	T OF HEALTH AND HU R MEDICARE & MEDI						RM APPROVED 1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	ì í	JILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	TER	155 E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
F 0000 Bldg. 00 F 0554 SS=D Bldg. 00	Licensure Survey. Investigation of C Complaint IN0043 the allegations are Survey dates: June Facility number: 0 Provider number: AIM number: 100 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Typ Medicare: 4 Medicaid: 95 Other: 11 Total: 110 These deficiencies accordance with 4 Quality review con 483.10(c)(7) Resident Self-Ad §483.10(c)(7) Th medications if the defined by §483. that this practice Based on observat	e 18, 19, 20, 21 and 24, 2024 00177 155278 289860 e: • reflect State Findings cited in	F 0.		PLAN OF CORRECTION F BLOOMINGTON CARE CEI F000 INITIAL COMMENTS The creation and submission this Plan of Correction does constitute an admission by t provider of any conclusion s in the statement of deficience of any violation of regulation This provider respectfully re that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Comp and requests a desk review of a post survey review on of July 12, 2024.	NTER n of not his et forth cies, or lance in lieu or after <b>hed</b>	07/12/2024
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	е	TITLE		(X6) DATE

# LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Lana Ballard Area Vice President/HFA 07/11/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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. PRINTED:

07/12/2024

STATEMEN	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	ì í	UILDING	DNSTRUCTION 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIE		TED	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR		
BRICKY		E - BLOOMINGTON CARE CEN	IER	BLOOK	/INGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medication adminis	stration assessment was			have been affected by the		
	complete for reside	nts with medications left at			deficient practice;		
	bedside for 1 of 1 r	andom observations. (Resident			It is the policy of Bloomington		
	80)				Care Center that any residen	t who	
					self-administers medication h		
	Findings include:				an assessment and care plan	in	
	Ĭ				place. The director of nursing		
	On at 6/19/24 at 9::	50 a.m., Resident 80 was			completed self-administration		
		m lying in bed next to the			assessment and added care		
		ne bedside table in a plastic			indicating resident 80 may		
		re 2 tablets of medication			administer medication		
	-	g (milligrams) each of Sevelamer			independently. A lock box wa	s	
		used for persons on dialysis to			provided to resident to store	5	
		nate levels). No facility staff			medication safely until		
		ent in the room at that time.			administration time. (See Exh	ihit	
	· ·	ed she took the medication				IDIL	
		did not eat that morning, and			A)	4h a	
		edication on her bedside table			How other residents having		
	and left the room.	edication on her bedside table			potential to be affected by the		
	and left the room.				same deficient practice will		
	Denting on internity				identified and what correctiv	/e	
		v on 6/19/24 at 9:55 a.m., the			action(s) will be taken;		
		g indicated the medication			All residents have the potenti		
		en left with the resident, as			be affected by the alleged de		
		stration was to be observed by			practice. Staff education prov	Ided	
		ualified staff unless the			about leaving medication at		
		ed to be able to self administer			bedside and assessing for		
	medications.				self-administration of medicat	ion.	
					(see exhibit B)		
		5 a.m., Resident 80's clinical					
		d. The diagnoses included, but			What measures will be put i	nto	
		, end stage renal disease and			place and what systemic		
	• •	State Optional Minimum Data			changes will be made to		
		ed 3/21/24, indicated the			ensure that the deficient		
	resident was cognit	ively intact.			practice does not recur:		
					The nursing staff reviewed		
		with a start date of $1/23/24$			medication administration pol	icy	
		ent was prescribed 2-800 mg			(see Exhibit B). An audit tool		
	tablets of Sevelame	er HCL three times a day with			"Medication Administration", (	see	
	meals.	-			Exhibit C), will be utilized to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FGGE11 Facility ID: 000177

If continuation sheet Page 2 of 21

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION <u>00</u>	СОМ	e survey pleted <b>4/2024</b>
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155	ET ADDRESS, CITY, STATE, ZIP ( E BURKS DR OMINGTON, IN 47401	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
		lacked a self medication		bedside. DNS or design complete daily audits in weeks, 3x/week for 6 monthly until compliant achieved. By what date the systic changes for each def will be completed. Af submitting an accept of correction, it is def that the correction wit completed by the dat previously submitted Division need to be co as soon as possible. will need to submit and amended plan of corre with the updated plant correction date. Date of compliance: 1	for two weeks, then ice is temic ficiency ter able plan termined ill not be e l, The ontacted The facility n rection n of	
= 0623 SS=D Bldg. 00	Before a facility to resident, the facil (i) Notify the resider representative(s) and the reasons a language and ro- facility must send representative of Long-Term Care (ii) Record the re- discharge in the accordance with section; and	ents Before ge tice before transfer. ransfers or discharges a ity must- dent and the resident's of the transfer or discharge for the move in writing and in manner they understand. The I a copy of the notice to a the Office of the State				

	R MEDICARE & MEDIC					OMB NO. 0938-0	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	<b>IULTIPLE CO</b>	NSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMI	PLETED
		155278	B. V	VING		- 06/2	4/2024
JAME OF	PROVIDER OR SUPPLIEF	}		STREET A	D		
BRICKY		E - BLOOMINGTON CARE CEN	IIER	BLOOM	IINGTON, IN 47401		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		COMPLET
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	in paragraph (c)(5	) of this section.					
	§483.15(c)(4) Tim	ing of the notice					
		ified in paragraphs (c)(4)(ii)					
		section, the notice of					
		rge required under this					
		nade by the facility at least					
		e resident is transferred or					
	discharged.						
	(ii) Notice must be	e made as soon as					
	practicable before	transfer or discharge when-					
	(A) The safety of i	ndividuals in the facility					
	would be endange	ered under paragraph (c)(1)					
	(i)(C) of this section						
		individuals in the facility					
	-	ered, under paragraph (c)(1)					
	(i)(D) of this section						
		health improves sufficiently					
		nmediate transfer or					
	section;	paragraph (c)(1)(i)(B) of this					
		transfer or discharge is					
		sident's urgent medical					
	-	agraph (c)(1)(i)(A) of this					
	section; or						
	(E) A resident has for 30 days.	not resided in the facility					
	§483.15(c)(5) Cor	ntents of the notice. The					
		cified in paragraph (c)(3) of					
		include the following:					
	(i) The reason for	transfer or discharge;					
	.,	ate of transfer or discharge;					
	(iii) The location to	o which the resident is					
	transferred or disc	charged;					
	(iv) A statement o	f the resident's appeal					
		ne name, address (mailing					
		elephone number of the					
		ves such requests; and					
	I information on ho	w to obtain an appeal form					

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155278	· /	VILDING NG	INSTRUCTION 00	COM 06/2	te survey ipleted 2 <b>4/2024</b>
	PROVIDER OR SUPPLIEI	R E - BLOOMINGTON CARE CEN	TER	155 E B	ADDRESS, CITY, STATE, ZIP CO BURKS DR IINGTON, IN 47401	DD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC
TAG	and assistance in submitting the ap (v) The name, add and telephone nu State Long-Term (vi) For nursing fa intellectual and de related disabilities address and telep responsible for the of individuals with established under Developmental Di Bill of Rights Act of codified at 42 U.S (vii) For nursing fa mental disorder o mailing and email number of the age protection and ad mental disorder e Protection and Act Individuals Act. §483.15(c)(6) Cha If the information to effecting the tra facility must upda notice as soon as updated informati §483.15(c)(8) Not closure In the case of faci who is the admini provide written no impending closure Agency, the Office Care Ombudsman	R LSC IDENTIFYING INFORMATION completing the form and peal hearing request; dress (mailing and email) mber of the Office of the Care Ombudsman; cility residents with evelopmental disabilities or a, the mailing and email whone number of the agency e protection and advocacy developmental disabilities • Part C of the isabilities Assistance and of 2000 (Pub. L. 106-402, .C. 15001 et seq.); and acility residents with a r related disabilities, the address and telephone ency responsible for the vocacy of individuals with a stablished under the lvocacy for Mentally III anges to the notice. in the notice changes prior ansfer or discharge, the te the recipients of the practicable once the on becomes available. ice in advance of facility lity closure, the individual strator of the facility must tification prior to the e to the State Survey e of the State Long-Term h, residents of the facility, epresentatives, as well as		TAG			DATE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILD	DING	TRUCTION 00		LETED
		155278	B. WING			06/24	/2024
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CENT	1	55 E BU	dress, city, state, zip cod RKS DR IGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
TAG	the plan for the tr relocation of the 483.70(l). Based on interview failed to ensure the for a transfer and of resident and the re residents reviewed 54 and Resident 64 Findings include: 1. Residents 54's c 6/24/24 at 9:55 a.m were not limited to disease and chroni Resident 54's prog resident was sent t 2/15/24. The clinic of written Notice of having been provid resident representa 2. Resident 64's cli 6/24/24 at 9:45 a.m were not limited to chronic kidney dis Resident 64's prog resident was sent t clinical record lack Notice of Transfer been provided to th During an intervie Director of Nursin facility did not pro- resident representa	ansfer and adequate residents, as required at § w and record review, the facility e written notification required lischarge was provided to the sident representative for 2 of 3 for hospitalization. (Resident 4) linical record was reviewed on n. The diagnoses included, but o, chronic obstructive pulmonary c kidney disease. ress notes indicated the o the hospital on 1/27/24 and cal record lacked documentation of Transfer and Discharge forms ded to the resident and the tive. inical record was reviewed on n. The diagnoses included, but o, type II diabetes mellitus and ease. ress notes indicated the o the hospital on 6/17/24. The ced documentation of written and Discharge forms having he resident. w on 6/24/24 at 10:04 a.m., the g Services (DNS) indicated the vided the resident nor the tive the Notice of Transfer and	F 0623	F V L r a F H C C n r r e r t t C C n r r e r t t T F S S i i a A L F F H C C n r r e F T T S T F T T S T F F F F F F F F F F	E 623 = D What corrective action(s) wi be accomplished for those residents found to have bee offected by the deficient practice; t is the policy of Bloomington Care Center that all residents esident representatives recei- notice of transfer or discharge Medical records department ensure copies are sent to resi- epresentative. Clinical staff educated on documentation of notification, as well as docum o provide. See Exhibit D- Transfer and Discharge Polic How other residents having potential to be affected by the same deficient practice will be dentified and what corrective for action(s) will be taken; All residents have the potentia be affected by the alleged defi- practice. All resident transfer and discharges will be review during IDT for completion of documentation, and that documentation was provided esident as well as their epresentative. What measures will be put in	n and ve s. to dent f ents cy" the be re al to icient rs ed	DATE 07/12/2024
	-	writing. The facility sent the			place and what systemic		

Event ID:

FGGE11 Facility ID: 000177

If continuation sheet Page 6 of 21

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/24/2024
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155 E	t address, city, state, zip cod BURKS DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) RIATE COMPLETIC DATE
0625	forms with the res transferred to anot On 6/24/24 at 1:50 facility's policy,"T undated, and indic being used by the indicated, "4. The	ident when they were her facility. ) p.m., the DNS provided the ransfer and Discharge" ated it was the policy currently facility. A review of the policy facility's transfer/discharge vided to the resident and the tative"		<ul> <li>changes will be made to ensure that the deficient practice does not recur:</li> <li>The clinical staff reviewed th policy "Transfer and Dischar Policy" (see exhibit D). An at tool "Discharge/Transfer Aud (see exhibit E), will be utilize determine provision of dischar transfer documentation to re and their representative. Aud will be completed daily for 2 weeks, 3x/week for 6 weeks monthly until compliance is achieved. Process will be reviewed at QAPI meeting to assess if compliance is achie</li> <li>By what date the systemic changes for each deficienc will be completed. After submitting an acceptable p of correction, it is determin that the correction will not completed by the date previously submitted, The Division need to be contact as soon as possible. The fat will need to submit an amended plan of correction with the updated plan of correction date.</li> <li>Date of compliance: July 12 2024</li> </ul>	e ge udit jit", d to arge sident dits , then o eved. y lan ed be ted acility
SS=D Bldg. 00	Notice of Bed Ho	ld Policy Before/Upon Trnsfr e of bed-hold policy and			

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155	et address, city, state, zip cod E BURKS DR OMINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETIO DATE
	nursing facility tra hospital or the re leave, the nursing information to the representative th (i) The duration of any, during which return and resum facility; (ii) The reserve b state plan, under any; (iii) The nursing f bed-hold periods with paragraph (e permitting a resic (iv) The informati (1) of this section §483.15(d)(2) Be At the time of tran hospitalization or facility must prov resident represer specifies the dura described in para Based on interview failed to ensure the policy required for the hospital was pa- residents reviewed 54 and Resident 64 Findings include:	if the state bed-hold policy, if the resident is permitted to be residence in the nursing ed payment policy in the § 447.40 of this chapter, if acility's policies regarding , which must be consistent e)(1) of this section, lent to return; and on specified in paragraph (e) d-hold notice upon transfer. Insfer of a resident for therapeutic leave, a nursing ide to the resident and the native written notice which ation of the bed-hold policy ugraph (d)(1) of this section. v and record review, the facility e notification of the bed-hold a resident who transferred to ovided in writing to the dent representative for 2 of 3 for hospitalization. (Resident	F 0625	F 625 = D         What corrective action(s) will         be accomplished for those         residents found to have bee         affected by the deficient         practice;         It is the policy of Bloomington         Care Center that all residents         resident representatives rece         notice of transfer or discharge	ill n s and ive	07/12/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION X 00	3) DATE SURVEY COMPLETED 06/24/2024
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155 E E	address, city, state, zip cod BURKS DR MINGTON, IN 47401	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
TAG	<ul> <li>6/24/24 at 9:55 a.m were not limited to disease and chroni</li> <li>Resident 54's prog resident was sent t 2/15/24. The clinic of written notificat bed-hold policy haresident or the resi</li> <li>2. Resident 64's cli 6/24/24 at 9:45 a.m were not limited to chronic kidney dis</li> <li>Resident 64's prog resident was sent t clinical record lack notification which policy having beer</li> <li>During an intervier</li> <li>Director of Nursin facility did not proresident representate Bed-Hold forms in forms with the resist transferred to anotification or twill provide to the</li> </ul>	ress notes indicated the o the hospital on 1/27/24 and cal record lacked documentation ion which specified the facility's wing been provided to the dent representative. inical record was reviewed on a. The diagnoses included, but b, type II diabetes mellitus and ease. ress notes indicated the o the hospital on 6/17/24. The ced documentation of written specified the facility's bed-hold a provided to the resident. w on 6/24/24 at 10:04 a.m., the g Services (DNS) indicated the vided the resident nor the tive the notification of a writing. The facility sent the ident when they were her facility.	TAG	Medical records department to ensure copies are sent to resider representative. Clinical staff educated on documentation of notification, as well as document to provide. See Exhibit D- "Transfer and Discharge Policy" How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged defici practice. All resident transfers and discharges will be reviewed during IDT for completion of documentation, and that documentation was provided to resident as well as their representative. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The clinical staff reviewed the policy "Transfer and Discharge Policy" (see exhibit D). An audit tool "Discharge/Transfer Audit", (see exhibit E), will be utilized to determine provision of discharge transfer documentation to reside and their representative. Audits will be completed daily for 2 weeks, 3x/week for 6 weeks, the	ts e co ent

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FGGE11 Facility ID: 000177

If continuation sheet Page 9 of 21

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155278	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155 E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-12(a)(25) 3.1-12(a)(26)			monthly until compliance is achieved. Process will be reviewed at QAPI meeting to assess if compliance is achie	,	
				By what date the systemic changes for each deficiency will be completed. After submitting an acceptable p of correction, it is determin that the correction will not completed by the date previously submitted, The Division need to be contact as soon as possible. The fa will need to submit an amended plan of correction with the updated plan of correction date.	lan ed be red cility	
F 0698 SS=D Bldg. 00	require dialysis re consistent with p practice, the com	is. ensure that residents who eceive such services, rofessional standards of prehensive person-centered e residents' goals and		Date of compliance: July 12 2024	2,	
	Based on interview failed to have an o dialysis center rega dialysis for 1 of 1 care. (Resident 63)	and record review, the facility ngoing communication with the arding dialysis care while at residents reviewed for dialysis	F 0698	<u>F 698 = D</u> What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice;		
	Findings include:			It is the policy of Bloomingto	on	

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/24/2024
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155 E B	ddress, city, state, zip cod URKS DR INGTON, IN 47401	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O         On 6/20/24 at 10:1         record was reviewed         were not limited to         hypertension, and d         The physician order         following:         - Dialysis treatment         Friday (start date 1         - Monitor Post Dial         every Monday, We         date 7/28/23).         - Pre Dialysis Asse         7/28/23).         - Send Dialysis Co         resident to dialysis         Friday (start date 7         A care plan, dated         received hemodial	R LSC IDENTIFYING INFORMATION 3 a.m., Resident 63's clinical ed. The diagnoses included, but o end stage renal disease, dementia. ers, dated 6/24/24 indicated the at on Monday, Wednesday, and 1/3/23). lysis dressing for bleeding ednesday, and Friday (start essment every Monday, riday (start date 7/28/23). essment every shift (start date mmunication Binder with on Monday, Wednesday, and	TAG		the e be e
	The In-Facility Pos lacked any docume communication.	communicating with the facility. st Dialysis Form, dated 6/3/24, entation of dialysis center st Dialysis Form, dated 6/5/24,		practice does not recur: The nursing staff reviewed hemodialysis policy (see Exhil G). An audit tool "Dialysis Aud (see Exhibit F), will be utilized monitor for assessment and	lit",
	lacked any docume communication. The Dialysis/Obse	entation of dialysis center rvation Communication Form, red documentation of dialysis		documentation compliance. D or designee will complete daily audits for two weeks, 3x/week 6 weeks, then monthly until compliance is achieved.	y

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FGGE11 Facility ID: 000177

If continuation sheet Page 11 of 21

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	ì í	JILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIEF	E - BLOOMINGTON CARE CEN	TER	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401		
BRICKY (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF center communication The Dialysis/Obser dated 6/12/24, lack center communication The In-Facility Pos lacked any docume communication. The Dialysis/Obser dated 6/17/24, lack center communication The Dialysis Comm lacked documentation information. The Dialysis Comm at 9:00 a.m., lacked center information. The Dialysis Comm at 8:48 a.m., lacked center and post-dial During an interview Assistant Director of indicated Resident with his dialysis co dialysis center did n	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> fon. vation Communication Form, ed documentation of dialysis fon. t Dialysis Form, dated 6/14/24, ntation of dialysis center vation Communication Form, ed documentation of dialysis fon. nunication Form, dated 6/19/24, on of post-dialysis nunication Form, dated 6/21/24 documentation of the dialysis	TER			y lan ed be cility	(X5) COMPLETI DATE
	ADNS indicated wh dialysis, they would the top of the dialys While at dialysis, th	y on 6/24/24 at 11:42 a.m., the nen Resident 63 goes to d send his dialysis binder with his communication fill out. he dialysis center would fill out nformation. When he returns t, the dialysis center					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CO	(X3) DATE SURVEY COMPLETED 06/24/2024	
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CEN			STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR ITER BLOOMINGTON, IN 47401					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
IAG	information was b			IAG			DATE	
= 0757 SS=D Bldg. 00	Services provided "Hemodialysis." re- was the policy cur the policy indicate coordinate and col assure that: d. The and collaboration is implementation of nursing home and 3.1-37(a) 483.45(d)(1)-(6) Drug Regimen is Drugs §483.45(d) Unne Each resident's of from unnecessar drug is any drug §483.45(d)(1) In duplicate drug th §483.45(d)(2) Fo §483.45(d)(2) Fo §483.45(d)(3) Wi or §483.45(d)(4) Wi for its use; or §483.45(d)(5) In consequences w should be reduce §483.45(d)(6) Art	Free from Unnecessary cessary Drugs-General. drug regimen must be free y drugs. An unnecessary when used- excessive dose (including						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/24/2024 155278 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 155 E BURKS DR BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (5) of this section. Based on interview and record review, the facility F 0757 F 757 = D 07/12/2024 failed to ensure medications were administered What corrective action(s) will with adequate indications for use for 1 of 5 be accomplished for those residents reviewed for unnecessary medications. residents found to have been Medications were administered outside of affected by the deficient physician order parameters. (Resident 88) practice; Findings include: It is the policy of Bloomington Care Center that any resident who On 6/21/24 at 11:38 a.m., Resident 88's clinical receives hypertension medication record was reviewed. The diagnoses included, but will have blood pressure were not limited to, congestive heart failure, monitoring with parameters in hypertension, and dementia. place. Clinical staff will receive training on blood pressure Resident 88's physician orders dated 6/24/24 monitoring and when to hold indicated the following: medication. - Lisinopril (medication used to treat high blood How other residents having the pressure) 20 milligrams (mg) by mouth one time a potential to be affected by the day for hypertension. Hold medication if the same deficient practice will be systolic blood pressure was less than 90 or identified and what corrective diastolic blood pressure less than 60. If systolic action(s) will be taken; blood pressure was greater than 160 and diastolic blood pressure was greater than 90, administer the All residents have the potential to medication and notify the MD. Recheck blood be affected by the alleged deficient pressure in 30 minutes and document blood practice. Staff education pressure (start date 4/18/24). completed regarding blood pressure monitoring and when to - Metoprolol succinate extended release hold medication based on (medication used to treat high blood pressure) 25 parameters. mg by mouth one a day for hypertension. Hold medication if the systolic blood pressure was less What measures will be put into than 90 or diastolic blood pressure less than 60. If place and what systemic systolic blood pressure was greater than 160 and changes will be made to diastolic blood pressure was greater than 90, ensure that the deficient administer the medication and notify the MD. practice does not recur: Recheck blood pressure in 30 minutes and document blood pressure. Hold medication if DNS or designee will complete pulse was less than 60 (start date 4/18/24). audit (See Exhibit H- BP

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FGGE11 Facility II

Facility ID: 000177

If continuation sheet

Page 14 of 21

07/12/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		(X2) MULTIPLE C A. BUILDING B. WING	005TRUCTION	(X3) DATE SURVEY COMPLETED 06/24/2024				
	PROVIDER OR SUPPLIE	R E - BLOOMINGTON CARE CEN	155 E	STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR ER BLOOMINGTON, IN 47401				
X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	Resident 88's May Administration Re - On 5/2/24 at 9:00 administered. Her (diastolic blood pr clinical record lack medication being 1 - On 5/2/24 at 9:00 extended release 2 blood pressure wa pressure was less to lacked documenta - On 5/12/24 at 9:0 extended release 2 pulse was 52. The documentation of - On 5/24/24 at 9:0 extended release 2 pulse was 52. The documentation of - On 5/24/24 at 9:0 extended release 2 pulse was 56. The documentation of - On 5/25/24 at 9:0 administered. Her (diastolic blood pr clinical record lack medication being 1 - On 5/25/24 at 9:0 extended release 2 blood pressure wa pressure was less to lacked documentation	<ul> <li>a.m., lisinopril 20 mg was blood pressure was 106/54</li> <li>essure was less than 60). The keed documentation of held.</li> <li>a.m., metoprolol succinate</li> <li>5 mg was administered. Her s 108/54 (diastolic blood than 60). The clinical record tion of medication being held.</li> <li>a.m., metoprolol succinate</li> <li>5 mg was administered. Her clinical record lacked medication being held.</li> <li>a.m., metoprolol succinate</li> <li>5 mg was administered. Her clinical record lacked medication being held.</li> <li>a.m., metoprolol succinate</li> <li>5 mg was administered. Her clinical record lacked medication being held.</li> <li>a.m., metoprolol succinate</li> <li>5 mg was administered. Her clinical record lacked medication being held.</li> <li>a.m., lisinopril 20 mg was blood pressure was 110/50 essure was less than 60). The ked documentation of held.</li> <li>a.m., metoprolol succinate</li> <li>f mg was administered. Her s 110/50 (diastolic blood than 60). The clinical record tion of medication being held.</li> </ul>	TAG	parameter audit) to ensure medication is being held or administered based on parameters. Audits will be completed daily for 2 weeks, 3x/week for 6 weeks, then monthly until compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable pl of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contact as soon as possible. The fa will need to submit an amended plan of correction with the updated plan of correction date. Date of compliance: July 12 2024.	/ lan ed be ed cility			
		00 a.m., lisinopril 20 mg was blood pressure was 124/56						

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	· · ·	<u> </u>		(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIEF	E - BLOOMINGTON CARE CEI	15	5 E BL	DDRESS, CITY, STATE, ZIP C JRKS DR NGTON, IN 47401	COD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETI
TAG	REGULATORY OF	TA	G	DEFICIENCY)	AFFROFRIATE	DATE	
	clinical record lack medication being h	ssure was less than 60). The ed documentation of eld. 0 a.m., metoprolol succinate					
	extended release 25 blood pressure was	mg was administered. Her 124/56 (diastolic blood nan 60). Her pulse was 58. The					
	•	ed documentation of					
	Resident 88's June Administration Rec	2024 Medication ord indicated the following on:					
	administered. Her b (diastolic blood pre	a.m., lisinopril 20 mg was blood pressure was 142/59 ssure was less than 60). The ed documentation of eld.					
	extended release 25 blood pressure was pressure was less th	a.m., metoprolol succinate f mg was administered. Her 142/59 (diastolic blood aan 60). Her pulse was 53. The ed documentation of eld.					
	administered. Her b (diastolic blood pre	a.m., lisinopril 20 mg was blood pressure was 106/58 ssure was less than 60). The ed documentation of eld.					
	extended release 25	a.m., metoprolol succinate mg was administered. Her 106/58 (diastolic blood tan 60).					
		0 a.m., lisinopril 20 mg was blood pressure was 130/48					

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FORM APPROVED

STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATI	(X3) DATE SURVEY		
AND PLAN OF CORRECTION			00		COMPLETED	
	155278	A. BUILDING B. WING		06/24/2024		
		STREET A	ADDRESS, CITY, STATE, ZIP	COD		
NAME OF PROVIDER OR SUPPLIE	R	155 E E	BURKS DR			
BRICKYARD HEALTHCAR	E - BLOOMINGTON CARE CEN	ITER BLOOM	/INGTON, IN 47401			
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX (EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI	
TAG REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	essure was less than 60). The					
clinical record lack	ted documentation of					
medication being h	neld.					
- On 6/17/24 at 9:0	0 a.m., metoprolol succinate					
	5 mg was administered. Her					
	s 130/48 (diastolic blood					
-	han 60). The clinical record					
	ion of medication being held.					
	0 a.m., metoprolol succinate					
	5 mg was administered. Her					
_	clinical record lacked					
documentation of i	nedication being held.					
	7/27/23, indicated she had					
hypertension. Her	interventions were to					
administer medica	tion as ordered; obtain and					
document her vital	signs as ordered; and report					
abnormalities to th	e MD.					
During an intervie	w on 6/24/24 11:12 a.m.,					
Registered Nurse (	RN) 1 indicated Resident 88					
had hypertension a	nd was on lisinopril and					
	systolic blood pressure was					
less than 90 or her	diastolic blood pressure was					
less than 60, her lis	sinopril and metoprolol was held					
and the nurse pract	itioner would be notified. If her					
pulse was less than	1 60, her metroprolol would be					
held. If the medica	tion was held, they would					
	ication being held in the					
medication admini	stration record.					
During an intervie	w on 6/24/24 at 11:50 a.m., the					
_	g Services (DNS) indicated the					
	prolol was administrated to					
-	linical record lacked					
	isinopril and metoprolol being					
held per physician						
nera per physician						
					1	

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING				COI 06/	(X3) DATE SURVEY COMPLETED 06/24/2024	
	PROVIDER OR SUPPLIE ARD HEALTHCAR	ER RE - BLOOMINGTON CARE CENT	155	eet address, city, state, zi E BURKS DR DOMINGTON, IN 47401	P COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFI2 TAG	CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 0842 SS=D Bldg. 00	facility policy, "M undated, and indic being used. A revi Obtain and record per physician order medication for the physician's preserv 3.1-48(a)(4) 483.20(f)(5), 483 Resident Record §483.20(f)(5) Re (i) A facility may is resident-identif (ii) The facility m resident-identifia accordance with agent agrees no information exce itself is permitted §483.70(i) Medic §483.70(i) Medic §483.70(i)(1) In a professional star facility must main each resident tha (i) Complete; (ii) Accurately do (iii) Readily acce (iv) Systematical §483.70(i)(2) The confidential all in resident's record regardless of the the records, exce (i) To the individu	Is - Identifiable Information sident-identifiable information. not release information that fiable to the public. ay release information that is ble to an agent only in a contract under which the t to use or disclose the pt to the extent the facility t to do so. cal records. accordance with accepted ndards and practices, the ntain medical records on at are- becumented; ssible; and ly organized e facility must keep formation contained in the					

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FORM APPROVED

STATEME	NT OF DEFICIENCIES	OMB NO. 0938- (X3) DATE SURVEY						
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			COMPLETED 06/24/2024	
	of conduction	155278	B. WING					
				STREET	ADDRESS, CITY, STATE, ZIP (	COD		
NAME OF PROVIDER OR SUPPLIER				155 E E				
BRICKY	ARD HEALTHCARE	- BLOOMINGTON CARE CEN	TER	BLOOM	MINGTON, IN 47401			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	law;							
	(ii) Required by La	aw;						
	(iii) For treatment,	payment, or health care						
	operations, as per	mitted by and in						
	compliance with 4	5 CFR 164.506;						
	(iv) For public hea							
	abuse, neglect, or							
	oversight activities	s, judicial and administrative						
	proceedings, law	enforcement purposes,						
	organ donation pu	irposes, research purposes,						
	or to coroners, me	edical examiners, funeral						
	directors, and to a	vert a serious threat to						
	health or safety as	s permitted by and in						
	compliance with 4	5 CFR 164.512.						
	§483.70(i)(3) The	facility must safeguard						
	medical record inf	ormation against loss,						
	destruction, or un	authorized use.						
	§483.70(i)(4) Med	lical records must be						
	retained for-							
	(i) The period of ti	me required by State law; or						
	(ii) Five years from	n the date of discharge						
	when there is no i	equirement in State law; or						
	(iii) For a minor, 3	years after a resident						
	reaches legal age	under State law.						
	§483.70(i)(5) The	medical record must						
	contain-							
	(i) Sufficient inforr resident;	nation to identify the						
		e resident's assessments;						
		ensive plan of care and						
	services provided	•						
		, any preadmission						
		ident review evaluations and						
	-	nducted by the State;						
		irse's, and other licensed						
	professional's pro							
		diology and other diagnostic						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/24/2024 155278 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 155 E BURKS DR BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE services reports as required under §483.50. F 0842 F 842 = D 07/12/2024 Based on interview and record review the facility What corrective action(s) will failed to ensure staff documented neurological be accomplished for those assessments for 1 of 1 residents reviewed for falls. residents found to have been (Resident 105) affected by the deficient practice; Findings include: It is the policy of Bloomington On 6/24/24 at 10:18 a.m., Resident 105's clinical Care Center that neurological record was reviewed. The diagnoses included, but assessments be completed after were not limited to, morbid (severe) obesity, unwitnessed fall. Staff education abnormalities of gait and mobility, and edema. initiated on fall policy (Exhibit I) and neuro check procedures. Progress notes indicated the following: How other residents having the - On 4/20/24 at 11:10 a.m., the resident was potential to be affected by the transferring self with a walker to his wheelchair same deficient practice will be and stepped on barbell weights instead of the identified and what corrective floor. The resident complained of left knee pain action(s) will be taken. and a 6 centimeter (cm) by 0.5 cm abrasion was assessed on his left knee. All residents have the potential to be affected by the alleged deficient - On 4/20/24 at 2:06 p.m., a telehealth note practice. All residents with indicated the resident was found on the floor. He unwitnessed falls reported will did not know his bed was elevated when he tried have neuro checks initiated and to get up and lost his balance. The resident completed in scheduled time complained of left knee pain, but refused frame. Clinical staff will receive treatment. education on neuro check process and frequency. - On 4/20/24 at 2:30 p.m., the resident was playing game system. The author indicated neuro checks What measures will be put into continue and were within normal limits. No place and what systemic documentation was noted in regard to changes will be made to neurological assessment findings. ensure that the deficient practice does not recur: - On 4/20/24 at 3:22 p.m., the resident wanted to see what the x-rays before going to the ER IDT committee will review all falls (emergency room). The author indicated neuro in clinical start up meeting and checks continue and were within normal limits. verify if neuro checks were

Event ID:

FGGE11 Facility II

Facility ID: 000177

If continuation sheet

Page 20 of 21

07/12/2024

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NTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155278		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 06/24/2024 D	
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O PERRLA (pupils a light and accommon documentation was neurological assess A review of the res documentation, dat indicated neurolog performed 15 minu the fall, and 4 hour documentation ind assessments were r fall, 45 minutes po hours post fall, 2 an post fall, 5 hours p hours post fall, 11 f fall, 19 hours post During an interview Director of Nursing neuro check flowsh so some nurses wo others would make there were holes in documentation and	ment findings. ident's "Neuro Checks," ed 4/20/23 at 3:24 p.m., ical assessments were tes after the fall, 1 and 1/2 hours is after the fall. The icated neurological tot completed 30 minutes post fall, 60 minutes post fall, 2 nd 1/2 hours post fall, 3 hours post fall, 6 hours post fall, 7 hours post fall, 15 hours post fall, nor 23 hours post fall. v on 6/24/24 at 1:53 p.m., the g Services (DNS) indicated the neet was "kind of new" to them uld use the form and then a progress note. She indicated the resident's "Neuro Checks" progress notes, and the for staff to perform neuro		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY) initiated when indicated. Au will be completed daily for 2 weeks, 3x/week for 6 weeks monthly until compliance is achieved. Process will be reviewed at QAPI meeting t evaluate if compliance has a achieved. By what date the systemic changes for each deficient will be completed. After submitting an acceptable p of correction, it is determint that the correction will not completed by the date previously submitted, The Division need to be contact as soon as possible. The f will need to submit an amended plan of correction with the updated plan of correction date. Date of compliance: July 1 2024	AFE RIATE Judits s, then o been Cy olan hed be sted acility n	(X5) COMPLETION DATE

FGGE11 Facility ID: 000177

If continuation sheet Page 21 of 21