STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2023

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00395317 and IN00395454. Complaint IN00395317 - Unsubstantiated due to lack of evidence. Complaint IN00395454 - Unsubstantiated due to lack of evidence. Survey dates: February 2 and 3, 2023 Facility number: 011076 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 7, 2023.	R 0000		
R 0026	Residents' Rights - Noncompliance	R 0026	The following is the Plan of Correction for Brookdale	03/15/2023

	410 IAC 16.2-5-1.2(a) (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure a copy of the residents' rights was available in a publicly accessible area for 33 of 33 residents residing in the facility. Findings include: On 2/2/23 at 11:00 a.m., no posting of residents' rights was observed in the facility.		Granger regarding the Statement of Deficiencies dated February 3, 2023. 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. A plan of correction (POC) must be submitted for these state findings. The POC must contain the following: ·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident admitted to geri psych hospital on 1.30.23 for medication review. Resident readmitted to community with one on one sitter on 2.14.23. Resident will continue to have one on one care until exit	

	On 2/3/23 at 2:30 p.m., no posting of the residents' rights was observed in the facility. A large sign was posted outside of the business office, approximately 46 inches off of the ground. The sign did not include the Residents' Rights. On 2/3/23 at 3:33 p.m., the Business Office Manager (BOM) provided a copy of the facility's policy, "Indiana Resident Rights," revised on March, 2003, and indicated it was the policy currently being used. A review of the policy did not indicate the residents' rights were to be available in a publicly accessible area. During an interview at that time, the BOM indicated the large sign did not include the Indiana residents' rights and there was no posting of the rights in the facility. Based on observation, interview, and record review, the facility failed to ensure a copy of the residents' rights was available in a publicly accessible area for 33 of 33 residents residing in the facility. Findings include: On 2/2/23 at 11:00 a.m., no posting of residents' rights was observed in the facility. On 2/3/23 at 2:30 p.m., no posting of the residents' rights was observed in the facility. A large sign was posted outside of		seeking behaviors are resolved. ·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All ambulatory residents have the potential to be affected by alleged deficient practice. ·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Community will install wooden window stops in addition to manufacturer installed window stops to every exterior window in the community. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Director or designee will complete monthly inspections to windows and window stops. Inspections will be documented in work order system. ·By what date the systemic changes will be completed. Window stops to be installed no later than March 6, 2023. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	

	the business office, approximately 46 inches off of the ground. The sign did not include the Residents' Rights. On 2/3/23 at 3:33 p.m., the Business Office Manager (BOM) provided a copy of the facility's policy, "Indiana Resident Rights," revised on March, 2003, and indicated it was the policy currently being used. A review of the policy did not indicate the residents' rights were to be available in a publicly accessible area. During an interview at that time, the BOM indicated the large sign did not include the Indiana residents' rights and there was no posting of the rights in the facility.		practice;. Community will post a copy of the resident rights in a publicly accessible area of community. . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by alleged deficient practice. Community will post a copy of the resident rights in a publicly accessible area of community. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Community will post a copy of the resident rights in a publicly accessible area of community. . How	

			the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED or designee will do monthly checks for 12 months and until issue is resolved to ensure resident rights are posted in a publicly accessible area of community. . By what date the systemic changes will be completed. 3.15.23	
R 0033	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(h)(1-2) (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services.	R 0033	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Community will post addresses and phone numbers for Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service in an area of accessible to residents for 33 of 33 residents residing in the facility. . How	03/15/2023

	(D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation, interview, and record review, the facility failed to ensure the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were posted in an area accessible to residents for 33 of 33 residents residing in the facility. Findings include: On 2/2/23 at 11:00 a.m., no posting of the addresses nor telephone numbers were observed in the facility. On 2/3/23 at 2:30 p.m., no posting of the addresses nor telephone numbers were observed in the facility. A large sign was posted outside of the business office, approximately 46 inches off of the ground, had the ombudsman's information. The sign did not include the addresses nor telephone		the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by alleged deficient practice.Community will post addresses and phone numbers for Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service in an area of accessible to residents for 33 of 33 residents residing in the facility. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Community will post addresses and phone numbers for Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service in an area of accessible to residents. . How	

	numbers for the other organizations. On 2/3/23 at 3:30 p.m., the Business Office Manager (BOM) provided a copy of the facility's policy, "Indiana Resident Rights," revised on March, 2003, and indicated it was the policy currently being used. A review of the policy indicated, "...You may file a complaint concerning resident abuse, neglect, misappropriation (theft) of resident property and other practices of this community with the following departments: Indiana State Department of Health. The office of the secretary of family and social services ... The Area Agency on Aging. The local mental health center. Adult Protective Services. These numbers ... are posted in an area accessible to our residents..." During an interview at that time, the BOM indicated the large sign did not include the addresses and phone numbers for the other departments nor was the sign at an easily accessible height for wheelchair residents. Based on observation, interview, and record review, the facility failed to ensure the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local		the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;ED or designee will do monthly checks for 12 months or until issue is resolved to ensure appropriate addresses and phone numbers are posted in community. . By what date the systemic changes will be completed. 3.15.23	

	mental health center, and adult protective service were posted in an area accessible to residents for 33 of 33 residents residing in the facility. Findings include: On 2/2/23 at 11:00 a.m., no posting of the addresses nor telephone numbers were observed in the facility. On 2/3/23 at 2:30 p.m., no posting of the addresses nor telephone numbers were observed in the facility. A large sign was posted outside of the business office, approximately 46 inches off of the ground, had the ombudsman's information. The sign did not include the addresses nor telephone numbers for the other organizations. On 2/3/23 at 3:30 p.m., the Business Office Manager (BOM) provided a copy of the facility's policy, "Indiana Resident Rights," revised on March, 2003, and indicated it was the policy currently being used. A review of the policy indicated, "...You may file a complaint concerning resident abuse, neglect, misappropriation (theft) of resident property and other practices of this community with the following departments: Indiana State Department of Health. The office of the secretary of family and social			

	services ... The Area Agency on Aging. The local mental health center. Adult Protective Services. These numbers ... are posted in an area accessible to our residents..." During an interview at that time, the BOM indicated the large sign did not include the addresses and phone numbers for the other departments nor was the sign at an easily accessible height for wheelchair residents.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a	R 0092	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice. Community will hold fire drills monthly on rotating shifts. A fire and disaster drill in conjuction with the local fire department is scheduled for February 28, 2023. . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice.	03/15/2023

	facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure staff held at least 12 fire drills every year, and attempted to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. Findings include: On 2/2/23 at 11:28 a.m., the Maintenance Supervisor indicated the facility was missing some fire drills over the last year. He further indicated they had not involved the local fire department, however, he planned to involve them. A review of the facility's fire drills indicated 9 drills were performed over the last year. No drills were performed for the months of April 2022, June 2022, and July 2022. None of the drills involved the local fire department. On 2/3/23 at 3:00 p.m., the Business Office Manager provided a copy of the facility policy, "Fire Drills," revised on April, 2022, and indicated it was the policy currently being used. A review of the policy indicated,		Community will hold fire drills monthly on rotating shifts. A fire and disaster drill in conjuction with the local fire department is scheduled for 2.28.23. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Community will hold fire drills monthly on rotating shifts. A fire and disaster drill in conjuction with the local fire department is scheduled for 2.28.23. . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Maintenance Manager or designee will complete fire drills monthly on rotating shifts. Maintenance Manager will schedule and facilitate fire and disaster drill in conjuction with the local fire department at least every 6 months. ED or designee will verify that maintenance manager executes fire drills	

	"Fire Drills shall be conducted on a monthly basis ..." The policy did not indicate local fire department involvement. Based on interview and record review, the facility failed to ensure staff held at least 12 fire drills every year, and attempted to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months. Findings include: On 2/2/23 at 11:28 a.m., the Maintenance Supervisor indicated the facility was missing some fire drills over the last year. He further indicated they had not involved the local fire department, however, he planned to involve them. A review of the facility's fire drills indicated 9 drills were performed over the last year. No drills were performed for the months of April 2022, June 2022, and July 2022. None of the drills involved the local fire department. On 2/3/23 at 3:00 p.m., the Business Office Manager provided a copy of the facility policy, "Fire Drills," revised on April, 2022, and indicated it was the policy currently being used. A review of the policy indicated, "Fire Drills shall be conducted on a monthly basis ..." The policy did not indicate local fire		occur monthly on rotating shifts. ED or designee will verify that maintenance manager executes fire and disaster drill in conjunction with local fire department on February 28, 2023 and every 6 months after that. ED will audit to ensure all fire drills are completed for 12 months. . By what date the systemic changes will be completed. 3.15.23	

	department involvement.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a current	R 0117	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice. . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Community will ensure that there is always an employee with current CPR and First Aid certification. All QMAs and nurses will be certified in CPR and First Aid. Going forward LPNs and	03/15/2023

	Cardiopulmonary Resuscitation (CPR) and First Aid (FA) certification on each shift for 7 of 7 days reviewed. Findings include: On 2/2/23 at 2:30 p.m., the Business Office Manager (BOM) provided the schedule for the week 1/26/23 through 2/1/23. On 2/3/23 at 11:00 a.m., the BOM presented copies of the CPR and FA certifications for the employees on the schedule for the week reviewed. Review of the nurses and certified nursing assistant's schedule, dated 1/26/23 through 2/1/23 indicated the following: - On 1/26/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. - On 1/27/23, there were no staff members on the first, second, or third shift that were FA certified, and there were no staff members on 6:00 a.m. through 6:00 p.m. shift that were CPR certified. - On 1/28/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on 6:00 a.m. through 6:00 p.m. shift that were CPR certified.		QMAs will be certified in CPR and First Aid prior to working on the floor. ED or designee will audit all first aid and CPR certifications on a monthly basis. Nurses and QMAs who are not CPR and First Aid certified will be removed from schedule and replaced with someone who is certified until certifications are renewed. . How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED or designee will audit nursing work schedule 5xweekly x4 weeks; 1xweeklyx4 weeks and 1x monthly x 3 months and until deficient practice is resolved to ensure there is an employee with a current CPR and First Aid certification on the schedule at all times. ED or designee will audit CPR and First Aid certifications on a monthly basis for 12 months. . By what date the systemic changes will be completed. 3.15.23	

	- On 1/29/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on first and second shift that were CPR certified. - On 1/30/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. - On 1/31/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. - On 2/1/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on first shift that were CPR certified. During an interview on 2/3/23 at 2:15 p.m., the BOM indicated she had presented all the FA and CPR cards. The shifts lacked staff with certifications. On 2/3/23 at 3:05 p.m., the BOM provided the facility policy, "CPR Policy," revised 1/2023, and indicated it was the policy currently being used by the facility. A review of the policy lacked documentation of the facility having 1 employee with a current CPR or FA on each shift. Based on interview and record			

review, the facility failed to ensure a minimum of 1 employee with a current Cardiopulmonary Resuscitation (CPR) and First Aid (FA) certification on each shift for 7 of 7 days reviewed.

Findings include:

On 2/2/23 at 2:30 p.m., the Business Office Manager (BOM) provided the schedule for the week 1/26/23 through 2/1/23.

On 2/3/23 at 11:00 a.m., the BOM presented copies of the CPR and FA certifications for the employees on the schedule for the week reviewed.

Review of the nurses and certified nursing assistant's schedule, dated 1/26/23 through 2/1/23 indicated the following:

- On 1/26/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified.

- On 1/27/23, there were no staff members on the first, second, or third shift that were FA certified, and there were no staff members on 6:00 a.m. through 6:00 p.m. shift that were CPR certified.

- On 1/28/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on 6:00 a.m. through

	6:00 p.m. shift that were CPR certified. - On 1/29/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on first and second shift that were CPR certified. - On 1/30/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. - On 1/31/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. - On 2/1/23, there were no staff members on 6:00 a.m. through 6:00 p.m. that were FA certified, and there were no staff members on first shift that were CPR certified. During an interview on 2/3/23 at 2:15 p.m., the BOM indicated she had presented all the FA and CPR cards. The shifts lacked staff with certifications. On 2/3/23 at 3:05 p.m., the BOM provided the facility policy, "CPR Policy," revised 1/2023, and indicated it was the policy currently being used by the facility. A review of the policy lacked documentation of the facility having 1 employee with a current CPR or FA on each shift.			

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure pre-prepared beverages were labeled and dated, potentially affecting 33 of 33 residents served from the kitchen. Findings include: On 2/2/23 at 10:20 a.m. and 3:05 p.m., the small refrigerator in the resident dining area was observed to contain an unlabeled and undated pitcher of a brown liquid, an unlabeled and undated pitcher of an orange liquid, and an unlabeled and undated pitcher of a white liquid. On 2/3/23 at 10:50 a.m., the small refrigerator in the resident dining area was observed to contain an unlabeled and undated pitcher of a brown liquid, an unlabeled and undated pitcher of an orange liquid, and an unlabeled and	R 0273	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected by deficient practice. . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. All pre- prepared beverages will be labeled and dated. . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Pre-prepared drinks will be dated and labeled prior to being placed in refrigerator.	03/15/2023

	undated pitcher of a white liquid. A sour odor associated with outdated milk was smelled coming from the pitcher containing the white liquid. During an interview on 2/3/23 at 10:52 a.m., the Dietary Manager indicated the pitchers of liquid should have been labeled and dated to ensure freshness of the beverages. On 2/3/23 at 3:00 p.m., the Business Office Manager provided the Storage of Perishable Food policy, revised 5/10 and indicated it was the policy currently used by the facility. A review of the policy indicated, "...all pre-dished items must be covered, labeled,and dated..." Based on observation, interview, and record review, the facility failed to ensure pre-prepared beverages were labeled and dated, potentially affecting 33 of 33 residents served from the kitchen. Findings include:		. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED or designee will inspect all pre prepared drinks in the refrigerator 5xweekly x4 weeks; 1xweeklyx4 weeks and 1x monthly x 3 months and until deficient practice is resolved to ensure pre prepared drinks are dated and labeled. . By what date the systemic changes will be completed. 3.15.23	

On 2/2/23 at 10:20 a.m. and 3:05 p.m., the small refrigerator in the resident dining area was observed to contain an unlabeled and undated pitcher of a brown liquid, an unlabeled and undated pitcher of an orange liquid, and an unlabeled and undated pitcher of a white liquid.

On 2/3/23 at 10:50 a.m., the small refrigerator in the resident dining area was observed to contain an unlabeled and undated pitcher of a brown liquid, an unlabeled and undated pitcher of an orange liquid, and an unlabeled and undated pitcher of a white liquid. A sour odor associated with outdated milk was smelled coming from the pitcher containing the white liquid.

During an interview on 2/3/23 at 10:52 a.m., the Dietary Manager indicated the pitchers of liquid should have been labeled and dated to ensure freshness of the beverages.

On 2/3/23 at 3:00 p.m., the Business Office Manager provided the Storage of Perishable Food policy, revised 5/10 and indicated it was the policy currently used by the facility. A review of the policy indicated, "...all pre-dished items must be covered, labeled,and dated..."

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