting, bed mobility, and transfers. He was on a mechanical diet (consisting of foods that are modified to be easy to chew and swallow) and experienced a weight loss. His current weight was 156.0 pounds (lbs) and height was 66 inches.Current orders included, but were not limited to,weight monthly, ordered 3/1/25magic cup (supplement) at 5:00 P.M. with supper daily, ordered 2/1/25regular diet with mechanical soft texture, ordered 2/27/25A current Nutrition Care Plan, last revised 7/12/25, included, but was not limited to, the following interventions initiated on 6/27/24:Monitor monthly weightsMonitor/record/report to Medical Doctor (MD) as needed, a significant weight loss (greater than 5% in one month, greater than 7.5% in three months, or 10% in six monthsProvide and serve supplements to me as orderedRegistered Dietitian (RD) to evaluate and make recommendations as neededThe most recent Nutritional Risk Assessment, dated 7/12/25, completed by the RD recommended to increase the magic cup from daily to twice daily.The clinical record lacked documentation of the resident being seen by the RD since 7/12/25.The Medication Administration Record (MAR) for September 2025 was reviewed from 9/1/25 through 9/17/25 and indicated Resident 41 was only getting the magic cup with his supper.The clinical record lacked documentation of notification to the MD or Nurse Practitioner (NP) of the weight loss.On 6/1/25, the resident weighed 166.4 lbs. On 7/1/25, the resident weighed 155.6 lbs, which was a weight loss of 6.49%.The clinical record lacked documentation of notification to the MD or Nurse Practitioner (NP) of the weight loss.The clinical record lacked documentation of any weights completed since then.On 9/24/25 at 9:23 A.M., Certified Nurse Aide (CNA) 22 CNAs weighed the residents when the nurse notified them to do it. She indicated that, to her knowledge, he only got a magic cup with his supper.On 9/24/25 at 9:35 A.M., Registered Nurse 8 indicated he was a monthly weight. He should get the magic cup as ordered. At that time, she indicated the dietary manager usually went through the clinical records and looked for weight loss. They would notify the dietician, MD, and DON, and they would decide what to do. To her knowledge, the RD came to the facility monthly. During an interview on 9/24/25 at 10:06 A.M., the Dietary Manager indicated she just took over (9/5/25) and didn't have a list of residents with weight loss currently in the facility.On 9/25/25 at 9:40 A.M., the RD indicated she came to the facility 8 hours per month. The process was to see all residents on admission, quarterly, and as needed. Nursing or the Dietary Manager would refer her for evaluation. She had not seen the resident in August or 9/19/25 when she was at the facility. She was not sure why there was not a recent weight in Resident G's clinical record or why his magic cup was not increased. On 9/25/25 at 9:53 A.M., the Director of Nursing indicated the Assistant Director of Nursing (ADON) had papers on her desk with August and September 2025 weights for Resident G. His August weight was 154.4 lbs, and his September weight was 145.6 lbs, but these were not put into the clinical record. She said the resident had aspiration pneumonia recently, which could have been the cause of the weight loss, but generally, he ate well. She would usually be the one to notify the MD of the RD recommendations and was not sure why the magic cup was not increased after the 7/12/25 visit. She also had no visit notes from the dietician in August or September. She indicated that the weights not being in the clinical record would have caused the dietitian to miss seeing him, and the MD not being notified.On 9/25/25 at 12:06 P.M., a current Nutritional Risk Program Policy, last revised 9/10/13, was provided by the DON and indicated, It is the policy of this facility to monitor the weight status of each resident and that appropriate interventions be initiated should weight decline or incline unplanned . This citation relates to Intake 26070813.1-46(a)(1)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies to carry out the functions of food and nutrition services. The Dietary Manager lacked appropriate certification. Finding includes: On 9/16/25 at 8:05 A.M., the current Dietary Manager indicated she started in that role on 9/5/25 and lacked a current certification and was working to become re-certified. On 9/25/25 at 9:48 A.M., the Director of Nursing (DON) provided a current, undated, Dietary Manager job description as their policy that indicated, Required Qualifications Minimum requirements include one of the following: Certification as a dietary manager. Certification as a food service manager .Must also meet State requirements for food service managers or dietary managers . This Federal tag relates to Intake 2607081.3. 1-20(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to appropriately test the dishwasher to verify it was functioning correctly. Staff lacked knowledge of the test strips used to test the sanitation chemicals in 1 of 2 observations of dishwasher use. Finding includes: On 9/16/25 at 8:05 A.M., the Dietary Manager indicated she was unsure of what kind of dishwasher the facility had, and that staff checked to make sure the temperature reached 120 degrees Fahrenheit. At that time, she indicated that the staff failed to test the dishwasher with chlorine strips and was unable to find strips.During an observation on 9/16/25 at 8:18 A.M., Maintenance 11 indicated the dishwasher is a low-temperature dishwasher, and he verified the temperature reached 120 degrees Fahrenheit daily. At that time, he indicated he was not a dietary employee, so he did not check the chemicals on the dishwasher.During an interview on 9/16/25 at 9:45 A.M., the Maintenance Supervisor indicated the dishwasher should be tested with a chlorine strip every shift. At that time, she located a container of strips and tested the dishwasher. The strip showed 10 parts per million (ppm). The Maintenance Supervisor indicated it should be at 100 ppm.During an interview on 9/16/25 at 10:30 A.M., the Director of Nursing (DON) indicated kitchen staff should notify maintenance of any problems. At that time, she indicated they were not aware of the problem, and a call had been placed to the manufacturer of the dishwasher.On 9/16/25 at 9:45 A.M., the Maintenance Supervisor provided a current manual as a policy, dated 10/29/07, that indicated chlorine levels should be between 50-100 ppm.This Federal tag relates to Intake 2607081.3.1-21(i)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a homelike environment for 6 of 15 resident rooms reviewed for the environment. Rooms and a hall had a strong urine odor, peri-cleanser and cream (used for incontinence care) were found in a resident refrigerator, call light strings in the bathrooms were soiled, and grab bars and the toilet seat were loose. (East Hall, [NAME] Hall, Resident rooms and or shared bathrooms, Rooms 101, 102, 103/105, 108/110, 207/209, 204/206)Findings include:1. On 9/16/25 12:33 P.M., room [ROOM NUMBER] and the private bathroom was observed with a strong urine odor.On 9/24/25 at 9:10 A.M., the same was observed. 2. On 9/16/25 at 12:35 P.M., room [ROOM NUMBER], there was cream in an open clear cup and a bottle of peri-cleanser observed in Resident 8's refrigerator with three cans of soda.On 9/24/25 at 9:11 A.M., the same was observed.On 9/24/25 at 9:23 A.M., Certified Nurse Aide (CNA) 22 indicated those shouldn't be stored there, took them out, and discarded them in the trash can. 3. On 9/16/25 12:38 P.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a strong urine odor.On 9/24/25 at 9:08 A.M., the same was observed. 4. On 9/16/25 at 12:46 P.M., room [ROOM NUMBER] and bathroom (shared with 110) was observed with a strong urine odor, the handle bars and the toilet seat they were connected to were loose, and the call light cord was brown.On 9/24/25 at 9:06 A.M., the same was observed. 5. On 9/16/25 at 12:48 P.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a brown call light cord that was wrapped around a grab bar.On 9/24/25 at 9:04 A.M., the same was observed. 6. On 9/16/25 at 12:57 A.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a brown call light cord and a strong urine odor.On 9/24/25 at 9:02 A.M., the same was observed. During an interview on 9/24/25 at 9:25 A.M., Housekeeper 5 indicated they do have rooms that smell because the residents forget to flush or did't hold the handle down long enough. At that time, she indicated staff located the source and used bio enzymatic odor eliminator spray. They cleaned the rooms and bathrooms daily and as needed. If the call light cord was brown, it would need to be changed by maintenance. The housekeeper was responsible for taking the resident refrigerator temperatures daily and when they looked inside at thermometer, if there was something in it that shouldn't be, they would discard it. On 9/25/25 at 9:29 A.M., the Director of Nursing (DON) indicated the facility didn't really have a policy for the environment but they would follow the regulations. This citation relates to Intake 2607081. 3.1-19(f)