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	10/24/2025

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary interventions to prevent dislodgement of a gastrostomy tube (feeding tube) for 1 of 1 resident reviewed for feeding tubes. This deficient practice resulted in a hospitalization to remove the G-tube, sepsis, and cannot have a new G-tube placed for 6 weeks. (Resident B) Finding include: On 10/24/25 at 10:40 a.m., Resident B was observed to be sitting in a reclining wheelchair. A yellow nasogastric tube (a flexible tube inserted through the nose and down the throat into the stomach) was observed to have feeding infusing from a feeding pump. On 10/24/25 at 11:05 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), hemiplegia (paralysis or weakness on one side of the body), dysphagia (difficulty swallowing), and methicillin resistant staphylococcus aureus infection. An Operative Report, dated 9/5/25 at 5:21 p.m., indicated a Percutaneous Endoscopic Gastrostomy tube was placed. The care plan, dated 9/18/25 (dated prior to Resident B's admission), indicated Resident B had a tube feeding related dysphagia. The interventions were check for tube placement prior to medication administration, check for tube placement and gastric contents/residual volume per facility protocol and record. Baseline Care Plan, dated 9/29/25, indicated Resident B had a G-tube placed on 9/5/25 due to recent stroke. He had continuous feeding per G-tube. The Progress notes indicated the following: -On 9/26/25 at 9:43 a.m. Resident B arrived at the facility. He had a 20 French (size of G-tube) inserted in the left upper abdomen. He tolerated bolus feeding well. He had a grimaced facial expression with feeding and flush. -On 10/2/25 at 10:43 a.m., Resident B's G-tube was leaking around the insertion site. He winced when checking for placement of the G-tube and when medication was flushed. The nurse practitioner was notified and received an order to send him the emergency room. (continued on next page)

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

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F 0693 Level of Harm - Actual harm Residents Affected - Few	-On 10/2/25 at 11:00 a.m., Resident B was transported to the emergency room. -On 10/2/25 at 4:35 p.m., Resident B was transferred to the hospital for aspiration pneumonia and replacement of G-tube due to displacement. An untitled physician's hospital progress note, dated 10/2/25 at 7:58 p.m., indicated Resident B's G-tube was dislodged at the nursing facility. The hospital assessment/plan had hypotension, likely to septic shock secondary to aspiration pneumonia due to the malposition of the G-tube. The malposition of the G-tube caused feeding in his chest wall and abdomen. A Surgical Cosultation, dated 10/3/25 at 2:00 p.m., indicated the G-tube was dislodged. The G-tube site had a hard area with redness near the site and purulent drainage (a thick, cloudy fluid that is typically yellow, green, or brown in color) coming from around the G-tube. Resident B grimaced when the area was palpated and indicated pain. The G-tube was removed with large amount of purulent drainage and cottage cheese appearing material from the site. An untitled physician's hospital progress note, dated 10/6/25 at 10:40 a.m., indicated on evaluation in the emergency room (ER), it was discovered that the anchoring gastrostomy button had been retracted into the abdominal wall. The resident was diagnosed with sepsis/septic shock (a life-threatening response to infection with acute failure of multiple organs), likely due to combination of aspiration and dislodged G-tube. The assessment/plan indicated, for dislodged gastrostomy tube, G-Tube cannot be placed until infection and tube feeds have cleared, time frame indicated was approximately 6 weeks. The Physician orders indicated the following: -Vancomycin 750 milligrams intravenously every 12 hours for sepsis for 14 days (start date 10/21/25) -Amoxicillin-Pot Clavulanate tablet 875-125 milligrams by mouth every 12 hours for sepsis (start date 10/13/25) The clinical record lacked documentation of confirming the placement of feedings tube for Resident B on 9/27/25, 9/28/25, 9/29/25, and 10/1/25. On 10/24/25 at 11:15 a.m., Resident B was observed to be sitting in a reclining wheelchair. A yellow nasogastric tube was observed to have feeding infusing from a feeding pump. During an interview on 10/24/25 at 11:40 a.m., with LPN 1 indicated that she had taken care of Resident B when he was admitted on [DATE]. She indicated she completed a full assessment and verified placement of the G-tube. She indicated there were no issues with flushing the G-tube or with continuous feeds. LPN 1 indicated she also cared for Resident B on 9/30/25. She indicated there was no concerns with the G-tube at that time. She indicated placement confirmation of the G-tube would be completed prior to any medication administration or tubing changes for enteral feeds and this would be documented on the MAR/TAR (medication administration record/treatment administration record). (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/24/25 at 12:00 p.m., the Director of Nursing (DON) indicated she worked the night of 10/1/25 and helped care for Resident B. She indicated there were no concerns with the G-tube at that time. The DON indicated Resident B had no pain or grimacing and no drainage was noted during G-tube care. She indicated on 10/2/25 she was notified by a staff nurse that the G-Tube was leaking and the resident had grimacing anytime the area was touched and with an attempt to flush the tube. She indicated the nurse immediately stopped all care and contacted the Nurse Practitioner and an order was obtained to transfer the resident to the emergency room. The DON indicated the staff would document G-tube placement verification in the MAR/TAR During an interview on 10/24/25 at 12:25 p.m., the DON presented the September and October 2025 Medication and Treatment Record (MAR and TAR). She indicated she could not find the documentation of checking for placement prior to him going to the hospital on October 2, 2025. On 10/24/25 at 12:45 p.m., the DON presented the G-tube policy and procedures in-service attendance, dated 9/26/25. All nurses had signed the G-tube training and policy and procedures except LPN 2. On 10/24/25 at 1:50 p.m., the DON indicated LPN 2 worked on 9/27/25, 9/28/25, and 10/1/25 and would been the nurse taking care of Resident B. On 10/24/25 at 12:30 p.m., the DON provided a facility policy labeled Administering Medications through an Enteral Tube (feeding tube), revised November 2018. She indicated this was a current policy being used by the facility. A review of the policy indicated, .5. Verify placement of feeding tube, .Using stethoscope and syringe: push 5-10 ml (milliliters) of air into g-tube while listening to abdomen [above g-tube] to ensure placement by hearing a swish/movement . On 10/24/25 at 1:58 p.m., the DON provided a facility policy labeled Confirming Placement of Feeding Tubes, revised November 2018. She indicated this was a current policy being used by the facility. A review of the policy indicated, .The purpose of this procedure is to ensure proper placement of an existing feeding tube prior to administering enteral feedings or medication .Documentation - The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure . This citation relates to Intake 2646692. 3.1-44(a)(2)