STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE BLOOMINGTON	3802 SARE RD 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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00411847, IN00413875, and IN00415113. Complaint IN00411847 - No deficiencies related to the allegations are cited. Complaint IN00413875 - No deficiencies related to the allegations are cited. Complaint IN00415113 - State deficiencies related to the allegations are cited at R0064. Survey date: September 12, 2023 Facility number: 011076 Residential Census: 27 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed September 13, 2023.	R 0000	This Plan of Correction is being submitted as a requirement of the Indiana State Department of Health and is not intended to be an admission of the deficiency cited.	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to protect the residents property from theft for 1 of 3 residents reviewed. Staff witnessed a nurse take medications from residents supply on 2	R 0064	All facility residents have the potential to be affected by this alleged deficient practice. The corrective action(s) taken for the deficiency cited are as follows; the	11/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tonia Lea Davis	Executive DIrector	10/31/2023

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	separate days. (Resident B) Finding includes: During an interview on 9/12/23 at 9:42 a.m., QMA 2 (Qualified Medication Aide) indicated she did not work with LPN 1 the day she took metoprolol (a medication used to treat high blood pressure). QMA 2 did work with LPN 1 a few weeks before when she watched LPN 1 take Resident B's gabapentin capsule (prescription medication used to treat epilepsy and nerve pain) and an amitriptyline tablet (a prescription medication used to treat depression). LPN 1 put the medications in her mouth and told QMA 2 that LPN 1 had a prescription for the medication but didn't think she could get to the pharmacy before the pharmacy closed. QMA 2 reported LPN 1 when QMA 2 was asked about another incident that involved LPN 1. QMA 2 indicated she should have reported LPN 1 immediately after she took the medications. During an interview on 9/12/23 at 10:03 a.m., the Administrator indicated during an investigation LPN 1 admitted to taking metoprolol and she did not remember taking gabapentin or amitriptyline. The facility was not sure who the metoprolol belonged to because LPN 1 flipped through the medications until she came across metoprolol and popped the pill out. It should have been reported to the facility immediately. LPN 1 did not tell the Administrator who she took the metoprolol from, but LPN 1 did tell the Administrator that she had her sister bring in her bag and LPN 1 replaced the metoprolol with her own metoprolol. During an interview on 9/12/23 at 10:40 a.m., QMA 1 indicated LPN 1 came into work around 6:00 a.m. on 8/9/23 and seemed upset. LPN 1 asked QMA 1		LPN in question was immediately suspended pending investigation when administration was notified of the allegation. Subsequently, her employment was terminated. Measures put into place put into place to ensure that the deficient practice does not recur - Facility nursing staff was re-educated on Abuse, Neglect and Exploitation policy including reporting immediately. Corrective Actions put into place will be monitored by use of auditing tools to confirm staff knowledge and understanding of immediate reporting and policy. These audit tools will be monitored by QA committee weekly x 12 weeks, bi-weekly 3 months, and then monthly x 3 months or until QA committee is able to determine that sufficient compliance has occurred. These systemic changes will be in place no later than 11/20/2023	

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	to check her blood pressure. LPN 1's blood pressure was high, so LPN 1 opened the medication cart and flipped through some medications. LPN 1 pulled a pill out of the cart and indicated she had a metoprolol tablet and that she thought it was for blood pressure. LPN 1 put the medication in her mouth in front of QMA 1. QMA 1 was not sure which resident the medication belonged to. QMA 1 reported this the next day. LPN 1 told QMA 1 that she brought her own gabapentin capsule in and replaced Resident B's gabapentin. The clinical record for Resident B was reviewed on 9/12/23 at 11:05 a.m. The diagnoses included, but were not limited to, idiopathic progressive neuropathy and generalized anxiety disorder. The current physician's orders indicated Resident B was prescribed: - Amitriptyline tablet 25 mg (milligrams), give 50 mg orally at bedtime for generalized anxiety disorder, initiated 6/30/21. - Gabapentin capsule, give 600 mg, 3 times daily for idiopathic progressive neuropathy, initiated 4/14/23. On 9/12/23 at 10:00 a.m., the Administrator provided a copy of an incident investigation, dated 8/10/23. A review of the investigation indicated type of allegation: allegation of associate stealing resident medications. LPN 1 indicated she came in for her shift on 8/9/23, and wasn't feeling well. LPN 1 sat down and QMA 1 checked LPN 1's blood pressure. LPN 1's blood pressure was stroke level and LPN 1 had to either take the medication or have a cardiac arrest. LPN 1 indicated she got into the medication cart and			

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	found a metoprolol and took it. LPN 1 indicated her sister brought her bag in and LPN 1 replaced the pill from her personal medication supply. QMA 1 indicated LPN 1 came into work on 8/9/23, and was visibly upset. LPN 1 sat down in the chair and QMA 1 checked her blood pressure. QMA 1 indicated LPN 1's blood pressure was high. LPN 1 stood up, got into the medication cart, and flipped through medications. LPN 1 said isn't metoprolol for blood pressure and then popped one pill out and put it in her mouth. QMA 1 told LPN 1 that she could never do that again. After going home QMA 1 felt that she needed to report this to the Administrator. On 9/12/23 at 10:00 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Neglect and Exploitation Policy, dated 5/2021, and indicated this was the current policy used by the facility. A review of the policy indicated instances of abuse, neglect or exploitation should be treated seriously and must be reported immediately. If an associate encounters an abusive situation involving a resident, they should attempt to take necessary steps to protect the resident, which may include removing the associate immediately. This State tag relates to Complaint IN00415113.			