PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155278	B. WING		04/25/2025	
			STREE	T ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R		BURKS DR		
BRICKYA	ARD HEALTHCAR	E - BLOOMINGTON CARE CENTE		OMINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
	This visit was for a	a Recertification and State	F 0000	The facility is requests desk		
	Licensure Survey.	This visit included the		review. Preparation and/or		
	Investigation of Co	omplaint IN00457404.		execution of this plan does no	t	
				constitute admission or agree		
		7404 - No deficiencies related to		by the provider that a deficien	су	
	the allegations are	cited.		exists.		
	Survey dates: Apri	121, 22, 23, 24, and 25, 2025		This response is also not to be construed as an admission of		
	Facility number: 0	00177		by the facility, its employees, agents or other individuals wh	10	
	Provider number:			draft or may be discussed in t		
	AIM number: 100289860			response and plan of correction		
	7 HIVI Hamber: 1002	207000		This plan of correction is	511.	
	Census Bed Type:			submitted as the facility's cred	lible	
	SNF/NF: 118			allegation of compliance.	AIDIO	
	Total: 118					
	Census Payor Type	e:				
	Medicare: 2					
	Medicaid: 92					
	Other: 24					
	Total: 118					
	These deficiencies	reflect State Findings cited in				
	accordance with 41					
		npleted May 2, 2025.				
F 0623	483.15(c)(3)-(6)(8	3)				
SS=D	Notice Requireme					
Bldg. 00	Transfer/Dischar					
Diag. 00			F 0623	p="" paraid="1436615042"	05/17/2025	
	Based on interview and record review, the facility failed to ensure the written notification required		1 0023	paraeid="{a409dcdd-56bd-40		
		lischarge was provided to the		ad-1cfc4ad927bc}{12}" f623=		
		sident representative for 1 of 1		notice="" of="" transfer=""		
		for hospitalization. (Resident		discharge <="" p="">		
	53)	1 (				
	,					
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

(X6) DATE

Zachary Wilson Administrator 05/28/2025

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

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/25/2025				
	ROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD  155 E BURKS DR  BLOOMINGTON, IN 47401					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	4/23/25 at 2:15 p.m	al record was reviewed on  The diagnoses included, but congestive heart failure and		What corrective actions will be accomplished for those reside found to have been affected be deficient practice?	ents			
	resident was sent to 3/11/25. The clinical of written notificating discharge forms have resident and the resident and interview. Director of Nursing facility did not have indicated the transfer provided in writing resident's representation on 4/25/25 at 12:06 facility's policy,"Trundated, and indicated indicated, " 3. The notice will be proviresident's representation of the proviresident's representation.	ess notes indicated the the hospital on 1/9/25 and all record lacked documentation on of the transfer and ring been provided to the ident representative.  If on 4/24/25 at 12:11 p.m., the Services (DNS) indicated the edocumentation which er and discharge forms were to Resident 53 and the ative.  If p.m., the DNS provided the eansfer and Discharge" ted it was the policy currently incility. A review of the policy er facility's transfer/discharge ded to the resident and the ative in a language and ey can understand"		Resident 53 was provided the facility Transfer/Discharge not how other resident having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?  The facility has determined the residents have the potential to affected. Any deficient practice identified will be addressed and corrected immediately.  What measures will be put into place and what systemic charming will be made to ensure that the deficient practice does not recommend the procedure will be re-educated on the facility pol and procedure Bed Hold Notice.	at all be e and onges e cur?			

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	ON IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155278	B. WI	NG		04/25/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			BURKS DR		
BRICKY	ARD HEALTHCARE	- BLOOMINGTON CARE CENTE	R		MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					How the corrective action will		
					monitored to ensure the defici	ent	
					practice will not recur?		
					The Director of Nursing or		
					designee will monitor resident		
					Transfers/discharges to ensur		
					compliance with providing the	Bed	
					Hold notice to resident or		
					responsible party by reviewing	-	
					(10) records per week for one		
					month then five (5) records ev	•	
					two (2) weeks for two (4) mon		
					Discrepancies will be promptly		
					reported to the Administrator.		
					plan of correction will be moni		
					at the monthly Quality Assurar meeting until such time consis		
					substantial compliance has be		
					met.	;611	
					met.		
					By what date the systemic		
					changes for each deficiency w	/ill	
					be completed?		
					5/17/2025		
					p="" paraid="738692707"		
					paraeid="{3ac851ac-cc71-49e	eb-82	
					a3-41b97e98b4a0}{12}" f623=	:""	
					notice="" of="" transfer=""		
					discharge <="" p="">		
F 0625	400 4E(d)(4)(0)						
SS=D	483.15(d)(1)(2)	d Policy Before/Upon Trnsfr					
Bldg. 00	Notice of Dea Hold	a Folicy belote/opon Thisii					
Diag. 00	Based on interview	and record review, the facility	F 06	525	p="" paraid="738692707"		05/17/2025

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/25/2025				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD BURKS DR				
BRICKY	ARD HEALTHCARE	E - BLOOMINGTON CARE CENT	ΓER		MINGTON, IN 47401				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		notification of the bed-hold			paraeid="{3ac851ac-cc71-49				
		a resident who transferred to			a3-41b97e98b4a0}{12}">F 6				
		ovided in writing to the			Bed Hold Notice What corre				
		lent representative for 1 of 1			actions will be accomplished				
		or hospitalization. (Resident			those residents found to have				
	53)				been affected by the deficien	t			
	F. 1				practice? Resident 53 was				
	Findings include:				provided the facility Bed Hold				
	D 11 . 501 11 1				Notice. How other having th				
		al record was reviewed on			potential to be affected by the				
	_	. The diagnoses included, but			same deficient practice will b				
		, congestive heart failure and			identified and what corrective				
	kidney failure.				action will be taken? The fac	•			
	D 11 . 50				has determined that all reside				
		ess notes indicated the			have the potential to be affect				
		the hospital on 1/9/25 and			Any deficient practice identification				
		al record lacked documentation		will be addressed and correct immediately. What measure					
		on which specified the facility's							
		s provided to the resident or			be put into place and what				
	the resident represe	ntative.			systemic changes will be ma				
	D	4/24/25 4 12 11 3			ensure that the deficient prac				
		v on 4/24/25 at 12:11 p.m., the			does not recur? All facility no				
	_	Services (DNS) indicated the			will be re-educated on the fac	-			
		e documentation which			policy and procedure regardi	ng			
		old forms were provided in			Bed Hold Notice. How be	.: 4			
	writing to Resident	53 or the resident's			monitored to ensure the defic	cient			
	representative.				practice will not recur? The				
	0:: 4/05/05 + 1.07	Alex Administration			Director of Nursing or design	ee will			
		p.m., the Administrator			monitor resident				
	_	y's policy,"Bed Hold Notice"			Transfers/discharges to ensu	ıre			
	· ·	ted it was the policy currently			compliance with providing				
		acility. A review of the policy			Transfer/Discharge notice to				
		he policy of this facility to			resident and responsible part				
	_	ormation to the resident and/or			reviewing ten (10) records pe				
	_	ntative regarding bed hold			week for one (2) month then				
practices both well in advance, and at the time of,				(5) records every two (2) wee	eks for				

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3.1-12(a)(25)

a transfer for hospitalization or therapeutic leave

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two (4) months. Discrepancies will be promptly reported to the Administrator. This plan of

correction will be monitored at the

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		A. BUILDING	00	COMPLETED	
		B. WING		04/25/2025	
	PROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENT	155 E	T ADDRESS, CITY, STATE, ZIP COD E BURKS DR DMINGTON, IN 47401	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	3.1-12(a)(26)			monthly Quality Assurance meeting until such consistent substantial compliance has be met. By what date be completed? 5/17/2025	een
F 0656	402 21/h\/1\/2\				
SS=D Bldg. 00		nt Comprehensive Care Plan			
	review, the facility interventions were at risk for falls for	on, interview, and record failed to ensure care plan fall in place for a resident who was of 4 residents reviewed for	F 0656	F 656 Develop/Implement Comprehensive Care Plan	05/17/2025
	accidents. (Residen Findings include:	t 107)		Immediate action(s) taken for resident(s) found to have bee affected include:	<b>I</b>
	observed to be resti	7 a.m., Resident 107 was ng in his bed. The bed was h no mat observed to be		·Fall Care plan(s) of the res 107 were reviewed and updat indicated.	
	observed to be resti	2 a.m., Resident 107 was ng in his bed. The bed was h no mat observed to be		Identification of other resident having the potential to be affe was accomplished by:	
	observed to be resti	p.m., Resident 107 was ng in his bed. The bed was h no mat observed to be		·The facility has determined all residents have the potential be affected.	
	record was reviewe were not limited to, depressive disorder	a.m., Resident 107's clinical d. The diagnoses included, but traumatic brain injury, major , muscle weakness, anxiety,		Actions taken/systems put into place to reduce the risk of futu occurrence include:	ure
	glaucoma, and dem	entia.		·All interdisciplinary care plate team members responsible for	

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The quarterly MDS (Minimum Data Set), dated

Event ID:

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writing care plans will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/25/2025 155278 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 155 E BURKS DR BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3/31/25, indicated Resident 107 had moderate re-educated on the facility's policy cognitive impairment and had 2 or more falls with and procedure for developing no injury. Comprehensive Care Plans. A care plan, dated 8/8/24, indicated Resident 107 How the corrective action(s) will be was at risk for falls. On 3/19/25, the intervention monitored to ensure the practice was to place a mat by the bed. will not reoccur: During an interview on 4/24/25 at 10:23 a.m., LPN 1 indicated Resident 107 had history of falls. LPN 1 ·Care plans will be reviewed indicated Resident 107 did not have a mat beside weekly in accordance with the his bed. care plan review schedule by the MDS Coordinator(s). All care During an interview on 4/24/25 at 11:20 a.m., LPN 2 plans will be updated as indicated Resident 107 had history of falls. She indicated. was unsure if Resident 107 required a mat beside his bed. When a resident gets a new fall The Director of Nursing Services interventions, they would be in the physician (DNS), or designee, will complete orders. She looked in the physician orders and did random weekly audits of care not see an order for mat beside the bed. She did plans for six (6) consecutive not look at the Kardex (system used by nurses to weeks. Random audits will be quickly assess resident information for their daily completed to ensure that care plan) or the care plan. comprehensive care plans are developed for residents. During an interview on 4/25/25 at 2:15 p.m., the Director of Nursing Services (DNS) indicated all Audit records will be reviewed by nursing staff could find resident's fall the Risk Management/Quality interventions in the Kardex or in the care plan. Assurance Committee until such consistent substantial compliance On 4/25/25 at 2:57 p.m., the DNS provided the has been achieved as determined facility's policy, "Fall Prevention Program," by the committee. undated, and indicated it was the policy being used. A review of the policy indicated, "...d. By what date be completed? Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assisi devices...." 5/17/2025 3.1-35(g)(2)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/25/2025	
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENT	ER	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Standards Based on interview failed to provide car residents reviewed it Insulin was not held (Resident 107)  Findings include:  On 4/24/25 at 11:20 record was reviewed were not limited to, brain injury, and de  The April 2025 Med (MAR) indicated to units subcutaneouls meals. Hold if the b mg/dl (milligrams p The MAR indicated - On 4/5/25 before to were administered. which was less than lacked documentation - On 4/5/25 before of were administered. which was less than lacked documentation - On 4/5/25 before of were administered. which was less than lacked documentation - On 4/5/25 before of were administered. which was less than lacked sess than	and record review, the facility reper the plan of care for 1 of 5 for unnecessary medications. It per physician's orders.  D. a.m., Resident 107's clinical d. The diagnoses included, but diabetes mellitus, traumatic mentia.  dication Administration Record inject Humalog (insulin) 3 y (under the skin) before lood sugar is less than 150 per deciliter), ordered 3/21/25.	F 06		F 658 Services provided Mee Professional Standards  Immediate action(s) taken for resident(s) found to have bee affected include:  -that insulin was given outs parameters for resident 107.  Identification of other resident having the potential to be affected was accomplished by:  -The facility has determined all residents have the potential be affected.  Actions taken/systems put implace to reduce the risk of fut occurrence include:  - The Director of Nursing Services or provided in-serviced ucation for all Medication Administration.  How the corrective action(s) monitored to ensure the practivity in the process of the process o	r the en ide of ts ected d that al to to cure	05/17/2025
		unch, the Humalog 3 units The blood sugar was 132			The Director of Nursing Serv	ices or	

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/25/2025		
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE		155 E B	DDRESS, CITY, STATE, ZIP COD URKS DR INGTON, IN 47401		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING DIFORMATION		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG	which was less than lacked documentati  On 4/6/25 before of were administered. which was less than lacked documentati  On 4/19/25 before were administered. which was less than lacked documentati  On 4/20/25 before were administered. which was less than lacked documentati  A care plan, dated 8 had diabetes mellitu was to administer d by the physician.  During an interview Director of Nursing Resident 107 was awhen his blood sug.  On 4/25/25 at 2:57 facility's policy, "Mundated, and indica used. A review of the Obtain and record were physician orders."	p.m., the DNS provided the edication Administration," ted it was the policy being ne policy indicated, "8. ital signs, when applicable or s. When applicable, hold e vital signs outside the		TAG	will monitor medication administration for ten (10) rec per week for one (2) month the five (5) records every week for months 1) record every week (2) months.  This plan of correction will be monitored at the monthly Qua Assurance meeting until such consistent substantial complia has been met.  5. By what date be complete  5/17/2025	cords nen or (2) for ality n	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u> CO			LETED	
		155278	B. WI	B. WING 04/			/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.			BURKS DR		
BRICKYA	ARD HEALTHCARE	- BLOOMINGTON CARE CENTE	R		MINGTON, IN 47401		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0921 SS=E	483.90(i)	it/Oft-bl Fin					
SS=E Bldg. 00	Sate/Functional/Sa	anitary/Comfortable Environ					
blug. 00	Rased on observation	on, interview, and record	F 09	12.1	/p>		05/17/2025
		failed to provide a homelike	Г US	/21	///		03/17/2023
	_	damage, disrepair, and odor of					
		ared units and 5 of 7 resident			Immediate action(s) taken for	the	
		environment. (Reflections 2			resident(s) found to have been		
		om 44, Room 45, Room 47, Room			affected include:	•	
	48)	, , ,					
	,						
	Findings include:				·The Maintenance Supervise	or or	
					addressed all environmental		
	1. On 4/23/25 at 1:2	20 p.m., 4/24/25 at 2:10 p.m., and			concerns on the Reflections u	nit.	
	4/25/25 at 10:40 a.n	n., the bathroom off the dining					
		tions 2 unit was observed to			Identification of other resident	s	
		of urine and had brown stained			having the potential to be affe	cted	
	substance around th	e base of the toilet.			was accomplished by:		
	2 On 4/25/25 at 10:	:45 a.m., the 2 shower room					
		ions 2 unit shower room were			·All residents on the Reflecti	ione	
		brown stained substance			unit have the potential to be .	10115	
		s where the walls meet the			unit have the potential to be.		
	floors.				Actions taken/systems put into	)	
					place to reduce the risk of futu		
	3. On 4/25/25 at 10:	:50 a.m., the base of the			occurrence include:		
	bathroom door in th	e Lounge Room 39 was					
	observed to have br	oken wall board.					
					·Facility staff will be educate	ed	
		:55 a.m., Room 43 was observed			the Safe Environment policy a	ıs	
		ywall a the head of the 2 beds.			well as how to enter work orde	ers.	1
		stained substance around the					
	baseboards and clos	set track.			How the corrective action(s) w		
	5 0 4/05/05 : 10	57 D 44 ' '			monitored to ensure the practi	ice	
		:57 a.m., Room 44 was observed			will not reoccur:		
		wall by the bathroom,					
		baseboard on both sides of			The Mainte		1
		unit, 4 nails and 4 screws			The Maintenance Supervisor		
		wall across from both beds,			will conduct monthly inspectio		

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

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
155278		B. WING			04/25/2025		
NAME OF PROVIDER OR SUPPLIER  BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  155 E BURKS DR				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the toilet.  6. On 4/25/25 at 11 Rooms 45 and 47 stained substance at 7. On 4/25/25 at 11 to have an oversize wall next to the cle brown stained subscloset doors was marked subsclose to door subsclose to door subsclose to door subsclose to door was touch.  During an interview Administrator indicenvironmental confortable, home residents.  On 4/25/25 at 2:05 Admissions provide undated, and indicenting the currently use the Residents Right	1:00 a.m., the shared bathroom of was observed to have brown around the base of the toilet.  1:05 a.m., Room 48 was observed ed thumbtack pressed into the bock. The closet door tracks had stance in them and one of the			concerns will be entered as we orders and addressed promption of the second pr	ork ly. e ch nce	
	3.1-19(f)						

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