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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLI				
		155532	B. WI	NG		01/04/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		AND REHABILITATION CENTER			MILLER DR MINGTON, IN 47401		
			1		I		715)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	CY MUST BE PRECEDED BY FULL DISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
E 0000	REGULATORT OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
L 0000							
Bldg							
Ŭ	An Emergency Prep	paredness Survey was	E 00	000	Bloomington		
		idiana Department of Health in			By submitting the enclosed		
	accordance with 42				material, we are not confirming	g the	
					truth or accuracy of any specif		
	Survey Date: 01/04	1/23			findings or allegations. We res the right to contest the findings		
	Facility Number: 0	00460			part of any proceedings and	<i>,</i> 40	
	Provider Number:				submit this response pursuant	to	
	AIM Number: 1002				our regulatory obligations. The		
					facility request that the plan of		
	At this Emergency	Preparedness survey,			correction be considered our		
	Bloomington Nursi	ng and Rehabilitation Center			allegation of compliance effect	tive	
	was found in substa	ntilal compliance with			February 10 2023 for the life s	afety	
	Emergency Prepare	dness Requirements for			audit completed on January th	е	
		caid Participating Providers			4th 2023.		
	and Suppliers, 42 C	FR 483.73			The facility is requesting a des	k	
	TEL C :1:4 1	'4 C20 4'C 11 1 1			review		
		apacity of 38 certified beds and					
	nad a census of 2/ a	at the time of this visit.					
	Quality Review con	npleted on 01/05/23					
E 0004	403.748(a), 416.5	4(a), 418.113(a),					'
SS=C	` , .	5(a), 483.475(a), 483.73(a),					
Bldg	484.102(a), 485.6						
	485.727(a), 485.9						
	491.12(a), 494.62	(a)					
	Develop EP Plan,	Review and Update					
	Annually						
	- , , -	6.54(a), §418.113(a),					
	- , , -	0.84(a), §482.15(a),					
	- , , -	475(a), §484.102(a),					
	` ` ` `	625(a), §485.727(a),					
	` ,, .	3.360(a), §491.12(a),					
	§494.62(a).						
	The [facility] must	comply with all applicable					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURF		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Faith Arvin Administrator 01/19/2023

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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/04/2023			ETED	
	PROVIDER OR SUPPLIE INGTON NURSING	R AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	Federal, State an preparedness recomprehensive e program that mee section. The eme program must incomprehensive elements are the following elements. (a) Emergency Place develop and mair preparedness place.	an. The [facility] must ntain an emergency n that must be [reviewed], ast every 2 years. The plan	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§485.625(a):] Em or CAH] must cor Federal, State, ar preparedness red CAH] must development of the comprehensive exprogram that measurements are to the comprehensive exprogram that measurement of the comprehensive exprogram that measurement is a [For LTC Facilities Emergency Plan. develop and main preparedness play and updated at letter and updated at letter [For ESRD Facilities Emergency Plan.	ergency Plan. The [hospital and local emergency plan. The [hospital and local emergency plan and maintain a mergency preparedness ets the requirements of this an all-hazards approach. es at §483.73(a):] The LTC facility must an an emergency previewed, ast annually. lities at §494.62(a):] The ESRD facility must an emergency					
	and updated at le . Based on record re	n that must be [evaluated], ast every 2 years. view and interview, the facility and maintain an emergency	E 00	04	Bloomington By submitting the enclosed		02/10/2023

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETE			ETED	
		155532	B. WI	NG		01/04/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER			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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	preparedness plan that was reviewed and updated				material, we are not confirming	g the	
	at least annually in accordance with 42 CFR				truth or accuracy of any specif	fic	
	483.73(a). This def	icient practice could affect all			findings or allegations. We res	serve	
	occupants.				the right to contest the finding	s as	
	Findings include:				part of any proceedings and		
					submit this response pursuant	t to	
					our regulatory obligations. The)	
	Based on review of the facility's Disaster Plan on				facility request that the plan of	•	
	01/04/23 from 9:40	a.m. to 12:55 p.m. with the			correction be considered our		
	Maintenance Direct	tor, the emergency plan			allegation of compliance effec	tive	
	available has not be	een reviewed within the past 12			February 10 2023 for the life s	afety	
	months due to no da	ate being found in the plan.			audit completed on January th	ne	
	Based on interview with the Administrator, she				4th 2023.		
	agreed there was no	annual review date provided			The facility is requesting a des	sk	
	for the Emergency	Preparedness plan at the time			review		
	of the survey.						
					E004		
	_	viewed with the Administrator			The facility develops and		
	and Maintenance D	rector at the exit conference.			implements emergency		
					preparedness plans and are		
					evaluated and updated at leas	st	
					annually		
					Disaster plan has been review		
					and updated if needed with the	е	
					date of review documented.		
					All residents have the potentia	ıl to	
					be affected by this finding.		
					The maintenance director rece	eived	
					in service education on		
					requirement for the disaster pl		
					to be kept current and reviewe	ed at	
					a minimum annually.		
					The administrator will monitor		
					emergency preparedness plar		
					including but not limited to the		
					disaster plan monthly times si	X	
					months. The findings of the		
					monitoring will be reported to		
					QAPI committee monthly by the	ne	
			1		maintenance director or his		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
THE TERM	e. condenon	155532	B. WI			01/04/	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
F 0040	400 740(1) 440 7	44.) 440.4404.)			designee. if 100% compliance not been achieved this will continue until the threshold habeen met. Completion date 2/10/2023		
E 0013 SS=C Bldg	484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §416. §441.184(b), §460. §483.73(b), §483. §485.68(b), §485. §485.920(b), §486. §494.62(b).	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),					
	on the emergency (a) of this section, paragraph (a)(1) c communication pla section. The police	ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. T develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of	s at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this					

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section. The policies and procedures must

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	ETED
		155532	B. WI	NG		01/04/	/2023
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	•	120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	*Additional Requir ESRD Facilities: *[For PACE at §46 procedures. The develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policiaddress managem nonmedical emerglimited to: Fire; eq failure; care-related disasters likely to safety of the partic The policies and previewed and updates and procedures. The policies and previewed and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies.	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water ad emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be ated at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must					
	years. These eme not limited to, fire, failures, care-relat supply interruption	ergencies include, but are equipment or power ded emergencies, water n, and natural disasters					
	area.	ne facility's geographic	E 00)13	E013		02/10/2023

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155532	B. WING		01/04/2023	
NAME OF A			STREE	T ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	· ·	120 E	MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER	BLOC	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	nd implement emergency		The facility develops and		
		es and procedures. The		implements emergency		
		ures must be reviewed and		preparedness policies and		
	_	nually in accordance with 42		procedures.		
		nis deficient practice could affect		The policies and procedures f		
	all residents in the facility.			emergency preparedness we		
				reviewed, dated, and updated		
	Findings include:			needed, according to the faci	lities	
				current set.		
		the facility's Disaster Plan on		All residents have the potential	al to	
		a.m. to 12:55 p.m. with the		be affected by this finding.		
		tor, the emergency plan		The maintenance director rec	eived	
		ive a review date during the		in service education on the		
		od. Based on interview with the		necessity for the emergency		
		agreed there was no annual		preparedness programs and		
	_	ed for the Emergency		policies and procedures to be	kept	
	Preparedness plan a	at the time of the survey.		current, reviewed, and dated		
				accordingly, a minimum of		
		viewed with the Administrator		annually.		
	and Maintenance D	rirector at the exit conference.		The Administrator or designed	∌ Will	
				monitor the emergency		
				preparedness monthly times s	SIX	
				months. The finding will be		
				reported to the QAPI committee	ee	
				by the Administrator or her		
				designee if 100% complianc		
				has not been achieved this wi		
				continue until the threshold ha	as	
				been met.		
				Completion date 2/10/2023		
E 0029	403.748(c), 416.5	4(c) 418 113(c)	1			
SS=C	` '	5(c), 483.475(c), 483.73(c),	1			
Bldg	484.102(c), 485.6					
ug.	485.727(c), 485.9	, ,				
	491.12(c), 494.62					
	` '	communication Plan				
	-	6.54(c), §418.113(c),				
	- , , -	0.84(c), §482.15(c),				
	- , , -	475(c), §484.102(c),				
	1 3 .55 5(5), 3 .66.	5(5), 3 .552(5),	1	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155532	B. WING		01/04/2023
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
	§485.920(c), §486 §494.62(c). (c) The [facility] man emergency preplan that complies local laws and must least every 2 years failed to develop are preparedness common with Federal, State, with 42 CFR 483.7 could affect all occurrence in the second of th	625(c), §485.727(c), 6.360(c), §491.12(c), sust develop and maintain eparedness communication is with Federal, State and lest be reviewed and updated ears [annually for LTC]. Wiew and interview, the facility and maintain an emergency frunciation plan that complies and local laws in accordance (a). This deficient practice upants. The facility's Disaster Plan on a.m. to 12:55 p.m. with the tor, the emergency plan are a review date during the end. Based on interview with the agreed there was no annual end for the Emergency at the time of the survey. Viewed with the Administrator birector at the exit conference.	E 0029	E029 The facility develops and maintains an emergency preparedness communication that complies with the federal, state and local laws. The current disaster plan was reviewed, updated if needed a dated, including the emergency preparedness communication plan. All residents have the potential be affected by this finding. The maintenance director recein service education on the necessity for the disaster plan be kept current, dated and reviewed at least annually. The administrator will monitor emergency preparedness reviassure it is reviewed annually including an emergency preparedness communication plan. The findings of the monitoring will be reported to QAPI committee monthly. If 10 compliance has not been achithis will continue until threshol has been met	and cy al to eived the iew to , the 00% ieved

completion date 2/10/2023

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLICATION COMPLETED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING — COMPLETED				
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER 120 E MILLER DR BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF TH			155532	B. Wl	NG		01/04/	/2023
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLIANCE OF COMPLIANCE OF COMPLIANCE OF COMPLIANCE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DAT					120 E M	IILLER DR		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DAT						(EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
E 0036 403.748(d), 416.54(d), 418.113(d),	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
SS=C Bldg. — 441.184(d), 482.15(d), 485.68(d), 486.86(d), 486.82(d), 486.86(d), 486.86(d), 486.86(d), 486.86(d), 486.8727(d), 486.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing \$403.748(d), \$416.54(d), \$448.113(d), \$441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$483.475(d), \$484.102(d), \$485.92(d), \$485.92(d), \$484.102(d), \$485.92(d), \$485.92(d), \$485.92(d), \$485.92(d), \$491.12(d), \$494.62(d). "[For RNCHIs at \$403.748, ASCs at \$416.54, Hospice at \$418.113, PRTFs at \$441.184, PACE at \$460.84, Hospitals at \$482.15, HHAs at \$484.102, CORFs at \$485.82.15, HHAs at \$484.102, CORFs at \$485.82.15, HHAs at \$484.102, CORFs at \$485.80, CAHs at \$486.625, "Organizations" under 485.727, CMHCs at \$495.920, OPOs at \$486.360, and RHC/FHQs at \$491.12] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) for this section, and the communication plan at paragraph (c) of this section, and the communication plan at paragraph (c) of this section, and the emergency preparedness training and testing program must be reviewed and updated at least every 2 years. "[For LTC facilities at \$483.73(d);] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) of this section, risk assessment at paragraph (a) of this section, risk assessment at paragraph (a) of this section, policies and procedures at paragraph (b) of this section, and the	E 0036 SS=C	403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §466 §483.73(d), §483. §485.68(d), §485. §485.920(d), §486 §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness train that is based on the in paragraph (a) of assessment at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The I and maintain an et training and testin the emergency pla of this section, rish (a)(1) of this section (a)(1) of this section (b) of this section, rish (a)(1) of this section	64(d), 418.113(d), 5(d), 483.475(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 620(d), 486.360(d), 62(d) Festing 6.54(d), §418.113(d), 6.84(d), §482.15(d), 6.475(d), §484.102(d), 6.360(d), §491.12(d), 6.360(d), 6					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/04/2023	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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	
	section. The train	an at paragraph (c) of this ing and testing program and updated at least				
	testing. The ICF/II maintain an emergand testing progratemergency plans this section, risk a (a)(1) of this section at paragraph (b) ocommunication plasection. The train must be reviewed 2 years. The ICF/II	483.475(d):] Training and D must develop and gency preparedness training in that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures if this section, and the an at paragraph (c) of this ing and testing program and updated at least every ID must meet the evacuation drills and training				
	Training, testing, a dialysis facility mu emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) or procedures at parand the community of this section. The orientation program updated at every 2					
	failed to develop an preparedness training was reviewed and u	riew and interview, the facility d maintain an emergency ag and testing program that pdated at least annually in CFR 483.73(d). This deficient t all occupants.	E 0036	E036 The facility develops and maintains an emergency preparedness training and test program that is based on the emergency plan. The training and testing program.		

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/04/2023	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120	EET ADDRESS, CITY, STATE, ZIP COD E MILLER DR DOMINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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	
	01/04/23 from 9:30 Maintenance Direct updated training and the facility within the period was not avail interview with the A was no annual revie training and testing.	the facility's Disaster Plan on a.m. to 12:55 p.m. with the or, documentation of an distriction testing program reviewed by the most recent twelve-month table for review. Based on administrator, she agreed there we date provided for the plan at the time of the survey.		has been reviewed, dated and updated if needed. All residents have the potential be affected by this finding. The maintenance director recein service education on the necessity for the training and testing program to be reviewed dated and updated if needed a least annually. The Administrator or designed monitor that the training and testing program has been reviewed, dated and updated least annually, monthly times a months. The finding will be reported to the QAPI committed times six months. if 100% compliance has not been achit this will continue until the threshold has been met. Completion date 2/10/2023	eived d, eat e will and six	
K 0000						
Bldg. 01	A Life Safety Code	Recertification and State	K 0000	Bloomington		
	Licensure Survey w Department of Healt 483.90(a). Survey Date: 01/04 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Life Safety C Nursing and Rehabi	as conducted by the Indiana th in accordance with 42 CFR //23 00460 155532	K 0000	By submitting the enclosed material, we are not confirming truth or accuracy of any specifindings or allegations. We result the right to contest the findings part of any proceedings and submit this response pursuant our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effect February 10 2023 for the life saudit completed on January the	eerve s as to et ive afety	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155532	B. WI	NG		01/04/	/2023	
			Ь,					
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
DI 001411		AND DELIABILITATION OF NITED			MILLER DR			
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER		BLOOM	IINGTON, IN 47401			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLYDED IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	MATION TAG		DEFICIENCY)	16	DATE	
	in Medicare/Medicaid, 42 CFR Subpart 483.90(a),				4th 2023.			
	Life Safety from Fire and the 2012 edition of the				The facility is requesting a des	sk		
	National Fire Protect	ction Association (NFPA) 101,		review				
	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.							
	This one story facil	ity was determined to be of						
	Type II (111) const	ruction and was fully						
	sprinklered. The fa	cility has a fire alarm system						
	with hard wired sm	oke detectors in the corridors						
and spaces open to the corridors, plus battery								
	operated smoke ala	rms in all resident sleeping						
	rooms. The facility has a capacity of 38 and had a							
census of 27 at the time of this survey.								
	All areas where resi	idents have customary access						
	were sprinklered an	nd all areas providing facility						
	services were sprint	klered, except two detached						
	sheds used for facil	ity storage.						
	Quality Review cor	mpleted on 01/05/23						
K 0291	NFPA 101							
SS=E	Emergency Lightii	-						
Bldg. 01	Emergency Lightii	~						
		ig of at least 1-1/2-hour						
		ed automatically in						
	accordance with 7	7.9.						
	18.2.9.1, 19.2.9.1							
		on and interview, the facility	K 02	291	K291		02/10/2023	
		battery powered emergency			The facility strives to ensure th			
		ned in accordance with LSC 7.9.			all battery powered emergence	y		
		pattery operated emergency			lights are maintained in			
		reliable types of rechargeable			accordance with the regulation			
	_	vith suitable facilities for			The battery-operated emerger	тсу		
	_	n properly charged condition.			light outside of the exit was			
		ch lights or units shall be			removed as there are other lig	hts		
		ntended use and shall comply			above functioning properly.			
		onal Electric Code. LSC 7.9.2.7			Residents that use this exit ha			
	states the emergenc	y lighting system shall be			the potential to be affected by	this		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		a. Building <u>01</u>			COMPLETED		
155532			B. WING 01/04/2023				
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ.	ID	PROUPERS N. IV OF CORRECTION		(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	either be continuous	sly in operation or shall be			finding.		
		automatic operation without			The maintenance director rece	eived	
		n. This deficient practice could			in service education of the		
	affect residents and	staff using the side exit.			necessity to ensure emergend	-	
	Findings include:				lighting is functioning properly. The Administrator or designee		
					monitor that the emergency		
		on with the Maintenance			lighting system is functioning		
	-	n. on 01/04/23 during a tour of			according to the rule 5 days a		
	the facility, the battery operated emergency light				week x 1 month, weekly x 1		
	outside the side exit failed to function when its				month, then monthly x 4 month		
	respective test button was pushed three times.				the findings will be reported to	the	
	Based on interview at the time of observation, the Maintenenance Director stated battery operated				QAPI committee monthly.		
					If 100% compliance has not be		
	-	are tested monthly, and			achieved this will continue unt	il the	
		mentioned battery operated			threshold has been met		
		led to function when its			Completion date 2/10/2023		
	respective test butto	on was pushed.					
	_	viewed with the Administrator irector at the exit conference.					
	3.1-19(b)						
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
	List in the REMAR	RKS section any LSC					
	Section 18.3 and	_					
	requirements that	are not addressed by the					
	provided K-tags, b	out are deficient. This					
	information, along	with the applicable Life					
		FPA standard citation,					
		d on Form CMS-2567.					
		review, interview and	K 03	300	K300		02/10/2023
		ility failed to ensure			The facility ensures		
		he preventative maintenance			documentation for the prevent		
	-	operated smoke alarms in			maintenance of battery operat		
		complete. NFPA 101 in			smoke alarms in resident roon	ns is	
4.6.12.3 states existing life safety features obvious			1		completed.		

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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 COMPLETED 01 B. WING 01/04/2023 155532 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 120 E MILLER DR BLOOMINGTON NURSING AND REHABILITATION CENTER BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to the public, if not required by the Code, shall be Itemized list of resident room maintained. NFPA 72, 29.10 Maintenance and battery operated smoke alarms Tests. Fire-warning equipment shall be maintained was updated to ensure and tested in accordance with the manufacturer's functionality testing is completed published instructions and per the requirements monthly with documentation of of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, such for each alarm. testing, and maintenance programs shall satisfy All smoke detectors were the requirements of this Code and conform to the discarded and replaced with new equipment manufacturer's published instructions. ones. The itemized room list will This deficient practice could affect all residents, include the manufacturers date of staff, and visitors. each current alarm. The maintenance director received Findings include: in service education to ensure that an itemized list is kept, showing Based on review of the Battery Operated Detector that the smoke detectors are reports on 01/04/23 from 9:30 a.m. to 12:55 p.m. tested monthly with with the Maintenance Director present, there was documentation on each, individual no itemized list of resident room battery operated alarm as well as assuring alarms smoke alarms tested for functionality on a are not greater than 10 years old. monthly basis during the past twelve months. The administrator or designee will Based on interview at the time of review, the monitor monthly x 6 months that Maintenance Director agreed the battery-operated the smoke detectors are being smoke detector testing documentation was not tested monthly and documented itemized by location. Based on observations individually, per the itemized list between 12:55 p.m. and 1:45 p.m. during a tour of and that the manufacturer's date the facility with the Maintenance Director, battery is included on the list, and the operated smoke alarms were observed in all 18 batteries are changed annually. resident sleeping rooms. The findings of the monitoring will be reported to the QAPI This finding was reviewed with the Administrator committee monthly. If 100% and Maintenance Director at the exit conference. compliance has not been achieved this will continue until the 2. Based on observation and interview; the facility threshold has been met. failed to ensure all battery-operated smoke alarms Completion date 2/10/2023 in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and

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Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVET A. BUILDING 01 COMPLETED B. WING 01/04/2023			ETED	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	λΤΕ	(X5) COMPLETION DATE
K 0345	tested in accordance published instruction of Chapter 14. Sect testing, and mainter the requirements of equipment manufact Section 14.4.8.1 starecommended by the instructions, single alarms shall be replaced to operability tests longer than 10 year. This deficient pract staff, and visitors. Findings include: Based on observation with Maintenance In p.m., the battery-operate mounted on the cein inspected. This smoon February 11, 20 old. Based on interport Director at the time observation, the Mathewas unaware of single action smoked every battery operates ident rooms to not be replaced because old. This finding was resident and maintenance of the second of the cein inspected. This smoon is the second of the cein inspected of the second of the cein inspected. This smoon is the second of the cein inspected of the second of the cein inspected of the cein inspected. This smoon is the second of the cein inspected	e with the manufacturer's ons and per the requirements ion 14.2.1.1.1 Inspection, nance programs shall satisfy of this Code and conform to the exturer's published instructions. It is unless otherwise the manufacturer's published and multiple-station smoke aced when they fail to respond that shall not remain in service is from the date of manufacture. It is could affect all residents, on during a tour of the facility Director on 01/04/23 at 1:28 the serated smoke detector ling in resident room #3 was toke detector was manufactured 12 and was more than 10 years wiew with the Maintenance of the above-mentioned anintenance Director stated that the manufactured date of the endarm and he would check ted smoke alarms in all make sure they did not need to be they were more than 10 years wiewed with the Administrator director at the exit conference.					
SS=F	Fire Alarm Syster	n - Testing and					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532			A. BUILDING	01	COMPLETED
			B. WING	<u></u>	01/04/2023
					1
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD	
				MILLER DR	
BLOOMII	NGTON NURSING	AND REHABILITATION CENTE	R BLOO	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 APPROPRIAT	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
Bldg. 01	Maintenance				
	Fire Alarm Systen	n - Testing and			
	Maintenance				
	A fire alarm syste	m is tested and maintained			
	in accordance wit	h an approved program			
	complying with the	e requirements of NFPA 70,			
	National Electric (Code, and NFPA 72,			
		m and Signaling Code.			
		n acceptance, maintenance			
	and testing are re				
		IFPA 70, NFPA 72			
	Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in		K 0345	K345	02/10/2023
				The facility maintains the fire	1
		FPA 72, as required by LSC 101		alarm system in accordance w	ith
		and 9.6. NFPA 72, Section		the rule.	
		nless otherwise permitted by		A visual inspection of the fire	
		ections shall be performed in		alarm system was completed of	on
	_	e schedules in Table 14.3.1, or		1/19/2020 with an itemized listi	
		red by the authority having		of initiating devices.	
	_	14.3.1 states that the following		All residents have the potential	l to
	l -	spected semi-annually:		be affected by this finding.	
	a. Control unit trou	-		The maintenance director rece	ived
	b. Remote annuncia	_		in service education on the	
	c. Initiating devices	s (e.g. duct detectors, manual		necessity for the visual inspect	ion
		eat detectors, smoke detectors,		of the fire alarm system that m	
	etc.)	•		be done semiannually to include	
	d. Notification appl	liances		an itemized listing of initiating	
	e. Magnetic hold-op			devices.	
		cice could affect all occupants		The Administrator or designee	will
	in the facility.			monitor the semiannual visual	
				the fire alarm system monthly	
	Findings include:			times six months. The finding of	of
	<i>5</i>			the monitoring will be reported	
	Based on record rev	view on 01/04/23 between 9:30		the QAPI committee monthly. I	l l
		. with the Maintenance Director,		100% compliance has not been	
		provided for a visual		achieved this will continue until	

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semi-annual fire alarm system inspection on

07/07/22, however the initiating devices were not

itemized. Based on interview at the time of record review, the Maintenance Director stated he was

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threshold has been met

Completion date 2/10/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/04/2023				ETED
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
	not aware that the seneeded to be itemize 01/04/23, the annual conducted on 04/15. This finding was re-	emi-annual visual inspection ed. Based on record review on Il fire alarm testing was					
K 0712 SS=F Bldg. 01	alarm signal and so conditions. Fire drand unexpected ti conditions, at least The staff is familia aware that drills a routine. Where drawine. Where drawine and 6:00 announcement mandible alarms.	ay be used instead of					
	failed to conduct questimes under varying This deficient pract staff and visitors in Findings include: Based on review of Documentation: "Findings include: 9:30 a.m. to 12:55 properties of the properties of t	Direct Supply TELS Logbook	K 0	712	K712 The facility conducts fire drills unexpected times under varying conditions on every shift at least quarterly. The fire drill for third shift was conducted immediately. All residents have the potential be affected by this finding. The maintenance man receives service education on the necessities to conduct fire drill quarterly, on each shift at unexpected times under varying conditions.	ng est Il to ed in s	02/10/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		r í	JILDING	onstruction 01	(X3) DATE COMPL 01/04 /	ETED	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, 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
K 0741 SS=E Bldg. 01	conducted within the on 02/08/22, 05/23/conducted at, respect and 6:15 p.m. Based record review, the Mathematical fire drills were not of under varying conducted within the period on 03/11/22 p.m. and 12/23/22 at third shift drills. This finding was reand the Maintenanc conference. 3.1-19(b) NFPA 101 Smoking Regulation Smoking Regulation Smoking Regulation Shall include not be provisions: (1) Smoking shall ward, or compartnown liquids, combustibused or stored and location, and such signs that read NC posted with the intermoking. (2) In health care of smoking is prohibiting prominently placed.	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with O SMOKING or shall be ternational symbol for no occupancies where ted and signs are d at all major entrances, vith language that prohibits			A calendar has been complete aid in monitoring random date and times. The administrator or designee monitor that the fire drills are to completed as required, this monitoring will be conducted monthly times six (6) months. The findings of the monitoring be reported to the QAPI committee monthly. If 100% compliance has not been achithis will continue until the threshold has been met. Completion date 2/10/2023	s will peing will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532			A. BUILDING <u>01</u> COMP			(X3) DATE COMPL 01/04/	ETED
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(3) Smoking by paresponsible shall I (4) The requirement apply where the pare supervision. (5) Ashtrays of notes as a design shall I where smoking is (6) Metal contained devices into which shall be readily averaged as moking is permitted as a smoking is permitted. The shall be readily averaged as a smoking is permitted to ensure 1 of the maintained by disposited as a smoking area. Findings include: Based on observation of the facility, outside the facility, outside the facility, outside the smoking area. It is finding the signated smoking area. This finding was resulted to the facility of the smoking area. This finding was resulted to the smoking area.	atients classified as not be prohibited. Int of 18.7.4(3) shall not atient is under direct atient is under direct ancombustible material and be provided in all areas permitted. In a shtrays can be emptied realiable to all areas where ted. In and interview; the facility of 1 smoking areas were being cigarette butts in a metal container with self-closing deficient practice could affect and staff in the designated on with the Maintenance of the back exit by resident room that at smoking area is located, being area is located	K 074		K741 The facility ensures that smok areas are maintained by dispocigarette butts into a metal or noncombustible container with self-closing covered devices. All the cigarette butts were cleaned up immediately. All residents have the potentiabe affected by this finding. A in service education was provided to all staff and reside (who smoke) regarding using proper receptacles for discard cigarette products As part of the groundskeeping maintenance has posted signs assist those in disposing of the cigarettes in approved contain maintenance will add this findit to his preventative maintenance The Administrator or designee monitor that cigarette butts an like products are disposed of i the containers 5 days a week times 4 weeks, biweekly times weeks, and then monthly	esting al to ents the ing er ing ce e will d in	02/10/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/04/2023			
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER 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		
				thereafter times 4 months. The findings of the monitoring be reported to the QAPI committee monthly. If 100% compliance has not b achieved this will continue unt threshold has been met Completion date 2/10/23	een		
K 0914 SS=C Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations and exceeding 12 mor (LIM), if installed, less than or equal the LIM test switch activates both visually LIM circuits with a manual test is per than or equal to 12 tested per 6.3.3.3. renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99)	oom or area tested, and					
	Based on observation interview, the facility	on, record review and ty failed to ensure electrical 18 resident sleeping rooms	K 0914	K914 The facility ensures electrical receptacles are tested at leas	02/10/2023		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532			 JILDING	onstruction 01	(X3) DATE COMPL 01/04/	ETED	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
		receptacles and init receptacles. NFPA 2012 Edition, Section to listed as hospital locations and in loc general anesthesia is at intervals not exce Additionally, Sectic in Patient Care Roo integrity of each receptacles of the visual inspection. The grounding circuit in the verified. Correct connections in each confirmed; and reter blade of each electrolocking-type recept 115 grams (4 ounce could affect all residual affect all residual inspection. The grounding circuit in the verified. Correct connections in each confirmed; and reter blade of each electrolocking-type recept 115 grams (4 ounce could affect all residual affect all residual affect all residual affect all residual affect all receptacles in on-hospital grade in review at from 9:30 documentation avaitable sleeping room receptacles of the the receptacles of the recep	on 6.3.3.2, Receptacle Testing ams requires the physical preparency shall be confirmed by the continuity of the acach electrical receptacle shall to polarity of the hot and neutral electrical receptacle shall be notion force of the grounding ical receptacle (except acles) shall be not less than ses). This deficient practice dents. Ons during a tour of the facility ce Director on 01/04/23 and 1:45 p.m., the facility's oms contained three to four ses with a mix of hospital and receptacles. Based on records a.m. to 12:55 p.m., there was lable to show seven resident of tacles were tested on receptacle testing for the ere not documented. Based on e of the observation and Maintenance Director stated eptacles were tested but did		annually. Receptacle testing has been of in all rooms, including a visual inspection of each receptacle' physical integrity. An itemized of each receptacle was create with documentation to be done each receptacle verifying whe testing completed. Testing to include verifying the continuity the grounding circuits, correct polarity of the hot and neutral connections and retention force the grounding blade of each receptacle (except locking-typer receptacles) is not less than 1 grams (4 ounces). All residents have the potentiable affected by this finding. The maintenance director recein service education on the necessities of testing and documenting, the electrical receptacles according to the regulation. The Administrator or designed monitor tracking of the electric receptacle testing monthly x 6 months. The findings of the monitoring be reported to the QAPI committee monthly. If 100% compliance has not be achieved this will continue untithreshold has been met Completion date 2/10/2023.	s list d e on n of ee of e 15 ll to eived e will will een	

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Event ID:

NV6921

Facility ID: 000460

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PRINTED: 01/30/2023 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. BU	ILDING	01	COMPLETED		
		155532	B. WI	B. WING			01/04/2023	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER				120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	and Maintenance D conference. 3.1-19(b)	irector during the exit						

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