STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BLOOMINGTON	3802 SARE RD, BLOOMINGTON, , 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00385412, IN00385605, and IN00385872. Complaint IN00385412 - Substantiated. State deficiencies related to the allegations are cited at R349. Complaint IN00385605 - Substantiated. State deficiencies related to the allegations are cited at R52. Complaint IN00385872 - Substantiated. State deficiencies related to the allegations are cited at R349. Survey dates: July 21 and 22, 2022 Facility number: 011076 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed July 28, 2022.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility to prevent neglect of a resident by providing supervision to ensure a cognitively impaired resident did not exit the facility without staff knowledge 1 of 3 residents reviewed for elopement. This resulted in the resident being found by the police department at a neighboring apartment complex. (Resident B) Findings include: On 7/21/22 at 11:00 a.m., the Maintenance Director indicated the front door could be opened with the code, however, if the door did not latch correctly anyone could exit without the	R 0052	The following is the Plan of Correction for Brookdale Bloomington regarding the Statement of Deficiencies dated July 22, 2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R052 Residents' Rights - Resident B is no longer at this	08/15/2022

	alarm going off. At that time, the front door to the facility was observed to have the face plate off of the locking mechanism at the top. The Maintenance Director was observed to open the door with the keycode and hold the door open. The door did not alarm after it was observed to be opened and not shut completely. The Maintenance Director indicated that the facility had ordered parts to fix the door but they had been on backorder. If the alarm was set off, it had to be manually reset within the locking mechanism. On 7/21/22 at 11:30 a.m., the Executive Director (ED) provided a reportable incident from 7/17/22 which indicated Resident B had excited the facility without staff knowledge. Resident B was located in an adjoining apartment complex approximately 0.4 miles from the facility. Resident B was found by the local police department who contacted the facility. On 7/21/22 at 12:00 p.m., the ED indicated the facility's exit doors had a 15 second delay before alarming. She also indicated the facility had been waiting over 3 months for magnets which would shut off alarms if they were triggered. The ED indicated nursing had seen Resident B up and about		community having transferred to a locked memory care unit on 8/1/2022 located at Gentry Park in Bloomington, IN. -All residents have the potential to be affected. This community has secured doors but is not a secured memory care setting. -Brookdale staff were re-educated on Brookdale's Elopement Policy by Executive Director on July 19, 2022. Elopement Drill was conducted on July 19, 2022 by Maintenance Supervisor and Executive Director per community policy. . Brookdale staff were re-educated on Resident Right's on 8/8/2022. The Health and Wellness Director will audit resident clinical files for identified and documented elopement risks. The Health and Wellness Director will monitor current residents for change of conditions for documented elopement risks. The Health and Wellness Director will assess new admissions for identified and documented elopement	

	with walker on 7/17/22, however, the staff indicated they were in the back collecting trash, and did not see Resident B exit the facility. The ED indicated that the facility was unaware Resident B exited the facility and was unaware how. The ED indicated staff thought she went out the front door and towards a neighboring apartment complex. The door alarm was not sounding when the police department called to notify the facility Resident B was found. On 7/22/22 at 10:30 a.m., Resident B's clinical record was reviewed. The clinical record indicated upon admission Resident B was considered at risk for elopement. The Progress Notes, included but were not limited to: On 7/17/22 (no time given), LPN (Licensed Practical Nurse) 1 received a phone call from the (Name) Police department stating Resident B was located in a neighboring apartment community parking lot. A mini mental exam (no date noted), indicated Resident B had cognitive impairments and was a high risk for elopement. On 7/21/22 at 1:00 p.m., the ED provided the current "Elopement Risk Policy ", revised 1/2022, the policy indicated any incident		risks. -The Executive Director and/or designee will complete weekly audits on 5 residents for 3 months and then periodically. Any issues identified during the audit will be addressed immediately by the Executive Director and/or the Health and Wellness Director and will be discussed in the Daily Stand Up meeting Monday through Friday. -Completed by August 15, 2022	

	where a resident leaves the interior of the assisted living portion of the community, unescorted or unsupervised should be considered an elopement risk. This State tag relates to Complaint IN00385605. Based on observation, interview, and record review, the facility to prevent neglect of a resident by providing supervision to ensure a cognitively impaired resident did not exit the facility without staff knowledge 1 of 3 residents reviewed for elopement. This resulted in the resident being found by the police department at a neighboring apartment complex. (Resident B) Findings include: On 7/21/22 at 11:00 a.m., the Maintenance Director indicated the front door could be opened with the code, however, if the door did not latch correctly anyone could exit without the alarm going off. At that time, the front door to the facility was observed to have the face plate off of the locking mechanism at the top. The Maintenance Director was observed to open the door with the keycode and hold the door open. The door did not alarm after it was observed to be opened and not shut completely. The			

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R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review the facility failed to maintain accurate and complete clinical records for 1 of 3 residents reviewed for falls. (Resident C) Finding includes: On 7/22/22 at 11:00 a.m., Resident C's clinical record was reviewed. Resident C was a 2 person assist with transfers. Resident C's diagnosis included, but was not limited to, brain aneurysm. The clinical record lacked documentation of Resident C sustaining a fall on 7/8/22. On 7/22/22 at 11:53 a.m., the ED (Executive Director)	R 0349	The following is the Plan of Correction for Brookdale Bloomington regarding the Statement of Deficiencies dated July 22, 2022. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. R 349 -Resident C was not affected and has moved out of the community and now lives at home.	08/10/2022

	provided the facility investigation into Resident C's fall on 7/8/22. A review of the investigation indicated LPN 1 stated that Resident C was transferred to her recliner after dinner. Resident C then wanted to get up to brush her teeth. Staff transferred Resident C back to her wheelchair and brought her into the bathroom to brush her teeth. LPN 1 indicated that she notified LPN 2 at shift change that Resident C was still up brushing her teeth.		-All residents have the potential to be affected. -Brookdale staff were re-educated on Brookdale's Falls Management Policy, Post-Fall Evaluation Form, and entering a progress note in Point Click Care by Executive Director on August 8, 2022. -The Health and Wellness Director will ensure that all falls have a progress note entered and a post-fall evaluation form entered in Point Click Care. The Executive Director and/or designee will complete weekly audits on 2 resident falls for 3 months and then periodically. Any issues identified during the audit will be addressed immediately by the Executive Director and/or the Health and Wellness Director and discussed in the Daily Stand Up Meeting Monday through Friday. -Completed by August 10, 2022	

LPN 2's statement indicated she was doing rounds with CNA 3 when CNA 3 indicated to LPN 2 Resident C was on the floor in her bathroom. LPN 2 took Resident C's vitals and asked Resident C if she was in pain. LPN 2 indicated she assessed Resident C and put her back in bed. She denied LPN 1 told her Resident C was in the bathroom and needed to be placed in bed when finished. The ED indicated to LPN 2 she gave Resident C her medications at 8 p.m., per the medication administration record. The ED also asked LPN 2 if she advised the CNA's Resident C needed to be placed in bed after her brushing her teeth and she stated no. LPN 2 also denied telling the oncoming QMA (Qualified Medication Aide) that Resident C fell out of bed, not fell out of the wheelchair while her brushing teeth.

CNA 3 indicated when she was redirecting a resident she her a slight tapping. CNA 3 entered Resident C's room and found her on the bathroom floor. CNA 3 immediately called out to LPN 2 who helped her clean up Resident C who had vomited, and place her in her bed. She denied the outgoing CNA 1 told her that Resident C needed to be placed in her bed after she brushed her teeth.

On 7/22/22 at 1:00 p.m., the ED

indicated Resident C liked to brush her teeth and per interviews with the CNA and LPN who indicated they left Resident C in the bathroom in her wheelchair after dinner to brush her teeth. Staff had assumed at change of shift that Resident C was already in bed. Around midnight rounds, Resident C was found on the floor in her bathroom. Resident C was assessed to have no injuries and returned to bed. The ED indicated the next morning the she received a text from LPN 2 about the resident's fall, and that she did not call the family due to it being

late and when she did call she informed Resident C's family she had fallen out of bed.

On 7/22/22 at 12:16 p.m. the ED provided the current "Falls Management Policy", revised 2/2022. The policy indicated resident falls are noted in the resident record.

This State tag relates to Complaints IN00385412 and IN00385872.

Based on interview and record review the facility failed to maintain accurate and complete clinical records for 1 of 3 residents reviewed for falls. (Resident C)

Finding includes:

On 7/22/22 at 11:00 a.m., Resident C's clinical record was reviewed. Resident C was a 2 person assist with transfers. Resident C's diagnosis included, but was not limited to, brain aneurysm.

The clinical record lacked documentation of Resident C sustaining a fall on 7/8/22.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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