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	04/25/2025

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. This visit included the Investigation of Complaint IN00457404. Complaint IN00457404 - No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, and 25, 2025 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 2 Medicaid: 92 Other: 24 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 2, 2025.	F 0000	The facility is requests desk review. Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 1 of 1 resident reviewed for hospitalization. (Resident 53)	F 0623	p="" paraid="1436615042" paraeid="{a409dcdd-56bd-40e9-88ad-1cfc4ad927bc}{12}" f623="" notice="" of="" transfer="" discharge <="" p="">	05/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Wilson	Administrator	05/28/2025

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	Findings include: Resident 53's clinical record was reviewed on 4/23/25 at 2:15 p.m. The diagnoses included, but were not limited to, congestive heart failure and kidney failure. Resident 53's progress notes indicated the resident was sent to the hospital on 1/9/25 and 3/11/25. The clinical record lacked documentation of written notification of the transfer and discharge forms having been provided to the resident and the resident representative. During an interview on 4/24/25 at 12:11 p.m., the Director of Nursing Services (DNS) indicated the facility did not have documentation which indicated the transfer and discharge forms were provided in writing to Resident 53 and the resident's representative. On 4/25/25 at 12:06 p.m., the DNS provided the facility's policy,"Transfer and Discharge" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 3. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 53 was provided the facility Transfer/Discharge notice. 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 that all residents have the potential to be affected. Any deficient practice identified will be addressed and corrected immediately. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All facility nurses will be re-educated on the facility policy and procedure Bed Hold Notice.	

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			How the corrective action will be monitored to ensure the deficient practice will not recur? The Director of Nursing or designee will monitor resident Transfers/discharges to ensure compliance with providing the Bed Hold notice to resident or responsible party by reviewing ten (10) records per week for one (2) month then five (5) records every two (2) weeks for two (4) months. Discrepancies will be promptly reported to the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. By what date the systemic changes for each deficiency will be completed? 5/17/2025 p="" paraid="738692707" paraeid="{3ac851ac-cc71-49eb-82a3-41b97e98b4a0}{12}" f623="" notice="" of="" transfer="" discharge <="" p="">	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility	F 0625	p="" paraid="738692707"	05/17/2025

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	failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 1 of 1 resident reviewed for hospitalization. (Resident 53) Findings include: Resident 53's clinical record was reviewed on 4/23/25 at 2:15 p.m. The diagnoses included, but were not limited to, congestive heart failure and kidney failure. Resident 53's progress notes indicated the resident was sent to the hospital on 1/9/25 and 3/11/25. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy was provided to the resident or the resident representative. During an interview on 4/24/25 at 12:11 p.m., the Director of Nursing Services (DNS) indicated the facility did not have documentation which indicated the bed-hold forms were provided in writing to Resident 53 or the resident's representative. On 4/25/25 at 1:07 p.m., the Administrator provided the facility's policy,"Bed Hold Notice" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave ..." 3.1-12(a)(25)		paraeid="{3ac851ac-cc71-49eb-82a3-41b97e98b4a0}{12}">F 625 Bed Hold Notice What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 53 was provided the facility Bed Hold Notice. How other 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 that all residents have the potential to be affected. Any deficient practice identified will be addressed and corrected immediately. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All facility nurses will be re-educated on the facility policy and procedure regarding Bed Hold Notice. How be monitored to ensure the deficient practice will not recur? The Director of Nursing or designee will monitor resident Transfers/discharges to ensure compliance with providing Transfer/Discharge notice to resident and responsible party by reviewing ten (10) records per week for one (2) month then five (5) records every two (2) weeks for two (4) months. Discrepancies will be promptly reported to the Administrator. This plan of correction will be monitored at the	

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	3.1-12(a)(26)		monthly Quality Assurance meeting until such consistent substantial compliance has been met. By what date be completed? 5/17/2025	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to ensure care plan fall interventions were in place for a resident who was at risk for falls for 1 of 4 residents reviewed for accidents. (Resident 107) Findings include: On 4/21/25 at 11:37 a.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed. On 4/22/25 at 10:32 a.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed. On 4/23/25 at 2:04 p.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed. On 4/24/25 at 11:20 a.m., Resident 107's clinical record was reviewed. The diagnoses included, but were not limited to, traumatic brain injury, major depressive disorder, muscle weakness, anxiety, glaucoma, and dementia. The quarterly MDS (Minimum Data Set), dated	F 0656	F 656 Develop/Implement Comprehensive Care Plan Immediate action(s) taken for the resident(s) found to have been affected include: ·Fall Care plan(s) of the resident 107 were reviewed and updated as indicated. Identification of other residents having the potential to be affected was accomplished by: ·The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: ·All interdisciplinary care plan team members responsible for writing care plans will be	05/17/2025

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	3/31/25, indicated Resident 107 had moderate cognitive impairment and had 2 or more falls with no injury. A care plan, dated 8/8/24, indicated Resident 107 was at risk for falls. On 3/19/25, the intervention was to place a mat by the bed. During an interview on 4/24/25 at 10:23 a.m., LPN 1 indicated Resident 107 had history of falls. LPN 1 indicated Resident 107 did not have a mat beside his bed. During an interview on 4/24/25 at 11:20 a.m., LPN 2 indicated Resident 107 had history of falls. She was unsure if Resident 107 required a mat beside his bed. When a resident gets a new fall interventions, they would be in the physician orders. She looked in the physician orders and did not see an order for mat beside the bed. She did not look at the Kardex (system used by nurses to quickly assess resident information for their daily care plan) or the care plan. During an interview on 4/25/25 at 2:15 p.m., the Director of Nursing Services (DNS) indicated all nursing staff could find resident's fall interventions in the Kardex or in the care plan. On 4/25/25 at 2:57 p.m., the DNS provided the facility's policy, "Fall Prevention Program," undated, and indicated it was the policy being used. A review of the policy indicated, "...d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assisi devices...." 3.1-35(g)(2)		re-educated on the facility's policy and procedure for developing Comprehensive Care Plans. How the corrective action(s) will be monitored to ensure the practice will not reoccur: ·Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s). All care plans will be updated as indicated. The Director of Nursing Services (DNS), or designee, will complete random weekly audits of care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such consistent substantial compliance has been achieved as determined by the committee. By what date be completed? 5/17/2025	

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F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on interview and record review, the facility failed to provide care per the plan of care for 1 of 5 residents reviewed for unnecessary medications. Insulin was not held per physician's orders. (Resident 107) Findings include: On 4/24/25 at 11:20 a.m., Resident 107's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, traumatic brain injury, and dementia. The April 2025 Medication Administration Record (MAR) indicated to inject Humalog (insulin) 3 units subcutaneoulsy (under the skin) before meals. Hold if the blood sugar is less than 150 mg/dl (milligrams per deciliter), ordered 3/21/25. The MAR indicated the following: - On 4/5/25 before breakfast, the Humalog 3 units were administered. The blood sugar was 128 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/5/25 before lunch, the Humalog 3 units were administered. The blood sugar was 121 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/5/25 before dinner, the Humalog 3 units were administered. The blood sugar was 130 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/6/25 before lunch, the Humalog 3 units were administered. The blood sugar was 132	F 0658	F 658 Services provided Meet Professional Standards Immediate action(s) taken for the resident(s) found to have been affected include: ·that insulin was given outside of parameters for resident 107. Identification of other residents having the potential to be affected was accomplished by: ·The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: · The Director of Nursing Services or provided in-service education for all Medication Administration. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing Services or	05/17/2025

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	which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/6/25 before dinner, the Humalog 3 units were administered. The blood sugar was 130 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/19/25 before dinner, the Humalog 3 units were administered. The blood sugar was 140 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/20/25 before dinner, the Humalog 3 units were administered. The blood sugar was 147 which was less than 150. The clinical record lacked documentation the insulin was held. A care plan, dated 8/8/24, indicated Resident 107 had diabetes mellitus. On 8/8/24, the intervention was to administer diabetes medication as ordered by the physician. During an interview on 4/25/25 at 2:03 p.m., the Director of Nursing Services (DNS) indicated Resident 107 was administered Humalog 3 units when his blood sugar was less 150. On 4/25/25 at 2:57 p.m., the DNS provided the facility's policy, "Medication Administration," undated, and indicated it was the policy being used. A review of the policy indicated, "...8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters...." 3.1-35(g)(2)		will monitor medication administration for ten (10) records per week for one (2) month then five (5) records every week for (2) months 1) record every week for (2) months. This plan of correction will be monitored at the monthly Quality Assurance meeting until such consistent substantial compliance has been met. 5. By what date be completed? 5/17/2025	

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to provide a homelike environment free of damage, disrepair, and odor of urine for 1 of 2 secured units and 5 of 7 resident rooms reviewed for environment. (Reflections 2 Unit, Room 43, Room 44, Room 45, Room 47, Room 48) Findings include: 1. On 4/23/25 at 1:20 p.m., 4/24/25 at 2:10 p.m., and 4/25/25 at 10:40 a.m., the bathroom off the dining room on the Reflections 2 unit was observed to emit a strong odor of urine and had brown stained substance around the base of the toilet. 2. On 4/25/25 at 10:45 a.m., the 2 shower room stalls in the Reflections 2 unit shower room were observed to have a brown stained substance around the junctions where the walls meet the floors. 3. On 4/25/25 at 10:50 a.m., the base of the bathroom door in the Lounge Room 39 was observed to have broken wall board. 4. On 4/25/25 at 10:55 a.m., Room 43 was observed to have damaged drywall a the head of the 2 beds. There was a brown stained substance around the baseboards and closet track. 5. On 4/25/25 at 10:57 a.m., Room 44 was observed to have holes in the wall by the bathroom, damaged walls and baseboard on both sides of the air conditioning unit, 4 nails and 4 screws protruding from the wall across from both beds, and brown stained substance around the base of	F 0921	/p> Immediate action(s) taken for the resident(s) found to have been affected include: ·The Maintenance Supervisor or addressed all environmental concerns on the Reflections unit. Identification of other residents having the potential to be affected was accomplished by: ·All residents on the Reflections unit have the potential to be . Actions taken/systems put into place to reduce the risk of future occurrence include: ·Facility staff will be educated the Safe Environment policy as well as how to enter work orders. How the corrective action(s) will be monitored to ensure the practice will not reoccur: ·The Maintenance Supervisor will conduct monthly inspections for environmental concerns. All	05/17/2025

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	the toilet. 6. On 4/25/25 at 11:00 a.m., the shared bathroom of Rooms 45 and 47 was observed to have brown stained substance around the base of the toilet. 7. On 4/25/25 at 11:05 a.m., Room 48 was observed to have an oversized thumbtack pressed into the wall next to the clock. The closet door tracks had brown stained substance in them and one of the closet doors was missing. 8. On 4/23/25 at 1:30 p.m., 4/24/25 at 2:20 p.m., and 4/25/25 at 1:45 p.m., the inside of the Reflections 2 entry/exit door was observed to be sticky to the touch. During an interview on 4/25/25 at 1:50 p.m., the Administrator indicated the aforementioned environmental concerns existed and were in need of attention in order to provide a clean, comfortable, homelike environment for the residents. On 4/25/25 at 2:05 p.m., the Director of Admissions provided the Residents Rights, undated, and indicated these were the resident rights currently used by the facility. A review of the Residents Rights indicated, "...you have the right to a safe, clean, comfortable, and homelike environment..." 3.1-19(f)		concerns will be entered as work orders and addressed promptly. Results will be reviewed by the Risk Management/Quality Assurance Committee until such consistent substantial compliance has been achieved as determined by the committee. By what date be completed? 5/17/2025	