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	04/26/2024

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35318 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in multiple occupancy resident rooms for 3 of 18 resident rooms in the facility. (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]) Findings include: room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] were observed on 4/23/24 at 11:00 a.m. The rooms were observed to have the following number of beds: room [ROOM NUMBER] - 2 beds room [ROOM NUMBER] - 2 beds room [ROOM NUMBER] - 2 beds A review of the facility's Rooms Size Certification, received from the Administrator on 4/26/24 at 11:00 a.m., indicated the following: The floor areas of the following multiple resident rooms measured: room [ROOM NUMBER] - 2 beds, 153.19 sq. ft., 76.59 sq. ft. per resident, SNF/NF. room [ROOM NUMBER] - 2 beds 157.98 sq. ft., 78.99 sq. ft. per resident, SNF/NF. room [ROOM NUMBER] - 2 beds 152.97 sq. ft., 76.48 sq. ft. per resident, SNF/NF. During an interview on 4/26/24 at 11:15 a.m., the Administrator indicated room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] had the room variance waivers. The rooms were licensed for double occupancy and currently had two beds in the room. 3.1-19(l)(2)(A)

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