STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155388	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Core of Bedford	514 E 16th St Bedford, IN 47421

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34848 Based on interview and record review, the facility failed to ensure accurate reconciliation and disposition of controlled substances for 1 of 3 residents reviewed for medication reconciliation. (Resident B) Findings include: During an interview on 1/17/25 at 9:45 a.m., the Administrator (ADM) indicated she was notified regarding missing pills for Resident B. The ADM's investigation singled out two nurses, the Director of Nursing (DON) and LPN 1, during the time the pills went missing. The facility never found the missing pills. On 1/17/24 at 9:50 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, malignant neoplasm of the breast, history of malignant neoplasm of the brain, and low back pain. An 11/7/24 physician's order indicated the resident was ordered oxycodone (a controlled substance medication used to treat moderate to severe pain) 7.5-325 milligrams every 6 hours, as needed for pain. A review of the drug disposal form did not indicate the resident's oxycodone was disposed. A review of the controlled substance inventory count sheet indicated one card was removed from the A cart, on 12/4/24 for Resident B. The form did not contain the signatures of two licensed nurses for verification. During an interview on 1/17/25 at 10:41 a.m., the DON indicated she conducted an audit and discovered there was a discrepancy between the pill count and inventory sheet. Someone had signed off they had removed a card, but there was no initial so she did not know who pulled the medication. She asked LPN 1 if she removed the medication and LPN 1 informed the DON they had destroyed the pills on 12/4/24. She indicated two nurses should sign off on the drug disposal sheet when the drug was destroyed. The DON indicated she did not destroy Resident B's medication, rather it was different resident's medication. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/25 at 1:30 p.m., the ADM provided the facility policy, DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES, dated 3/12/12, and indicated it was the policy currently being used. A review of the policy indicated, . B. When a dose of a controlled medication is removed from the container for administration . it is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose . This citation relates to Complaint IN00448728 3.1-25(e)(2) 3.1-25(e)(3)