

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	<p>This visit was for the Investigation of Complaint IN00154694.</p> <p>Complaint IN00154694 - Substantiated. Federal/State deficiencies related to the allegations are cited at F325 and F282.</p> <p>Survey dates: September 12 & 15, 2014</p> <p>Facility number: 000460 Provider number: 155532 AIM number: 100290620</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicaid: 33 Other: 1 Total: 34</p> <p>Sample: 03</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective for the complaint survey conducted on 9/15/2014. The facility also requests that our plan of correction be considered for paper compliance. The facility would be happy to submit to you any compliance paperwork you would need.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000282 SS=D	<p>22, 2014; by Kimberly Perigo, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure the care plan initiated on 7/23/14, was followed for monitoring nutrition/hydration/weights and notify physician and dietary referrals/screen as needed for 1 of 3 residents reviewed for weight loss.</p> <p>Findings Include:</p> <p>Resident #A's clinical record was reviewed on 9/12/14 at 7:00 a.m. and 9/15/14 at 12:30 p.m. Resident #A's Diagnoses included, but were not limited to: immunodeficiency virus, depression, suspected dementia, and hypertension.</p> <p>A care plan problem dated 7/23/14, received from the DON on 9/15/14 at 9:30 a.m., indicated Resident #A was at</p>	F000282	<p>It is the practice of this facility to assure the services provided or arranged by the facility is provided by qualified person in accordance with each resident's written plan of care. This resident no longer resides at this facility All residents have the potential to be affected by this finding. Using a monitoring tool, all weights were reviewed and residents that were exhibiting weight loss/poor nutritional status were identified. Care plans were updated with any needed interventions. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All staff has been re=educated regarding the identification and communication regarding weight loss and/or poor nutrition. The corrective action monitoring tool has been established to identify</p>	10/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>risk for rapid physical or mental decline related to immunodeficiency virus disease process, with interventions including but not limited to: Administer multi-immunoviral medication as ordered and monitor for side effects. Monitor nutrition/hydration/weights and notify physician and dietary referrals as needed.</p> <p>Review of Resident #A's weekly weight sheet on 9/15/14 at 10:00 a.m., indicated Resident #A was losing weight weekly. Admission weight done on 7/23/14, indicated his weight was 148.2 lbs; on 7/28/14 his weight was 132.6 lbs (a decrease of 10.2 lbs); on 8/4/14, his weight was 128.4 lbs (a decrease of 4.2 lbs); on 8/11/14 his weight was 125.2 (a decrease of 3.2 lbs); and on 9/25/14 his weight was 124.2 (a decrease of 1 lb).</p> <p>Interview with the DON on 9/15/14 at 1:00 p.m., indicated she was not made aware of Resident #A's weight dropping.</p> <p>Interviews conducted with the DON and primary RN for Resident #A, on 9/15/14 at 2:00 p.m., indicated neither were aware of Resident #A's continued weight loss.</p> <p>The DON indicated she could not explain why physician notification and/or dietary referrals were not done as indicated by</p>		<p>weight concerns and identify that care plan interventions are established and followed. The DON or her designee will be responsible for completion of this tool. This tool will be completed weekly x 4 weeks, monthly for 6 month for a random selection of 5 residents. The quality assurance committee will review the results of the tool at the regularly scheduled meetings. The committee will make additional recommendations/amendments as needed. The systemic changes will be completed by October 15, 2014.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000325 SS=D	<p>Resident #A's care plan initiated 07/23/14.</p> <p>This Federal tag relates to Complaint IN00154694.</p> <p>3.1.35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure accurate and consistent assessment of a resident's nutritional status on admission, failed to ensure the resident maintained acceptable parameters (149-183 lbs) for residents body weight, and failed to accurately communicate a resident's continued weight loss for approximately 32 days from admission for 1 of 3 residents</p>	F000325	It is the practice of this facility to ensure that a resident maintains acceptable parameters of nutritional status and receive a therapeutic diet when there is a nutritional problem. This resident no longer resides at this facility. All residents have the potential to be affected by this finding. Using a monitoring tool, all weights were reviewed and residents that were exhibiting weight loss/poor nutritional status were identified.	10/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>reviewed for weight loss. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 9/12/14 at 8:15 a.m. and on 9/15/14 at 9:20 a.m.. Diagnoses included, but were not limited to: immunodeficiency virus, depression, and suspected dementia.</p> <p>Review of Resident #A's weekly weight sheet on 9/15/14 at 10:00 a.m., indicated Resident #A was losing weight weekly. Admission weight done on 7/23/14, indicated his weight was 148.2 lbs; on 7/28/14 his weight was 132.6 lbs (a decrease of 10.2 lbs); on 8/4/14, his weight was 128.4 lbs (a decrease of 4.2 lbs); on 8/11/14 a weight of 125.2 lbs (a decrease of 3.2 lbs); on 9/25/14, his weight was 124.2 lbs (a decrease of 1 lb). A total loss of 18.6 lbs in 32 days. Interview with the DON on 9/15/14 at 12:20 p.m., indicated she was not made aware of Resident #A's weight dropping.</p> <p>Review, on 9/15/14 at 11:00 a.m., of the Registered Dieticians (RD) nutrition assessment dated 8/4/14, the RD failed to accurately document and assess Resident #A's current weight of 128.4 lbs. The RD documented and based the assessment from Resident #A's admission weight, of</p>		<p>Care plans were updated with any needed interventions. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The Registered Dietitian was re-educated regarding assessments, ideal body weight and proper documentation on admission. Inservice training of all nursing and dietary staff regarding weight recording, communication and care plans was conducted. A monitoring tool has been established to identify weight concerns and identify that care plan interventions are established and followed. The DON or her designee will be responsible for completion of this tool. This tool will be completed weekly x 4 weeks, then monthly for 6 months for a random selection of 5 residents. The quality assurance committee will review the results of the tool at the regularly scheduled meetings. The committee will make additional recommendations/amendments as needed. The systemic changes will be completed by October 15, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>142.8 lbs. On this assessment the RD recommended Resident #A receive an enhanced breakfast. However, on her assessment given to the facility, it included Ensure (nutritional shake) one can BID (twice a day). An order for Ensure BID was written on 8/9/14 (5 days after the RD recommendation). Interview with the DON on 9/15/14 at 12:20 p.m., indicated the ensure was requested on 8/5/14, and it can take a few days for the physician to ok the order. When asked why the admission weight was used to base the assessment rather than the current weight, the DON could not say as she did not know.</p> <p>Further review of RD nutrition assessment, indicated Resident #A's admission weight of 142.8 pounds was below the Ideal Body Weight (IBW) of between 149 and 183 lbs. Review of facility's admission notes, dated 7/23/14 at 1:30 p.m., gave no indication Resident #A's weight was below the normal range.</p> <p>Review of Resident #A's MAR (Medication Administration Record), indicated Resident #A was accepting and drinking the Ensure. Resident #A was also noted to be eating the enhanced breakfast that was recommended. Resident #A's meal intake record reviewed 9/12/14 at 9:30 a.m., indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 E MILLER DR BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Resident #A ate between 50% and 100% of each meal. With implementation of the enhanced breakfast and Ensure twice a day, Resident #A was noted to have gained one lb.</p> <p>Interviews conducted with the DON and primary RN for Resident #A, on 9/15/14 at 2:00 p.m., indicated neither were aware of Resident #A's continued weight loss.</p> <p>This Federal tag relates to Complaint IN 00154694</p> <p>3.1-46(1)</p>			