Ashley Woodcox

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

02/26/2023

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted '2023			
	PROVIDER OR SUPPLIER			3802 SA	DDRESS, CITY, STATE, ZIP COD ARE RD IINGTON, IN 47401					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION			
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
R 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFECT.		DATE			
Bldg. 00	Survey. This visit in Complaints IN0039 Complaint IN00395 lack of evidence. Complaint IN00395 lack of evidence. Survey dates: Febru Facility number: 01 Residential Census:	1076 33	R 00	000						
	accordance with 410	tial Findings are cited in DIAC 16.2-5. pleted February 7, 2023.								
R 0026	410 IAC 16.2-5-1.2	• •								
Bldg. 00	rights recognized I licensee shall esta regarding resident responsibilities in a and shall be respondinistrator, for the policies and any a changes thereto significant the resident, staff, general public. Ear advised of resident admission and shall license shall be shall b	e the right to have their by the licensee. The ablish written policies s' rights and accordance with this article ansible, through the heir implementation. These dopted additions or hall be made available to legal representative, and ch resident shall be								
LABORATOR	Y DIRECTOR'S OR PROV	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X6) DATE								

Any defiency statement 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 disclodays 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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Area Director

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/03/2023	
	PROVIDER OR SUPPLIE		3802 S	ADDRESS, CITY, STATE, ZIP COD ARE RD MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
	documentation the receipt of the desiresponsibilities. A rights must be avaccessible area. least 12-point type resident understate Based on observation review, the facility residents' rights was accessible area for the facility.  Findings include:  On 2/2/23 at 11:00 rights was observed on 2/3/23 at 2:30 prights was observed was posted outside approximately 46 is sign did not include on 2/3/23 at 3:33 prights was observed was posted outside approximately 46 is sign did not include on 2/3/23 at 3:33 prights was observed was posted outside approximately 46 is sign did not include on 2/3/23 at 3:33 prights was observed was posted outside approximately 46 is sign did not include outside approximately 46 is sign did no	fon, interview, and record failed to ensure a copy of the as available in a publicly 33 of 33 residents residing in a.m., no posting of residents'	R 0026	The following is the Plan of Correction for Brookdale Grar regarding the Statement of Deficiencies dated February 3 2023. This Plan of Correction not to be construed as an admission of or agreement withe findings and conclusions i Statement of Deficiencies, or related sanction or fine. Rath is a submitted as confirmation our ongoing efforts to comply statutory and regulatory requirements. In this docume we have outlined specific action response to identified issue We have not provided a detail response to each allegation of finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services an will continue to make changes improvement to satisfy that objective.  A plan of correction (POC) must continue to must continue to make changes improvement to satisfy that objective.  What corrective action(	th n the any er, it of with nt, ons s. led r ind s and

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
			B. W	NG		02/03/	2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ARE RD		
BROOKE	DALE BLOOMING	ΓΟN			MINGTON, IN 47401		
BROOKE				BLOOK			
(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	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will be accomplished for those		
					residents found to have been		
					affected by the deficient practi		
					Resident admitted to geri psyc		
					hospital on 1.30.23 for medical	ition	
					review. Resident readmitted to		
					community with one on one si	tter	
					on 2.14.23. Resident will conti	nue	
					to have one on one care until		
					seeking behaviors are resolve		
					· How the facility will ider	ntify	
					other residents having the		
					potential to be affected by the		
					same deficient practice and w		
					corrective action will be taken		
					ambulatory residents have the		
					potential to be affected by alle	ged	
					deficient practice.		
					· What measures will be	put	
					into place or what systemic		
					changes the facility will make		
					ensure that the deficient pract		
					does not recur; Community wi		
					install wooden window stops i		
					addition to manufacturer insta		
					window stops to every exterio	r	
					window in the community.	)	
					How the corrective action		
					will be monitored to ensure the		
					deficient practice will not recui	,	
					i.e., what quality assurance program will be put into place;	and	
					Maintenance Director or design		
					will complete monthly inspecti		
					to windows and window stops		
					Inspections will be documented		
					work order system.	iu III	
					•	nio	
					<ul> <li>By what date the syster changes will be completed.</li> </ul>	IIIC	
					Window stops to be installed r	,	
I	I		ı		I AAUTOOM STODS TO DE ILISTUILEO I	i U	

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMP	PLETED 3/2023
	ROVIDER OR SUPPLIEI ALE BLOOMINGT		3802 S	ADDRESS, CITY, STATE, ZIP CO ARE RD MINGTON, IN 47401	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
			What corrective action(s accomplished for those found to have been affected deficient practice;. Communication of the communication of	e) will be residents cted by the		
				post a copy of the reside in a publicly accessible a community.  How the facility wi	ent rights area of ill identify	
				other residents having the potential to be affected by same deficient practice a corrective action will be residents have the potential affected by alleged deficient practice. Community will copy of the resident righ publicly accessible area community.	oy the and what taken; All ntial to be cient I post a ts in a	
				· What measures we into place or what system changes the facility will rensure that the deficient does not recur; Commun post a copy of the reside in a publicly accessible a community.	mic make to practice nity will ent rights	
				How the corrective will be monitored to ensu deficient practice will not i.e., what quality assurar program will be put into or designee will do mont checks for 12 months ar issue is resolved to ensu	ure the t recur, nce place; ED thly nd until	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		02/03/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ARE RD		
BROOKE	DALE BLOOMINGT	ON			/INGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
					resident rights are posted in a		
					publicly accessible area of		
					community.		
					By what date the syster	mic	
					changes will be completed.	THE	
					3.15.23		
R 0033	410 IAC 16.2-5-1	.2(h)(1-2)					
		:-(۱)(1-2) :- Noncompliance					
Bldg. 00	_	ust furnish on admission the					
	following:						
	(1) A statement th	nat the resident may file a					
	complaint with the	e director concerning					
	resident abuse, n	eglect, misappropriation of					
	resident property	, and other practices of the					
	facility.						
		ently known addresses and					
		rs of the following:					
	(A) The departme						
	, ,	he secretary of family and					
	social services.						
	, ,	nan designated by the ity, aging, and rehabilitation					
	services.	ity, aging, and renabilitation					
	(D) The area age	ncy on aging					
		ntal health center.					
	(F) Adult protective						
		nd telephone numbers in this					
		be posted in an area					
		dents and updated as					
	appropriate.	·					
		on, interview, and record	R 00	033	· What corrective action(	s)	03/15/2023
		failed to ensure the known			will be accomplished for those	)	
	_	shone numbers of the Indiana			residents found to have been		
	_	lth, the office of the Secretary			affected by the deficient pract		
	-	al Services, the area agency on			Community will post addresse		
		ental health center, and adult			and phone numbers for Indiar		
	_	were posted in an area			Department of Health, the offi		
	accessible to reside	ents for 33 of 33 residents			the Secretary of Family and S	ocial	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 02/03/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
BROOKE	ALE BLOOMINGT	ON		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)	(X5) COMPLETION DATE
		a.m., no posting of the none numbers were observed		Services, the area agency on aging, the local mental health center, and adult protective s in an area of accessible to residents for 33 of 33 resident residing in the facility.  How the facility will ide	n service nts
	nor telephone number facility. A large sign business office, app ground, had the om sign did not include numbers for the oth On 2/3/23 at 3:30 p Manager (BOM) pr policy, "Indiana Remarch, 2003, and ir currently being used indicated, "You make the secretary of fame Area Agency on Agenter. Adult Protects	a.m., the Business Office ovided a copy of the facility's sident Rights," revised on adicated it was the policy d. A review of the policy may file a complaint concerning eet, misappropriation (theft) and other practices of this e following departments: the three of faily and social services The ging. The local mental health three Services. These numbers		How the facility will ide other residents having the potential to be affected by the same deficient practice and v corrective action will be taker residents have the potential to affected by alleged deficient practice. Community will post addresses and phone number Indiana Department of Health office of the Secretary of Famand Social Services, the area agency on aging, the local methealth center, and adult protes service in an area of accessit residents for 33 of 33 resident residing in the facility.  What measures will be into place or what systemic changes the facility will make ensure that the deficient prace	e what n; All to be t ers for n, the nilly a ental ective ble to nts
	residents" During BOM indicated the addresses and phon- departments nor wa	area accessible to our an interview at that time, the large sign did not include the e numbers for the other s the sign at an easily r wheelchair residents.		does not recur Community with post addresses and phone numbers for Indiana Department Health, the office of the Secret of Family and Social Services area agency on aging, the local mental health center, and addressed accessible to residents.  How the corrective actives	nent of etary s, the cal ult of

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	OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 02/03/2023
	PROVIDER OR SUPPLIER		3802 S	ADDRESS, CITY, STATE, ZIP COD ARE RD MINGTON, IN 47401	
BROOKL	DALE BLOOMINGTO	JN	BLOOK		
(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
R 0092 Bldg. 00	disaster preparedricontinuity of care of emergency as follows:  (1) Fire exit drills in transmission of a fixed simulation of emergency that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At least held every year. We between 9 p.m. and announcement manualible alarms.  (2) At least every sixed shall attempt to how in conjunction with	I Management -  It maintain a written fire and mess plan to assure of residents in cases of ows:  In facilities shall include the ire alarm signal and gency fire conditions, overwent of nonambulatory reas or to the exterior of required. Drills shall be ly on each shift to ty personnel with signals tion required under varied to twelve (12) drills shall be left of the drills are conducted.		will be monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place or designee will do monthly checks for 12 months or until issue is resolved to ensure appropriate addresses and phonumbers are posted in community.  By what date the system changes will be completed. 3.15.23	r, ; ED none

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		02/03/	/2023
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ARE RD		
BBOOKE	ALE BLOOMINGT	ON			MINGTON, IN 47401		
BROOKL	PALE BLOOMING I	ON		BLOOK	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documented with	the names and signatures					
	of the personnel p						
		and record review, the facility	R 0	092	<ul> <li>What corrective action(s</li> </ul>	3)	03/15/2023
		f held at least 12 fire drills			will be accomplished for those	;	
		mpted to hold a fire and			residents found to have been		
	disaster drill in conjunction with the local fire				affected by the deficient practi	ce;	
	department at least	every 6 months.			No residents were affected by		
					alleged deficient practice.	ļ	
	Findings include:				Community will hold fire drills	ļ	
					monthly on rotating shifts. A fi	re	
	On 2/2/23 at 11:28 a.m., the Maintenance				and disaster drill in conjuction	with	
	Supervisor indicated the facility was missing some				the local fire department is		
	fire drills over the last year. He further indicated				scheduled for February 28, 20	23.	
	they had not involved the local fire department,						
	however, he planned to involve them.				· How the facility will ider	itify	
					other residents having the		
		ility's fire drills indicated 9 drills	potential to be affected by the				
	_	er the last year. No drills were			same deficient practice and w		
	_	nonths of April 2022, June 2022,			corrective action will be taken;		
	_	e of the drills involved the local			residents have the potential to		
	fire department.				affected by the alleged deficie		
	0.000	1 5			practice. Community will hold		
	-	.m., the Business Office			drills monthly on rotating shifts		
		a copy of the facility policy,			fire and disaster drill in conjuc		
		d on April, 2022, and indicated			with the local fire department i	S	
		rrently being used. A review of			scheduled for 2.28.23.		
		l, "Fire Drills shall be				ļ	
		nthly basis" The policy did			)		
	not indicate local fi	re department involvement.			· What measures will be	put	
					into place or what systemic	4-	
					changes the facility will make		
					ensure that the deficient pract		
					does not recur Community will		
					hold fire drills monthly on rotal shifts. A fire and disaster drill i	-	
					conjuction with the local fire	11	
						ļ	
					department is scheduled for	ļ	
					2.28.23.		
					How the corrective setting	nn(n)	
					How the corrective action	лı(S)	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
			B. WI	NG		02/03/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	K			ARE RD		
BROOKE	DALE BLOOMINGT	TON	BLOOMINGTON, IN 47401				
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL  BLOCK IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	will be monitored to ensure th	Α	DATE
					deficient practice will not recu		
					i.e., what quality assurance	١,	
					program will be put into place	:	
					Maintenance Manager or des		
					will complete fire drills monthl	-	
					rotating shifts. Maintenance		
					Manager will schedule and		
					facilitate fire and disaster drill	in	
					conjuction with the local fire		
					department at least every 6		
					months. ED or designee will very that maintenance manager	erity	
					executes fire drills occur mon	thly	
					on rotating shifts. ED or desig	-	
					will verify that maintenance	1100	
					manager executes fire and		
					disaster drill in conjunction wi	th	
					local fire department on Febru		
					28, 2023 and every 6 months	after	
					that. ED will audit to ensure a		
					drills are completed for 12 mo	nths.	
					By what date the system	mic	
					changes will be completed.		
					3.15.23		
R 0117	410 100 46 2 5 4	1/b)					
	410 IAC 16.2-5-1 Personnel - Defic	• •					
Bldg. 00		sufficient in number,					
	, ,	d training in accordance with					
		aws and rules to meet the					
		nour scheduled and					
		ds of the residents and					
	services provided	d. The number, qualifications,					
		aff shall depend on skills					
		de for the specific needs of					
		minimum of one (1) awake					
		current CPR and first aid					
	certificates, shall	be on site at all times. If					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 02/03/2023	
	PROVIDER OR SUPPLIER		3802 5	ADDRESS, CITY, STATE, ZIP COD SARE RD 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)	(X5) COMPLETION DATE
	regularly receive r or administration of least one (1) nursi site at all times. R over one hundred receiving resident administration of r have at least one person awake and every additional fit shall be assigned they are trained to shall conform with Based on interview failed to ensure a m current Cardiopulm First Aid (FA) certi days reviewed.  Findings include:  On 2/2/23 at 2:30 p Manager (BOM) pr week 1/26/23 throu  On 2/3/23 at 11:00 of the CPR and FA employees on the see Review of the nurse assistant's schedule indicated the follow  - On 1/26/23, there p.m. through 6:00 a - On 1/27/23, there first, second, or thir and there were no s	a.m., the BOM presented copies certifications for the chedule for the week reviewed. es and certified nursing dated 1/26/23 through 2/1/23	R 0117	What corrective action will be accomplished for thos residents found to have been affected by the deficient pract No residents were affected by alleged deficient practice.  How the facility will ide other residents having the potential to be affected by the same deficient practice and v corrective action will be taker residents have the potential t affected by the alleged deficient practice.  What measures will be into place or what systemic changes the facility will make ensure that the deficient practice has not recur Community will ensure that there is always a employee with current CPR affirst Aid certification. All QMA and nurses will be certified in and First Aid. Going forward	ntify  ntify  what  n; All  o be ent  to tice ill  n and As CPR

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
			B. W	ING		02/03/	2023
				CTREET	ADDRESS SITE OF THE SOL		
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP COD		
DDOOKE	ALE DI COMINCE	ON			ARE RD		
BROOKL	ALE BLOOMINGT	UN		BLOOM	IINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- On 1/28/23, there	were no staff members on 6:00			and QMAs will be certified in C	PR	
	a.m. through 6:00 p	.m. that were FA certified, and			and First Aid prior to working o	n	
		members on 6:00 a.m. through			the floor. ED or designee will a		
	6:00 p.m. shift that were CPR certified.				all first aid and CPR certification		
	-	were no staff members on 6:00			on a monthly basis. Nurses an		
	a.m. through 6:00 p.m. that were FA certified, and				QMAs who are not CPR and F		
	there were no staff members on first and second				Aid certified will be removed fr		
	shift that were CPR certified.				schedule and replaced with		
		were no staff members on 6:00			someone who is certified until		
	·	.m. through 6:00 a.m. shift that were FA certified.			certifications are renewed.		
	-	were no staff members on 6:00			der unioquene are renewed.		
	p.m. through 6:00 a.m. shift that were FA certified.				· How the corrective action	n(s)	
	- On 2/1/23, there were no staff members on 6:00				will be monitored to ensure the		
	a.m. through 6:00 p.m. that were FA certified, and				deficient practice will not recur		
		members on first shift that			i.e., what quality assurance	,	
	were CPR certified.				program will be put into place;	ED	
	were er it certified.				or designee will audit nursing		
	During an interview	on 2/3/23 at 2:15 p.m., the			schedule 5xweekly x4 weeks;	WOIK	
	_	had presented all the FA and			1xweeklyx4 weeks and 1x		
	CPR cards. The ship	-			monthly x 3 months and until		
	certifications.	its lacked staff with			deficient practice is resolved to		
	certifications.				ensure there is an employee w		
	On 2/3/23 at 3:05 n	.m., the BOM provided the			a current CPR and First Aid	/IUI	
	_	R Policy," revised 1/2023, and				الم	
		policy currently being used			certification on the schedule at		
					times. ED or designee will aud		
		view of the policy lacked			CPR and First Aid certification		
		ne facility having 1 employee			a monthly basis for 12 months	•	
	with a current CPR	or FA on each shift.					
					By what date the systen	IIC	
					changes will be completed.		
					3.15.23		
D 0272	440 140 40 0 5 5	1 (f)					
R 0273	410 IAC 16.2-5-5.						
חומי סס		nal Services - Deficiency					
Bldg. 00		ation and serving areas					
	` •	n residents ' units) are					
		ordance with state and					
	local sanitation an	d safe food handling					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WI	NG		02/03/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	ROVIDER OR SUPPLIER	₹		l	ADDRESS, CITY, STATE, ZIP COD		
DDOOKE	NALE DI COMINICE	ON			ARE RD		
BROOKL	ALE BLOOMINGT	ON		BLOOM	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
	standards, includi	ng 410 IAC 7-24.					
		on, interview, and record	R 0273		· What corrective action(s	s)	03/15/2023
		failed to ensure pre-prepared		_, _	will be accomplished for those		
	beverages were labeled and dated, potentially				residents found to have been		
	-	esidents served from the			affected by the deficient practi	ce:	
	kitchen.				No residents affected by defici		
					practice.	0111	
	Findings include:				praesioe.		
	<i>5</i>				How the facility will iden	tifv	
	On 2/2/23 at 10:20 a.m. and 3:05 p.m., the small				other residents having the	,	
	refrigerator in the resident dining area was				potential to be affected by the		
	observed to contain an unlabeled and undated				same deficient practice and wl	nat	
	pitcher of a brown liquid, an unlabeled and				corrective action will be taken;		
	-	an orange liquid, and an			residents have the potential to		
	_	ted pitcher of a white liquid.			affected by the alleged deficie		
		real Persons and an American			practice. All pre- prepared		
	On 2/3/23 at 10:50	a.m., the small refrigerator in the	beverages will be labeled an				
		was observed to contain an			dated.		
	_	ted pitcher of a brown liquid,			datou.		
		ndated pitcher of an orange					
		peled and undated pitcher of a			· What measures will be	out	
	_	r odor associated with			into place or what systemic	Jul	
	-	smelled coming from the pitcher			changes the facility will make t	0	
	containing the white				ensure that the deficient practi		
	-5	1			does not recur Pre-prepared		
	During an interview	v on 2/3/23 at 10:52 a.m., the			drinks will be dated and labele	d	
	_	dicated the pitchers of liquid			prior to being placed in refrige		
		abeled and dated to ensure			prior to being placed in reinige		
	freshness of the bev						
		5			· How the corrective actic	n(s)	
	On 2/3/23 at 3:00 p	.m., the Business Office			will be monitored to ensure the		
	-	the Storage of Perishable Food			deficient practice will not recur		
		and indicated it was the policy			i.e., what quality assurance	,	
		ne facility. A review of the			program will be put into place;	ED	
		all pre-dished items must be			or designee will inspect all pre		
	covered, labeled,and	-			prepared drinks in the refrigera		
	- 5 . 515a, moored,uir	<del></del>			5xweekly x4 weeks; 1xweekly		
					weeks and 1x monthly x 3 month		
					and until deficient practice is	1010	
					resolved to ensure pre prepare	2d	
	1		1		I resolved to elistic hie hiehalt	<i>,</i> u	

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/03/2023		
NAME OF PROVIDER OR SUPPLIER BROOKDALE BLOOMINGTON				STREET ADDRESS, CITY, STATE, ZIP COD  3802 SARE RD  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)	TE	(X5) COMPLETION DATE	
					drinks are dated and labeled.  By what date the system changes will be completed. 3.15.23	nic		

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