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	02/10/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00397138, IN00399885, IN00400312, IN00400730, IN00400735, and IN00401386. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00397138 - Substantiated. Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00399885 - Substantiated. Federal/State deficiencies related to the allegations are cited at F679. Complaint IN00400312 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558. Complaint IN00400730 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00400735 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00401386 - Unsubstantiated due to lack of evidence. Survey dates: February 7, 8, 9, and 10, 2023 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 119 Total: 119	F 0000	The submission of this Plan of Correction, for survey event B1SQ11 conducted on 2/10/2023, 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Swaby	Executive Director	02/27/2023

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.

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	Census Payor Type: Medicare: 8 Medicaid: 103 Other: 8 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2023.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of resident needs for 1 of 3 residents reviewed. (Resident B) Finding includes: On 2/7/23 at 12:07 p.m., observed Resident B's room. Resident B shared the room with another resident, so his bed was located on the side of the room next to the window farthest from the doorway to enter the room. The privacy curtain was pulled, and the back and bottom of Resident B's bedside commode was observed sticking out underneath the privacy curtain, from the doorway entering the room. Just past the privacy curtain on Resident B's side of the room, there was an open space approximately 6 square feet. Resident B's	F 0558	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was offered a double room that would only be occupied by him during the actual survey. Resident B declined. Resident B's bed was moved back along the wall as requested in his current room. **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	03/02/2023

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	bedside commode had been pushed back into the privacy curtain. Resident B's bed was positioned so the head of the bed was up against the wall, and Resident B's wheelchair was located at the foot of the bed. There was an electrical outlet located on the wall approximately 4 feet above the floor. At that time, Resident B indicated he had his bed positioned so the side of his bed was against the wall. He needed his bed positioned that way because he was severely morbidly obese and needed more room when he transferred himself, used his bedside commode, and maneuvered around his room. He didn't feel like he had enough room to comfortably transfer himself from bed to wheelchair, nor sit up in his wheelchair and do therapy exercises on his own. He liked working with small weights in his room and didn't have room to do that anymore. The staff told him the health department and the fire marshal said he could not keep his bed positioned so the side of the bed was along the wall because that would have been considered a restraint and a fire hazard even though he had requested to have the bed positioned that way. This past Monday, the staff moved his bed, so the head of the bed was up against the wall and now he didn't have enough room. Resident B was observed to raise the bed into the highest position and the bed was not observed to touch the outlet. During an interview on 2/7/23 at 1:53 p.m., the DON (Director of Nursing) indicated if a resident wanted furniture moved around in their room, maintenance would have helped with that unless there was a safety risk. Resident B's bed was not allowed to be positioned with the side of the bed against the wall due to safety concerns. That would be a fire hazard and a restraint. During an interview on 2/7/23 at 2:02 p.m., the		be affected by the alleged deficient practice. Those residents who had their beds moved will be offered the choice of which direction they want their bed, along the wall or perpendicular to the wall. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated on the policy of resident rights (Exhibit A) and that a resident has the right to have their bed positioned the way they desire in their part of the room. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** The audit tool titled "Patient Advocate Rounds" (Exhibit B) will be utilized by the room round managers weekly for four months. Audited records will be reviewed by the Quality Assurance Committee monthly until such time when consistent compliance is achieved as determined by the Quality Assurance Committee. **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**	

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	Maintenance Supervisor indicated they were told, by their corporate leadership, that the residents could not have their beds positioned so the side of the bed were against the wall because that was a fire hazard and a restraint. Corporate leadership had given the directive to move all the resident's beds that had the side of the bed against the wall, so the beds were moved. During an interview on 2/7/23 at 2:03 p.m., the Unit Manager indicated their company said that having a resident's bed positioned so the side of the bed was up against the wall was a fire hazard and a restraint. We were told, by corporate leadership, to move all the beds so the side of the bed was not against the wall. During an interview on 2/7/23 at 2:09 p.m., the Administrator indicated the facility had a mock survey completed by their corporate leadership and were instructed by corporate leadership that the resident's beds were not allowed to be positioned with the side of the beds against the walls because that would be a fire hazard and a restraint even if a resident request the bed be positioned with side of bed against the wall. The clinical record for Resident B was reviewed on 2/7/23 at 12:17 p.m. The diagnoses included, but were not limited to, diabetes and severe morbid obesity. A Quarterly MDS (Minimum Data Set) assessment, dated 1/6/23, indicated Resident B was cognitively intact. On 2/10/23 at 9:04 a.m., the Administrator provided a copy of an undated document, titled Mock Survey Action Plan, and indicated the document was a list of the results from a mock		**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;** **3/2/2023**	

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	survey completed by corporate leadership. A review of the document indicated citation/issue: beds placed against electrical outlets in multiple rooms which is a fire hazard as well as an entrapment hazard. On 2/8/23 at 8:05 a.m., the Administrator provided a copy of an undated policy, titled Resident Rights, and indicated this was the current policy used by the facility. A review of the policy indicated the resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States. This Federal tag relates to Complaint IN00400312. 3.1-3(v)(1)			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 of 3 residents reviewed for abuse. A resident punch	F 0600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/02/2023

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	another resident in the face. This resulted in a resident being sent to the emergency room with bruising and a small laceration above the right eye and bridge of the nose. The resident required sutures above his right eye. (Resident C, Resident D) Finding includes: During an interview on 2/7/23 at 1:06 p.m., the Social Service Director indicated he received a phone call that there had been a resident to resident altercation between Resident C and Resident D. He came to the facility and interviewed Resident C and Resident D. Resident C wandered into Resident D's room. Resident D attempted to redirect Resident C out of his room. Resident C attempted to hit Resident D, so Resident D hit Resident C. The residents were separated, and Resident C was placed on 1 on 1 observation. Resident C was sent to the emergency room for evaluation and treatment. On 2/9/23 at 11:25 a.m., Resident C was observed resting in bed. A small purple discoloration to the side and just above Resident C's right eye was observed. At that time, Resident C was unable to remember any altercation with another resident and denied any pain. During an interview on 2/9/23 at 11:31 a.m., Resident D indicated Resident C entered his room. When Resident D tried to get him to leave his room by moving his hand to show him the way out of the room, Resident C swung at him. Resident D swung back and punched him in the face. During an interview on 2/10/23 at 9:29 a.m., LPN 1 (Licensed Practical Nurse) indicated she was the		**practice** Resident C was placed 1:1 and moved to a less stimulating unit. Resident C remains a 1:1. Resident D was educated to call staff and ask for staff assistance anytime another resident enters his environment that is not welcome. Resident D was educated to never strike another resident. **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;** No other 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:** Staff were educated on the policy of Abuse, Neglect, and Exploitation (Exhibit C). Staff will be educated on properly doing a 1:1 (Exhibit D). Administrative staff have been educated on reviewing documentation that may indicate a resident to resident altercation is probable so interventions can be applied before an altercation occurs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	nurse on duty when there was a physical altercation between Resident C and Resident D. She did not see the altercation. Around 8:30 p.m., she heard a yell, and saw the CNA (Certified Nursing Aide) bringing Resident C down the hallway and to his room. When LPN 1 entered Resident C's room, he was sitting on his bed. He had a small laceration above his right eye and some discoloration. When LPN 1 asked Resident C what happen, he indicated to her that he was hit by Resident D. The CNA indicated to her that Resident C had wandered into Resident D's room and when Resident D tried to push Resident C out of his room, Resident C tried to hit Resident D, so Resident D hit Resident C. When LPN 1 asked Resident D what happened, Resident D indicated to her that Resident C wandered into his room and when he tried to redirect him out of the room Resident C punched him 3 times, so Resident D punched Resident C in the face. The clinical record for Resident C was reviewed on 2/9/23 at 11:26 a.m. The diagnoses included, but were not limited to, traumatic brain injury, fractures, and multiple traumas. An Admission MDS (Minimum Data Set) assessment, dated 12/13/22, indicated Resident C was not cognitively intact. A progress note, dated 2/1/23 at 8:47 p.m., indicated CNA notified this nurse Resident C was struck in the face by Resident D. Resident C had a laceration to the right eye, an abrasion and laceration to bridge of nose, and complained of pain to the left side of his ribcage. Resident C was sent to the emergency room for evaluation and treatment. A progress note, dated 2/2/23 at 8:07 a.m.,		**assurance will be put into place; and** Audit tool titled “Resident Abuse” (Exhibit E) will be utilized by the DON or designee to audit for “resident to resident” events. The audit tool will be reviewed 5 x’s per week for 2 months, 3 x’s per week for 2 months, and weekly for 2 months. Audited records will be reviewed monthly 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. 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;** **3/2/2023**	

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indicated Resident C returned from the emergency room. Three sutures to laceration on outside of his right eye that was open to air. Resident C denied any pain and did not have any acute distress.

The clinical record for Resident D was reviewed on 2/9/23 at 11:40 a.m. The diagnoses included, but were not limited to, anxiety, depression, and diabetes.

A Quarterly MDS assessment, dated 1/3/23, indicated Resident D was cognitively intact.

A progress note, dated 2/1/23 at 8:17 p.m., indicated CNA reported to this nurse Resident D struck Resident C in the face. Resident D stated Resident C attempted to enter Resident D's room. Resident D attempted to push Resident C out of his room. Resident C struck Resident D in the face 3 times. Resident D then struck Resident C in the face. CNA then took Resident C to his room. Nurse assessed Resident D.

On 2/8/23 at 8:05 a.m., the Administrator provided a copy of an undated policy, titled Abuse, Neglect and Exploitation, and indicated this was the current policy used by the facility. A review of the policy indicated physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking...the facility will develop and implement written polices and procedures that prohibit and prevent abuse.

This Federal tag relates to Complaints IN00400730 and IN00400735.

3.1-27(a)(1)

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F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, interview, and record review, the facility failed to provide activities to residents residing on a secured memory care unit. This had the potential to affect 28 of 28 residents residing on the secured unit. (Horizon Secure Memory Care Unit) Finding includes: On 2/7/23 at 9:55 a.m., the Horizon Secured Memory Care Unit was observed. In the dining room, one resident was observed being assisted with a meal at a table. Across the table, a resident was observed to be sitting with her head down on the table. Four other residents were sitting at tables in the dining room. No activities were observed. On 2/7/23 10:10 a.m., observed the activity calendar for the Horizon Secure Memory Care Unit. The calendar indicated the following activities on 2/7/23. - At 9:30 a.m., morning circle - At 11:00 a.m., trivia - At 1:00 p.m., crafting corner	F 0679	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Staff began completing activities as scheduled per the unit calendar. **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 shall attend activities of their choice. Staff will assist residents to the common areas where activities will be conducted if desired. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	03/02/2023

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	- At 2:00 p.m., bingo - At 3:00 p.m., afternoon exercise During an interview on 2/7/23 at 10:12 a.m., LPN 2 (Licensed Practical Nurse) indicated the memory care social worker does all activities with the residents and sometimes the other activity director will come back and do them, but the aides and nurses do not do activities on this unit. She indicated they wouldn't have time for that. During an interview on 2/7/23 at 10:42 a.m., the social worker for the Horizon Memory Care Unit indicated she had been doing activities on Mondays and Fridays only. The activity department takes care of all other activities. During an interview on 2/7/23 at 10:47 a.m., the Activity Director indicated the secured memory care units have their own activity department. They had been helping them for several months. The Activity Director had not completed activities on the secured units. The Activity Assistant was the person that went to those units and helped with activities. During an interview on 2/7/23 at 10:55 a.m., the Activity Assistant indicated she does activities on the Horizon Memory Care Unit at 11:00 a.m. and 2:00 p.m. She did not do activities at any other time on that unit. She did not do an activity on the Horizon Memory Care Unit that morning (2/7/23). On 2/8/23 at 8:05 a.m., the Administrator provided a copy of an undated policy, titled Activities, and indicated this was the current policy used by the facility. A review of the policy indicated facility sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical,		The Activities Director, Activities Assistant, and the Unit Program Director have been educated on who and when they are responsible for the activities on the unit. All staff have been educated on the policy titled “Activities” (Exhibit F). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** The audit tool “Activities” (Exhibit G) will be utilized to determine compliance. The audit tool will be utilized weekly by the ACU Director or designee for 2 months, Bi-monthly for 2 months, and monthly for 2 months. The 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. 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**	

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	mental, and psychosocial well-being. This Federal tag relates to Complaint IN00399885. 3.1-33(a)		**correction date;** **3/2/2023**	
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 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 the kitchen floor was cleaned for 1 of 1 kitchen observations. Finding includes: During a tour of the kitchen on 2/7/23 from 9:20 a.m. to 9:40 a.m., under the flat cook top, stove, oven, and food preparation table observed a	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as being affected by the alleged deficient practice. **How other residents having**	03/02/2023

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	02/10/2023

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
	buildup of food particles ranging in size from crumbs to pieces approximately 1 square inch, as well as a piece of plastic approximately 4 inches long and 2 inches wide and 3 small pieces of paper. During an interview on 2/7/23 at 9:28 a.m., Cook 1 indicated the areas under the stove, flat cook top, oven and preparation table should have been cleaned last night. The floors are supposed to be cleaned every day. All of those food particles and garbage was not from today (2/7/23). On 2/8/23 at 8:05 a.m., the Administrator provided a copy of an undated facility policy, titled Environment, and indicated this was the current policy used by the facility. A review of the policy indicated all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. This Federal tag relates to Complaint IN00397138. 3.1-21(i)(2) 3.1-21(i)(3)		**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. 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:** The kitchen staff have been educated on the policy titled “Environment” (Exhibit H). Staff have been educated on moving tables and equipment to make sure that the areas underneath these surfaces are swept and cleaned as well. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** The audit tool titled “Floors” (Exhibit I) will be utilized by the Food Service Manager or designee to determine compliance. The audit tool will be completed daily for two months, bi-weekly for 2 months, and then weekly for two months. Audited records will be reviewed monthly by the Quality Assurance Committee until such time that consistent compliance is	

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			achieved as determined by the Quality Assurance Committee. **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;** **3/2/2023**	