STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00436387. Complaint IN00436387 - No deficiencies related to the allegations are cited. Survey dates: June 18, 19, 20, 21 and 24, 2024 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicare: 4 Medicaid: 95 Other: 11 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 28, 2024.	F 0000	PLAN OF CORRECTION FOR BLOOMINGTON CARE CENTER F000 INITIAL COMMENTS . The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after July 12, 2024.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self	F 0554	**F 554 = D What corrective action(s) will be accomplished for those residents found to**	07/12/2024

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

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	medication administration assessment was complete for residents with medications left at bedside for 1 of 1 random observations. (Resident 80) Findings include: On at 6/19/24 at 9:50 a.m., Resident 80 was observed in her room lying in bed next to the bedside table. On the bedside table in a plastic medication cup were 2 tablets of medication identified as 800 mg (milligrams) each of Sevelamer HCL (a medication used for persons on dialysis to lower blood phosphate levels). No facility staff members were present in the room at that time. Resident 80 indicated she took the medication with food, but she did not eat that morning, and the nurse left the medication on her bedside table and left the room. During an interview on 6/19/24 at 9:55 a.m., the Director of Nursing indicated the medication should not have been left with the resident, as medication administration was to be observed by the administering qualified staff unless the resident was assessed to be able to self administer medications. On 6/19/24 at 10:45 a.m., Resident 80's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease and hypertension. The State Optional Minimum Data Set assessment, dated 3/21/24, indicated the resident was cognitively intact. A physician's order with a start date of 1/23/24 indicated the resident was prescribed 2-800 mg tablets of Sevelamer HCL three times a day with meals.		**have been affected by the deficient practice;** It is the policy of Bloomington Care Center that any resident who self-administers medication have an assessment and care plan in place. The director of nursing completed self-administration assessment and added care plans indicating resident 80 may administer medication independently. A lock box was provided to resident to store medication safely until administration time. (See Exhibit A) **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 deficient practice. Staff education provided about leaving medication at bedside and assessing for self-administration of medication. (see exhibit B) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The nursing staff reviewed medication administration policy (see Exhibit B). An audit tool “Medication Administration”, (see Exhibit C), will be utilized to monitor for medications at	

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	The clinical record lacked a self medication administration assessment. 3.1-11(a)		bedside. DNS or designee will complete daily audits for two 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 plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024**	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described			

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	in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form			

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	and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as			

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	the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 2 of 3 residents reviewed for hospitalization. (Resident 54 and Resident 64) Findings include: 1. Residents 54's clinical record was reviewed on 6/24/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic kidney disease. Resident 54's progress notes indicated the resident was sent to the hospital on 1/27/24 and 2/15/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 2. Resident 64's clinical record was reviewed on 6/24/24 at 9:45 a.m. The diagnoses included, but were not limited to, type II diabetes mellitus and chronic kidney disease. Resident 64's progress notes indicated the resident was sent to the hospital on 6/17/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident. During an interview on 6/24/24 at 10:04 a.m., the Director of Nursing Services (DNS) indicated the facility did not provided the resident nor the resident representative the Notice of Transfer and Discharge forms in writing. The facility sent the	F 0623	**F 623 = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Bloomington Care Center that all residents and resident representatives receive notice of transfer or discharge. Medical records department to ensure copies are sent to resident representative. Clinical staff educated on documentation of notification, as well as documents 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 deficient 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**	07/12/2024

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	forms with the resident when they were transferred to another facility. On 6/24/24 at 1:50 p.m., the DNS provided the facility's policy,"Transfer and Discharge" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		**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 resident and their representative. Audits will be completed daily for 2 weeks, 3x/week for 6 weeks, then monthly until compliance is achieved. Process will be reviewed at QAPI meeting to assess if compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024**	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and			

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	return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 2 of 3 residents reviewed for hospitalization. (Resident 54 and Resident 64) Findings include: 1. Residents 54's clinical record was reviewed on	F 0625	**F 625 = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Bloomington Care Center that all residents and resident representatives receive notice of transfer or discharge.	07/12/2024

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	6/24/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic kidney disease. Resident 54's progress notes indicated the resident was sent to the hospital on 1/27/24 and 2/15/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative. 2. Resident 64's clinical record was reviewed on 6/24/24 at 9:45 a.m. The diagnoses included, but were not limited to, type II diabetes mellitus and chronic kidney disease. Resident 64's progress notes indicated the resident was sent to the hospital on 6/17/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident. During an interview on 6/24/24 at 10:04 a.m., the Director of Nursing Services (DNS) indicated the facility did not provided the resident nor the resident representative the notification of Bed-Hold forms in writing. The facility sent the forms with the resident when they were transferred to another facility. On 6/24/24 at 1:50 p.m., the DNS provided the facility's policy,"Bed Hold Notice Upon Transfer" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy ..."		Medical records department to ensure copies are sent to resident representative. Clinical staff educated on documentation of notification, as well as documents 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 deficient 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 resident and their representative. Audits will be completed daily for 2 weeks, 3x/week for 6 weeks, then	

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	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 achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024**	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to have an ongoing communication with the dialysis center regarding dialysis care while at dialysis for 1 of 1 residents reviewed for dialysis care. (Resident 63) Findings include:	F 0698	**F 698 = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Bloomington	07/12/2024

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	On 6/20/24 at 10:13 a.m., Resident 63's clinical record was reviewed. The diagnoses included, but were not limited to end stage renal disease, hypertension, and dementia. The physician orders, dated 6/24/24 indicated the following: - Dialysis treatment on Monday, Wednesday, and Friday (start date 11/3/23). - Monitor Post Dialysis dressing for bleeding every Monday, Wednesday, and Friday (start date 7/28/23). - Post Dialysis Assessment every Monday, Wednesday, and Friday (start date 7/28/23). - Pre Dialysis Assessment every shift (start date 7/28/23). - Send Dialysis Communication Binder with resident to dialysis on Monday, Wednesday, and Friday (start date 7/31/23). A care plan, dated 7/28/23, indicated Resident 63 received hemodialysis due to end stage renal disease. The care plan lacked any documentation of dialysis facility communicating with the facility. The In-Facility Post Dialysis Form, dated 6/3/24, lacked any documentation of dialysis center communication. The In-Facility Post Dialysis Form, dated 6/5/24, lacked any documentation of dialysis center communication. The Dialysis/Observation Communication Form, dated 6/10/24, lacked documentation of dialysis		Care Center that any resident who receives dialysis will have ongoing communication with dialysis facility. DNS or designee will monitor daily for completed dialysis documentation. (See Exhibit F- Dialysis Audit) **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 receiving dialysis have the potential to be affected by the alleged deficient practice. Staff education completed regarding dialysis policy and documentation. (See Exhibit G- Hemodialysis Policy) Dialysis Audit to be completed daily by IDT team. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The nursing staff reviewed hemodialysis policy (see Exhibit G). An audit tool “Dialysis Audit”, (see Exhibit F), will be utilized to monitor for assessment and documentation compliance. DNS or designee will complete daily audits for two weeks, 3x/week for 6 weeks, then monthly until compliance is achieved.	

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	center communication. The Dialysis/Observation Communication Form, dated 6/12/24, lacked documentation of dialysis center communication. The In-Facility Post Dialysis Form, dated 6/14/24, lacked any documentation of dialysis center communication. The Dialysis/Observation Communication Form, dated 6/17/24, lacked documentation of dialysis center communication. The Dialysis Communication Form, dated 6/19/24, lacked documentation of post-dialysis information. The Dialysis Communication Form, dated 6/21/24 at 9:00 a.m., lacked documentation of the dialysis center information. The Dialysis Communication Form, dated 6/24/24 at 8:48 a.m., lacked documentation of the dialysis center and post-dialysis information. During an interview on 6/21/24 at 10:30 a.m., the Assistant Director of Nursing Services (ADNS) indicated Resident 63 was at the dialysis center with his dialysis communication binder. The dialysis center did not fill out the dialysis center information on the communication forms. During an interview on 6/24/24 at 11:42 a.m., the ADNS indicated when Resident 63 goes to dialysis, they would send his dialysis binder with the top of the dialysis communication fill out. While at dialysis, the dialysis center would fill out the dialysis center information. When he returns from dialysis center, the dialysis center		**By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024**	

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	information was blank. On 6/24/24 at 2:00 p.m., the Director of Nursing Services provided the facility policy, "Hemodialysis." revised on 2/23, and indicated it was the policy currently being used. A review of the policy indicated, "...3. The facility will coordinate and collaborate with dialysis facility to assure that: d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialyses staff..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through			

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	155278	A. BUILDING 00 B. WING	06/24/2024

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	(5) of this section. Based on interview and record review, the facility failed to ensure medications were administered with adequate indications for use for 1 of 5 residents reviewed for unnecessary medications. Medications were administered outside of physician order parameters. (Resident 88) Findings include: On 6/21/24 at 11:38 a.m., Resident 88's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure, hypertension, and dementia. Resident 88's physician orders dated 6/24/24 indicated the following: - Lisinopril (medication used to treat high blood pressure) 20 milligrams (mg) by mouth one time a day for hypertension. Hold medication if the systolic blood pressure was less than 90 or diastolic blood pressure less than 60. If systolic blood pressure was greater than 160 and diastolic blood pressure was greater than 90, administer the medication and notify the MD. Recheck blood pressure in 30 minutes and document blood pressure (start date 4/18/24). - Metoprolol succinate extended release (medication used to treat high blood pressure) 25 mg by mouth one a day for hypertension. Hold medication if the systolic blood pressure was less than 90 or diastolic blood pressure less than 60. If systolic blood pressure was greater than 160 and diastolic blood pressure was greater than 90, administer the medication and notify the MD. Recheck blood pressure in 30 minutes and document blood pressure. Hold medication if pulse was less than 60 (start date 4/18/24).	F 0757	**F 757 = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Bloomington Care Center that any resident who receives hypertension medication will have blood pressure monitoring with parameters in place. Clinical staff will receive training on blood pressure monitoring and when to hold medication. **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 deficient practice. Staff education completed regarding blood pressure monitoring and when to hold medication based on parameters. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DNS or designee will complete audit (See Exhibit H- BP	07/12/2024

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	Resident 88's May 2024 Medication Administration Record indicated the following on: - On 5/2/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 106/54 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/2/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 108/54 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/12/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 52. The clinical record lacked documentation of medication being held. - On 5/24/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 56. The clinical record lacked documentation of medication being held. - On 5/25/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 110/50 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/25/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 110/50 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/28/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 124/56		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 plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024.**	

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	(diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/28/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 124/56 (diastolic blood pressure was less than 60). Her pulse was 58. The clinical record lacked documentation of medication being held. Resident 88's June 2024 Medication Administration Record indicated the following on: - On 6/2/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 142/59 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 6/2/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 142/59 (diastolic blood pressure was less than 60). Her pulse was 53. The clinical record lacked documentation of medication being held. - On 6/9/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 106/58 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 6/9/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 106/58 (diastolic blood pressure was less than 60). - On 6/17/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 130/48			

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	(diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 6/17/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 130/48 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 6/18/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 50. The clinical record lacked documentation of medication being held. A care plan, dated 7/27/23, indicated she had hypertension. Her interventions were to administer medication as ordered; obtain and document her vital signs as ordered; and report abnormalities to the MD. During an interview on 6/24/24 11:12 a.m., Registered Nurse (RN) 1 indicated Resident 88 had hypertension and was on lisinopril and metoprolol. If her systolic blood pressure was less than 90 or her diastolic blood pressure was less than 60, her lisinopril and metoprolol was held and the nurse practitioner would be notified. If her pulse was less than 60, her metroprolol would be held. If the medication was held, they would document the medication being held in the medication administration record. During an interview on 6/24/24 at 11:50 a.m., the Director of Nursing Services (DNS) indicated the lisinopril and metoprolol was administrated to Resident 88. The clinical record lacked documentation of lisinopril and metoprolol being held per physician orders.			

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	On 6/24/24 at 1:37 p.m., the DNS provided the facility policy, "Medication Administration," undated, and indicated it was the policy currently being used. A review of the policy indicated, "...8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters..." 3.1-48(a)(4)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement 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 information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on interview and record review the facility failed to ensure staff documented neurological assessments for 1 of 1 residents reviewed for falls. (Resident 105) Findings include: On 6/24/24 at 10:18 a.m., Resident 105's clinical record was reviewed. The diagnoses included, but were not limited to, morbid (severe) obesity, abnormalities of gait and mobility, and edema. Progress notes indicated the following: - On 4/20/24 at 11:10 a.m., the resident was transferring self with a walker to his wheelchair and stepped on barbell weights instead of the floor. The resident complained of left knee pain and a 6 centimeter (cm) by 0.5 cm abrasion was assessed on his left knee. - On 4/20/24 at 2:06 p.m., a telehealth note indicated the resident was found on the floor. He did not know his bed was elevated when he tried to get up and lost his balance. The resident complained of left knee pain, but refused treatment. - On 4/20/24 at 2:30 p.m., the resident was playing game system. The author indicated neuro checks continue and were within normal limits. No documentation was noted in regard to neurological assessment findings. - On 4/20/24 at 3:22 p.m., the resident wanted to see what the x-rays before going to the ER (emergency room). The author indicated neuro checks continue and were within normal limits.	F 0842	**F 842 = D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the policy of Bloomington Care Center that neurological assessments be completed after unwitnessed fall. Staff education initiated on fall policy (Exhibit I) and neuro check procedures. **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 deficient practice. All residents with unwitnessed falls reported will have neuro checks initiated and completed in scheduled time frame. Clinical staff will receive education on neuro check process and frequency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT committee will review all falls in clinical start up meeting and verify if neuro checks were	07/12/2024

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	PERRLA (pupils are equal, round and reactive to light and accommodation). No additional documentation was noted in regard to neurological assessment findings. A review of the resident's "Neuro Checks," documentation, dated 4/20/23 at 3:24 p.m., indicated neurological assessments were performed 15 minutes after the fall, 1 and 1/2 hours the fall, and 4 hours after the fall. The documentation indicated neurological assessments were not completed 30 minutes post fall, 45 minutes post fall, 60 minutes post fall, 2 hours post fall, 2 and 1/2 hours post fall, 3 hours post fall, 5 hours post fall, 6 hours post fall, 7 hours post fall, 11 hours post fall, 15 hours post fall, 19 hours post fall, nor 23 hours post fall. During an interview on 6/24/24 at 1:53 p.m., the Director of Nursing Services (DNS) indicated the neuro check flowsheet was "kind of new" to them so some nurses would use the form and then others would make a progress note. She indicated there were holes in the resident's "Neuro Checks" documentation and progress notes, and the standard of care is for staff to perform neuro checks on any unwitnessed falls. 3.1-50(a)(2)		initiated when indicated. Audits will be completed daily for 2 weeks, 3x/week for 6 weeks, then monthly until compliance is achieved. Process will be reviewed at QAPI meeting to evaluate if compliance has been achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **Date of compliance: July 12, 2024**	