DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	07/24/2023

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. Survey dates: July 18, 19, 20, 21 and 24, 2023 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 7 Medicaid: 97 Other: 11 Total: 115 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 28, 2023.	F 0000	The submission of this Plan of Correction, for survey event ID 1C4411 does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the residents	F 0641	**What corrective action(s) will be accomplished for those residents found to have been**	08/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Swaby	Executive Director	08/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	07/24/2023

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
	status for 2 of 3 residents reviewed for resident assessment. (Resident 34, Resident 36) Findings include: 1. On 7/24/23 at 10:40 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), other psychotic disorder, schizophrenia, anxiety, and major depressive disorder. An Annual MDS assessment, dated 12/19/22, indicated the resident was not evaluated by Level II Preadmission Screening and Resident Review (PASRR) and determined to have a serious mental illness. A Notice of PASRR Level II Outcome, dated 3/22/22, indicated based on the diagnoses, treatment history, current symptoms, and service needs, she met PASRR criteria. The Level II outcome indicated she was approved for long term care without specialized services. During an interview on 7/24/23 at 3:50 p.m., the MDS coordinator indicated the resident's MDS assessment was coded inaccurately because she had a Level II assessment. 2. On 7/24/23 at 10:05 a.m., Resident 36's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified psychosis, generalized anxiety disorder, mood disorder due to known physiological condition with mixed features, depressive episodes, and delusional disorders. An Annual MDS assessment, dated 3/15/23, indicated the resident was not evaluated by Level II Preadmission Screening and Resident Review		**affected by the deficient practice.** Resident 34 and Resident 36 did have Level II's completed but were not uploaded at the time the MDS was completed. Residents 34 and resident 36 MDS's have been modified to reflect the level II's **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 requiring a level II could be affected by this deficient practice. All Level II residents will be reviewed and MDS's modified as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** MDS Staff, Social Services, and Business Office Staff were educated on the process of the Level II's with the policy of "Resident Assessment-Coordination with PASRR" (Exhibit A) . The BOM will be responsible to upload the completed Level II's into the resident's electronic record. The Business Office, the MDS	

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	07/24/2023

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
	(PASRR) and determined to have a serious mental illness. A Notice of PASRR Level II Outcome, dated 2/15/18, indicated he was approved for long term care without specialized services. During an interview on 7/24/23 at 3:50 p.m., the MDS coordinator indicated the resident's MDS assessment was coded inaccurately because he had a Level II assessment. 3.1-31(d)		Director, and Social Services Director have access to Ascend and will monitor updates from the level I's. The Social Services Director shall be responsible for keeping track of each Resident's PASRR screening status, and referring to the appropriate authority. **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** The audit tool titled "Level II Audit Tool" (Exhibit B) will be utilized weekly for 2 months, bi-monthly for 2 months, and monthly for 2 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**; The compliance date will be 8/15/2023	
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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	07/24/2023

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
Bldg. 00	§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, interview, and record review, the facility failed to ensure staff implemented new weight loss interventions for a resident with an assessed weight loss for 1 of 7 residents reviewed for nutrition. (Resident 3) Finding includes: On 7/21/23 at 1:05 p.m., Resident 3 was observed to be sitting in her chair in her room eating a ham and cheese sandwich. At that time, Resident 3 indicated she did not want what was served for lunch, and she wanted a ham and cheese sandwich. On 7/21/23 at 11:07 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, osteoporosis, mood disorder,	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Director of Nursing and the Registered Dietician reassessed the nutritional status of Resident #3. Interventions were reviewed and updated as needed. The Plan of Care was updated as needed. Revised interventions were reviewed with staff. **How other residents having the potential to be affected by the same deficient practice will be**	08/15/2023

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	07/24/2023

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
	and anxiety. The quarterly Minimum Data Set (MDS) assessment, dated 7/3/23, indicated Resident 3 was cognitively intact, required supervision with eating, and had a 5% weight loss in the last month or a 10% weight loss in the last 6 months. The Care Plans incuded, but were not limited to, At risk altered nutrition/hydration. Resident has a history of significant weight loss and declining meals. Has a need for supplements to meet estimated needs. Resident 3's weight summary indicated the following: - On 2/1/23 at 1:35 p.m., Resident 3 weighed 102.2 pounds. - On 3/2/23 at 10:11 a.m., Resident 3 weighed 94.4 pounds (which was a 7.63% weight loss). - On 4/2/23 at 2:46 p.m., Resident 3 weighed 93 pounds. - On 5/1/23 at 3:00 p.m., Resident 3 weighed 77.6 pounds (which was a 16.56% weight loss). - On 6/1/23 at 12:34 p.m., Resident 3 weighed 77.4 pounds. - On 7/2/23 at 2:50 p.m., Resident 3 weighed 78.9 pounds (which was a 22.80% weight loss). A Nutrition Assessment, dated 3/20/23 at 8:00 p.m., indicated Resident 3's weight was 94.4 pounds. She had an 8 pound weight loss in the past month (7.8% significant) and a 20 pound weight loss in the past 6 months (17.5%		**identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. No other residents were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Director of Nursing, Nurse Managers, and Registered Dietician were educated on addressing nutritional interventions including weight documentation and monitoring. The policies included “Weight Monitoring” and “Nutritional Management” (Exhbits C). The Nursing Management team will review each weight report to ensure appropriate measurements are recorded and complete and to monitor weight fluctuation. The Director of Nursing, or designee, will complete audits and review all weight reports and residents with weight change to ensure that all changes are identified and appropriate interventions have been put into place or if new interventions are needed. Plans of Care will be reviewed and updated with new interventions as needed.	

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	07/24/2023

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
	significant). She triggered for at risk for malnutrition. She had no supplements currently ordered. The registered dietician recommended discussing supplements or fortified foods to help prevent further significant weight loss and help meet estimated needs. An Interdisciplinary Team (IDT) Nutrition-At-Risk (NAR) note, dated 4/5/23 at 11:53 p.m., indicated Resident 3's weight was 93 pounds. She had a 1.4 pound weight loss. The dietary stock of magic cups (a supplement adding calories and protein for those experiencing involuntary weight loss) were depleted. She will be getting suppplements as ordered next week. The list of interventions were on 3/22/23 to start vanilla magic cup at all meals; house shake (supplement) at medication pass; and lemon ice at each meal. An IDT NAR note, dated 4/12/23 at 2:30 p.m., indicated Resident 3's weight was 89.6 pounds. She was referred to speech therapy. Resident 3 reported trouble chewing and her oral intake was declining. She would benefit from soft sandwiches. The list of interventions were on 3/22/23 to start vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. An IDT NAR note, dated 4/19/23 at 6:06 a.m., indicated Resident 3's weight was 89.6 pounds and was down 3 pounds. Nursing will follow-up with speech therapy regarding a referral due to declining oral intake. Resident 3 reported trouble chewing and her oral intake was declining. She would benefit from soft sandwiches. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg		**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** The audit tool "F 692 Assisted Nutrition and Hydration" (Exhibit D) will be utilized to determine weight changes and interventions. It will be completed weekly for 2 months, Bi-monthly for 2 months, and monthly for 2 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. The compliance date will be 8/15/2023	

salad sandwich twice a day. On 4/19/23, her diet was downgraded to a mechanical soft diet.

An IDT NAR note, dated 5/5/23 at 6:31 a.m., indicated Resident 3's weight was 77.6 pounds and was down 7.4 pounds. IDT was aware of weight trends down. Resident 3 is refusing most food and care. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. On 4/19/23, her diet was downgraded to a mechanical soft diet.

An IDT NAR note, dated 5/10/23 at 6:35 a.m., indicated Resident 3's weight was 76.4 pounds. She was ill and her weight was stabilizing. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. On 4/19/23, her diet was downgraded to a mechanical soft diet.

An IDT NAR note, dated 5/17/23 at 8:27 a.m., indicated Resident 3's weight was 76.8 pounds. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. On 4/19/23, her diet was downgraded to a mechanical soft diet.

An IDT NAR note, dated 5/23/23 at 8:19 p.m., indicated Resident 3's weight was 75.6 pounds. This was significant weight loss of 5% in 30 days and 10% in 6 months. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. She had refused supplements in the

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	07/24/2023

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
	past. An IDT NAR note, dated 5/30/23 at 2:29 p.m., indicated Resident 3's weight was 77.4 pounds. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. She had refused supplements in the past. An IDT NAR note, dated 6/6/23 at 3:13 p.m., indicated Resident 3's weight was 81.5 pounds. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. She had refused supplements in the past. An IDT NAR note, dated 6/13/23 at 11:21 a.m., indicated Resident 3's weight was 80 pounds. She had a 1.5 pound weight loss for the week. The list of interventions were to start on 3/22/23 vanilla magic cup at all meals; house shake at medication pass; lemon ice at each meal; and start ham or egg salad sandwich twice a day. She had refused supplements in the past. Staff were to continue to offer and encourage intake. A Nutrition Assessment, dated 6/14/23 at 4:30 p.m., indicated Resident 3's weight was 80 pounds. She had a significant weight loss of 14 pounds (14.9%) in the past 3 months and a 28 pound weight loss in the past 6 months (26%). She was underweight and triggered for malnutrition. She had no supplements currently ordered. Her 5/26/23 labs indicated a low albumin (protein in the blood). The registered dietician recommended discussing supplements or fortified foods to help prevent further significant weight loss and help meet estimated needs.			

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	07/24/2023

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

An IDT NAR note, dated 6/20/23 at 10:51 a.m., indicated Resident 3's weight was 81.8 pounds. The list of interventions were magic cup with meals and house supplement three times a day.

An IDT NAR note, dated 6/27/23 at 10:24 a.m., indicated Resident 3's weight was 83 pounds. The list of interventions were magic cup with meals and house supplement three times a day.

An IDT NAR note, dated 7/11/23 at 12:34 p.m., indicated Resident 3's weight was 78.9 pounds which was a 4.1 pound weight loss in a week. The list of interventions were magic cup with meals and house supplement three times a day.

An IDT NAR note, dated 7/19/23 at 3:08 p.m., indicated Resident 3's weight was 78.9 pounds. The list of interventions were magic cup with meals and house supplement three times a day.

The Resident History Dietary Notification Log indicated the following:

- On 3/26/23 at 2:00 p.m., add a frozen nutritional treat to Resident 3's breakfast, lunch, and dinner.

- On 3/26/23 at 2:00 p.m., add a house shake to Resident 3's breakfast, lunch, and dinner.

- On 4/23/23 at 9:37 a.m., change Resident 3's diet to mechanical soft.

The clinical record lacked documentation of revising the interventions based on the assessed significant weight loss.

During an interview on 7/21/23 at 9:55 a.m., Certified Nursing Assistant (CNA) 1 indicated

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	07/24/2023

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
	Resident 3 had a poor appetite. She would refuse her meals and supplements. During an interview on 7/24/23 at 4:00 p.m., the Director of Nursing Services (DNS) indicated Resident 3 had a significant weight loss due to an recent illness. Her weight loss interventions were health shakes and magic cups which was initiated on 3/26/23. The clinical record lacked any documentation of revising the interventions for weight loss since 4/23/23 when Resident 3 diet was changed to mechanical soft. On 7/24/23 at 4:00 p.m., the DNS provided the facility's policy, "Weight Monitoring," dated 2022, and indicted it was the policy being used by the facility. A review of the policy indicated, "...The facility will utilize a systemic approach to optimize a resident's nutritional status...d. Monitoring the effectiveness of interventions and revising them as necessary..." 3.1-46(a)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	07/24/2023

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
	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 3 of 3 kitchen observations. Food was stored beneath a water line on which water had condensed and the kitchen walk-in freezer door and walk-in refrigerator seal gasket was in disrepair. Findings include: 1. During a tour of the facility's walk-in freezer on 7/24/23 at 10:30 a.m., food was observed to be stored beneath the freezer condenser water line, upon which water had condensed and ice had formed. Beneath the freezer condenser was a box of dough and a large covered pan of lasagna covered in ice that originated from the condenser water line. During an interview on 7/24/23 at 10:35 a.m., the Dietary Manager indicated the food should not have been kept under the freezer condenser. 2. During tours of the kitchen walk-in freezer on 7/18/23 at 10:30 a.m. and 7/24/23 at 10:20 a.m., the following observations were made: the freezer door seal gasket was observed to be out of alignment and in misshaped condition, preventing a tight seal. The door required excessive force to completely close. The freezer entry way strip	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No individual residents were affected by this alleged deficient practice. The strips identified as having a substance on them were cleaned immediately. **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 this alleged deficient practice. No residents were identified as being affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A heater strip was identified as	08/15/2023

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	07/24/2023

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
	curtains were ice covered, the freezer condenser was leaking water which formed into ice, and the shelves and ceiling had ice formed on them. 3. During tours of the kitchen walk-in refrigerator on 7/18/23 at 10:35 a.m. and 7/24/23 at 10:25 a.m., the refrigerator door seal gasket was observed to have a black powder-like substance on the top and sides. During an interview on 7/24/23 at 10:25 a.m., the Dietary Manager indicated the walk-in freezer door did not properly seal, resulting in the formation of ice on multiple surfaces, and the walk-in refrigerator door seal gasket was in need of cleaning to be rid of the black powder-like substance. During an interview on 7/24/23 at 2:10 P.M., the Corporate Dietary Manager indicated the facility used the Indiana State Department of Health Retail Food Establishment Sanitation Requirements, effective date, November 13, 2004, as the facility policy and procedure regarding food storage. A review of the policy indicated, "...410 IAC 7-24-178 Food storage; prohibited areas Sec. 178. (a) Food may not be stored as follows:...(2) Under the following:...under lines on which water has condensed...equipment shall be maintained in a state of repair...equipment components, such as (1) doors (2) seals (3) hinges..." 3.1-21(i)(2) 3.1-21(i)(3)		being deficient on the walk-in freezer which was preventing the door from closing due to ice build-up (See Exhibit G). It was replaced on 8/8/2023. The seals on the freezer and Walk-in cooler were ordered on 8/8/2023 and will be replaced as soon as they arrive at the building (See Exhibit G). The Executive Director, or Designee, will do weekly check ups on the status of the door seals. Staff were educated on the policy of "Food Storage: Cold Foods" (Exhibit E). **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** The audit tool titled "walk-in freezer and walk-in cooler Audit Tool" (Exhibit F) will be completed daily x 2 months, weekly for 2 months, and Bi-Monthly for 2 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**;	

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	07/24/2023

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
			The compliance date will be 8/15/2023	