STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING _____ B. WING _____	C 10/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00444190 and IN00444330. Complaint IN00444190 - No deficiencies related to the allegations are cited. Complaint IN00444330 - Federal/State deficiencies related to the allegations are cited at F600. Survey dates: October 17 and 18, 2024 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 2 Medicaid: 100 Other: 15 Total: 117 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 22, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 600	Continued From page 1 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (LPN 1, Resident C) Findings include: On 10/17/24 at 12:07 p.m., Resident C's clinical record was reviewed. The diagnosis included, but was not limited to, discitis (inflammation that develops between the intervertebral discs of the spine). Physician orders, dated 9/29/24, indicated Resident C's medications included, but were not limited to meropenem (an antibiotic) intravenous (IV) solution reconstituted 1 gm (gram) intravenously every 8 hours for discitis. The Admission Minimum Data Set (MDS) assessment, dated 8/15/24, indicated Resident C had no cognitive impairment. During a phone interview on 10/17/24 at 2:36 p.m., Resident C indicated he had a PICC line (a	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) inserted and received an IV medication each evening which took about 30 minutes to infuse. He had had trouble with LPN 1 in the past because she would not unhook the IV tubing when the medication was finished. On 9/29/24, he woke up about 4:00 a.m., with his arm caught in the tubing. He got out of bed, pulled his IV pole down the hall and found LPN 1. He asked her if she could take this "F------ [curse word]" thing out of his arm. LPN 1 then indicated to Resident C you are making a big deal out of nothing. Resident C indicated he then replied you are on the only nurse who doesn't unhook the medication and LPN 1 replied, "shut the F---- [curse word] up." Resident C indicated the verbal abuse escalated from there and as he walked back down the hall, LPN 1 continued to follow him and use expletives and to curse at him.

During an interview on 10/18/24 at 9:30 a.m., the Assistant Director of Nursing (ADON) indicated the verbal abuse incident between Resident C and LPN 1 happened about 4:00 a.m. on 9/29/24. There was another nurse (LPN 2) who witnessed the incident but she was no longer employed at the facility. LPN 1 was no longer employed by the facility.

On 10/18/24 at 10:00 a.m., a statement from Resident C regarding the incident was reviewed. The statement, dated 9/30/24 at 10:00 a.m., indicated, " ... I woke up around 4:00 a.m. I could feel the tubing pulling. I went to nurse to have her take off the IV and flush my line. I said to nurse will you take this F------ [curse word] thing off of my arm? She said, I don't know why you're making a big deal of this. Then I said, if you

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would do your job. She then said F--- [curse word] you. I went back to my room after I cussed back at her and called her names. Then went to my room. I know I didn't come at her very nicely either but she's the professional ..."

On 10/18/24 at 10:10 a.m., a statement from LPN 1 regarding the incident was reviewed. The statement, dated 9/30/24, indicated, " ... Resident C approached her about flushing his PICC line. She said just a minute and then he began cursing and calling her names. She stated it's not a big deal and he said if you would do your F------ [curse word] job and said F--- [curse word] you and she replied F--- [curse word] you too. We did exchange explicative's with each other. I had a bad night and I was having a hard time dealing with people getting in my face and reacting in an unkind manner. I had another guy who got in my face and cussed me before that ..."

On 10/18/24 at 10:20 a.m., a statement from LPN 2 regarding the incident was reviewed. The statement, dated 9/29/24, indicated, " ... I was in a patient's room and I heard a loud yelling and profanities. This nurse over heard Resident C and LPN 1 exchanging profanities. I told LPN 1 to go into the lounge. I approached Resident C to calm down and I walked him outside for a while and brought him back in. I notified nursing manager on call who told me to send her home pending investigation. I came back and told LPN 1 she needed to clock out and go home and I would take over her responsibilities. I watched LPN 1 clock out and leave the building ..."

On 10/18/24 at 10:44 a.m., the Clinical Nurse Consultant provided the facility's policy "Abuse, Neglect and Exploitation undated, and indicated it

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F 600	Continued From page 4 was the policy currently being used by the facility. A review of the policy indicated, "... Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident ... Verbal Abuse means the use or oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend ..." This deficient practice was corrected on 9/30/24 after the facility implemented a systemic plan of correction that included the following actions: all staff was educated on the abuse policy with ongoing monitoring and audits. This citation relates to Complaint IN00444330. 3.1-27(b)	F 600		