STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. BUILDING 00 B. WING	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 13, 14, 15, and 16, 2023 Facility number: 000460 Provider number: 155532 AIM number: 100290620 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 1 Medicaid: 28 Other: 1 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 21, 2023.	F 0000	1 F000 By submitting the enclosed material, we are not admitting to the truth or accuracy of any specific binding or allegations. We reserve the right to contest the finding or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the Plan of Correction be considered our allegation of compliance effective December 8th, 2023, for the annual recertification and state licensure.	
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Faith Arvin	Administrator	12/04/2023

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	manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on interview and record review, the facility failed to ensure residents had full access to their facility managed personal funds account during the weekend hours for 1 of 16 residents reviewed for personal funds. (Resident 5) Findings include: During an interview on 11/13/23 at 3:49 p.m., Resident 5 indicated he was unable to get the full	F 0567	F567 **The facility ensures that residents have the right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.** BOM followed up with R 5 to	12/08/2023

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	amount of money from his personal funds account on the weekends. The facility limited him on how much he could have. Resident 5's clinical record was reviewed on 11/15/23 at 10:00 a.m. The diagnosis included, but was not limited to, chronic obstructive pulmonary disease. The Quarterly Minimum Data Set (MDS) assessment, dated 9/4/23, indicated Resident 5 was cognitively intact. During an interview on 11/16/23 at 4:08 p.m., the Business Office Manager (BOM) indicated the residents would line up outside her office on Friday because they were only allowed to get between $5.00 and $10.00 out of their personal funds account on the weekend. She only kept $40.00 on hand. On 11/16/23 at 4:00 p.m., the BOM provided the facility's policy, "Resident Facility Trust Fund Policy and Procedure" undated, and indicated it was the one currently being used by the facility. A review of the policy indicated, "... Normal Process of Handling Resident Trust ... 3. The resident is able to request and receive funds from this account at any time ... 4. ... The resident can withdrawal cash to do what they choose with ..." 3.1-6		ensure he was good and satisfied with funds currently. All residents have the potential to be affected by this finding. All staff in-serviced on resident funds on Evenings and Weekends as well as the lock box with resident funds in Med Room. BOM in-serviced by Admin. on important of resident funds. Reminders posted at Nurses Station and in Med Room on Lock Box to call BOM and/or Admin. if insufficient funds to meet residents needs. BOM and/or Designee will audit on working days before EOS x6 Months as well as on Fridays before the Weekend to ensure sufficient funds are left and given to residents. BOM will audit 1 Resident a Week x 6 Months to ensure residents are satisfied with how they are receiving their funds, as well as receiving them on Evenings and Weekends. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan			

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a care plan was developed for a resident with a surgical wound who was on a long term antibiotic for 1 of 1 residents reviewed for antibiotic use. (Resident 9) Findings include: Resident 9's clinical record was reviewed on 11/16/23 at 9:45 a.m. The diagnoses included, but were not limited to, acquired absence of unspecified hip joint and acquired absence of left leg above knee. Current physician orders, dated 11/16/23, indicated Resident 9's orders included, but were not limited to: clindamycin HCL (an antibiotic) 150 mg (milligrams) give 1 capsule by mouth one time a day related to infection and inflammatory reaction due to internal left hip prosthesis. There was no stop dated listed for the antibiotic. The Quarterly Minimum Data Set (MDS) assessment, dated 8/21/23, assessed Resident 9 as taking an antibiotic 7 out of 7 days during the lookback period. A care plan, initiated on 3/21/14, for Resident 9 indicated: FOCUS: "... Is at risk for skin breakdown related to: The resident has impaired physical mobility r/t [related to] AKA [above knee amputation] ... Has surgical open area left hip ...	F 0656	F656 **The facility develops and improvements a comprehensive person-centered care plan for each resident that is consistent with the resident's rights that includes measurable objectives and timeframes to meet a residents medical, nursing , mental and psychosocial needs.** R9 was reviewed. The clinical record now contains documentation of long-term antibiotics for surgical wound. All residents have the potential to be affected by this finding. An in-service was conducted with the IDT in effort to provide a comprehensive care plan on all residents An audit of all care plans has been conducted to review for accuracy. DON and/or Designee will audit 3 residents weekly x6 months. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be	12/08/2023

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	GOAL: The resident will demonstrate the appropriate use of adaptive devices to increase mobility through the review date ... INTERVENTIONS: Invite the resident to activity programs that encourage activity, physical mobility such as exercise group ... The resident uses a wheelchair for locomotion ... Provide supportive care, assistance with mobility as needed ... PT [physical therapy] OT [occupational therapy] referrals as ordered ..." The care plan for Resident 9 lacked documentation of the resident being on a long term antibiotic for treatment of the infection in the surgical wound. During an interview on 11/16/23 at 10:47 p.m., the Minimum Data Set Coordinator indicated Resident 9 was on a long term antibiotic for the surgical wound on his left hip and there was no care plan for it. On 11/16/23 at 6:00 p.m., the Administrator provided the facility's policy, "Care Plans - Comprehensive" with a revised date of September 2010, and indicated it was the one currently being used by the facility. A review of the policy indicated, "... An individualized comprehensive care plan that includes measurable objective and timetables to meet the resident's medical, nursing mental and psychological needs is developed for each resident ..." 3.1-35(a)		monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility			

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	must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 6 of 120 days reviewed. Findings include: On 11/13/23 at 11:30 a.m., the facility's Payroll Based Journal (PBJ) Staffing Data Report was reviewed. The report indicated the facility had no RN Hours for 4/2/23, 4/9/23, 5/7/23, 5/21/23, 6/4/23, and 6/18/23. On 11/15/23 at 11:46 a.m., the third quarter staffing schedules (4/1/23-6/30/23) were reviewed. The staffing schedules indicated the facility had no RN scheduled on 4/2/23, 4/9/23, 5/7/23, and 6/4/23. A further review of the last thirty days of staffing schedules indicated there were no RN scheduled for 10/21/23 and 10/22/23. During an interview on 11/16/23 at 12:00 p.m. the ADM indicated they were late updating the schedule into a program accessible by computer and thought that may be why the PBJ report triggered so many days. She further indicated the facility did not have any RN coverage on 4/2/23,	F 0727	F727 **The facility ensures that there is RN coverage 8 consecutive hours a day, 7 days a week except when waived.** All residents have the potential to be affected by this finding. IDT in-serviced on the importance of RN coverage. Admin, DON, ADON/MDS in-serviced on the importance of RN coverage by RDO. Facility continues to recruit and hire staff to assist with staffing needs. An audit of RN coverage will be done by ADON/MDS (staffing) daily x6 months to ensure the facility is meeting the requirements of RN coverage. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or	12/08/2023

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	4/9/23, 5/7/23, 6/4/23, 10/21/21 and 10/22/23. During an interview on 11/16/23 at 4:38 p.m. the ADM indicated during the third quarter of 2023 (4/1/23-6/30/23), corporate staff was responsible for inputting data into the PBJ. They had performed a schedule audit and were trying to hire a RN. On 11/16/23 at 6:07 p.m., the Administrator provided the facility policy, "Departmental Supervision," revised April, 2006, and indicated it was the policy currently being used. A review of the policy indicated, "... 1. A Registered or Licensed Practical/Vocational Nurse ... is on duty twenty-four hours per day, seven days per week ... An RN shall be available in the facility, daily, for 8 consecutive hours each day..." 3.1-17(b)(3)		Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing sheet had the actual hours worked by staff for 4 of 4 days of daily posted nurse staffing reviewed. Findings include: During an observation on 11/13/23 at 11:39 a.m., the daily posted nursing staff sheet lacked the the actual hours staff worked. During an interview on 11/16/23 at 3:57 p.m., the Administrator provided the daily posted nursing staff sheets dated 11/13/23 through 11/16/23. At that time, the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheet lacked documentation of the actual hours worked by	F 0732	F732 **The facility must post the following information on a daily basis: Facility name, current date, total number, and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.** The staffing sheets for the facility were immediately modified to include the required information for each day including the “actual hours worked”. IDT in-serviced on the importance of daily staffing information being accurate, with the right	12/08/2023

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	staff.		information, and readily available. Admin, DON, ADON/MDS in-serviced on the importance of daily staffing information being accurate, with the right information, and readily available. An audit of daily staffing sheets will be done by Admin. daily x6 months to ensure the facility is meeting the requirements of posted information. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications			

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	for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to monitor a resident with a new medication order for 1 of 5 residents reviewed for unnecessary medications. Blood sugars were not obtained.(Resident 11) Findings include: On 11/16/23 at 10:36 a.m., Resident 11's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and cerebrovascular disease with left hemiplegia (stroke with paralysis on one side of the body). The diabetes mellitus care plan, dated 8/23/22, lacked any monitoring of blood sugar as interventions. The Physician Orders included, but were not limited to: - Blood sugar every morning and every bedtime and to call the physician if blood sugar less than 50 and greater than 500 (start date 10/3/23). - Insulin detemir (a medication used to treat diabetes mellitus), inject 10 units, in the evening (start date 10/3/23). The October 2023 Medication Administration Record lacked documentation of blood sugars. The November 2023 Medication Administration	F 0757	F757 **Each residents drug regimen must be free from unnecessary drugs.** R 11's drug regimen was immediately reviewed to ensure there were no longer any unnecessary drugs. All residents have the potential to be affected by this finding. R 11's MAR's lacked documentation of blood sugars. R 11's diabetes mellitus care plan lacked any monitoring of blood sugar as interventions. All nursing staff in-serviced on the importance of documentation as well as refusals. DON, ADON/MDS in-serviced on the importance of documentation as well as refusals, and on interventions being added for resident's care plans when not being followed by resident. An audit of all drug regimens has been conducted to review for accuracy. DON and/or Designee will audit 3 residents weekly x6 months. Any concerns will be addressed as discovered. If any patterns are identified, an action	12/08/2023

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	Record lacked documentation of blood sugars. On 11/16/23 at 4:10 p.m., the Assistant Director of Nursing indicated the clinical record lacked documentation of blood sugars on the Medication Administration Record. On 11/16/23 at 6:06 p.m., the Administrator provided the facility's policy, "Diabetes - Clinical Protocol," revised date of 12/2015, and indicated it was the policy being used by the facility. A review of the policy indicated, "...3. The Physician will order appropriate lab tests (for example, periodic finger sticks...) and adjust treatment based on these results....(3) For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin..." 3.1-48(a)(3)		plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0807 SS=E Bldg. 00	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview and record review, the facility failed to ensure residents were provided with fresh water on a routine basis for 5 out of 5 residents reviewed for hydration. (Resident 133, Resident 25, Resident 22, Resident 23, Resident 29) Findings include: 1. During an interview on 11/13/23 at 11:33 a.m.,	F 0807	F807 **The facility ensures that they provide, and each resident receives drinks, including water and other liquids consistent with resident needs and preferences sufficient to maintain resident hydration.** R 25, 13, 22, 29 and 23 were all passed fresh Ice Water as well as	12/08/2023

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	155532	A. BUILDING 00 B. WING	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 133 indicated she was not getting enough to drink because the facility did not pass water. No water was observed to be at the residents bedside during that time. During an observation on 11/14/23 at 1:59 p.m., Resident 133 was observed to be lying in her bed asleep. There was a gray pitcher with a straw observed on the back dresser that was undated and 3/4 full of warm water with no ice. During an interview on 11/14/23 at 3:16 p.m., Resident 133 indicated she had not known there was a gray water pitcher on the dresser next to the bed and she would have only noticed it if it had been on the bedside table. During an observation on 11/15/23 at 9:45 a.m., Resident 133 was out of the room attending PT (physical therapy). There was a gray pitcher with a straw observed on the bedside table that was undated and 1/4 full of warm water with no ice. During an observation on 11/15/23 at 11:38 a.m., Resident 133 was out sitting in her room in a wheelchair. There was a gray pitcher with a straw observed on the bedside table that was undated and full of ice and water. The resident indicated at that time that today was the first day she had seen the facility pass water. During an observation on 11/16/23 at 9:40 a.m., Resident 133 was out of the room sitting at the nurses station in her wheelchair. There was a gray pitcher with a straw observed on the bedside table that was undated and 3/4 full of warm water with no ice. Resident 133's clinical record was reviewed on 11/16/23 at 11:38 a.m. The diagnoses included, but		the remainder of residents who may be affected by this deficiency. All residents have the potential to be affected by this finding. All staff in-serviced on the importance of hydration and passing Ice Water on all shifts. DON and/or Designee will audit Ice Water Pass Each Shift on working days, Days and Nights to ensure residents are receiving proper hydration. This audit will be completed Daily Each Shift x 6 Months. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	

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	were not limited to, type II diabetes mellitus and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 11/14/23, was still in progress and had not assessed Resident 133's cognitively status at that time. 2. During an interview on 11/13/23 at 12:27 p.m., Resident 25 indicated she was not getting enough to drink because the facility did not pass water. No water was observed to be at the residents bedside during that time. During an observation on 11/14/23 at 1:56 p.m., Resident 25 was observed to be out of her room. No water was observed to be at the bedside. During an observation on 11/16/23 at 9:44 a.m., Resident 25 was observed to be asleep in bed. No water was observed to be at the bedside. During an observation on 11/15/23 at 11:39 a.m., Resident 25 was observed to be out of her room. No water was observed to be at the bedside. During an observation on 11/15/23 at 2:51 p.m., Resident 25 was observed to be out of her room. There was a gray pitcher with a straw observed on the bedside table that was undated and 3/4 full of warm water with no ice. During an observation on 11/16/23 at 10:39 a.m., Resident 25 was observed to be lying in bed asleep. A small clear cup of water 3/4 full used for med pass was observed at bedside however, no water pitcher with ice was observed. Resident 25's clinical record was reviewed on 11/16/23 at 11:52 a.m. The diagnoses included, but			

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	were not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 8/21/23, indicated Resident 25 was cognitively intact. 3. On 11/13/23 at 3:07 p.m., Resident 22 indicated he only gets ice water if he asked for it. At that time, Resident 22 had a clear medication glass at beside which was almost empty. On 11/14/23 at 3:04 p.m., Resident 22 was observed to have a clear medication cup on his bedside table which was half full. On 11/15/23 at 9:18 a.m., Resident 22 was observed to have a clear medication glass on his bedside table which was one quarter full. On 11/16/23 at 11:06 a.m., Resident 22's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and muscle weakness. The dehydration care plan, dated 5/8/23, indicated the staff were to encourage good fluid intake with dietary parameters. 4. During an observation on 11/13/23 at 2:56 p.m., Resident 23 was not observed to have a water pitcher at bedside. During an observation on 11/15/23 at 9:49 a.m., Resident 23 was observed to have a clear water glass at bedside which was one quarter full. A water pitcher was not observed to be at bedside. On 11/16/23 at 9:45 a.m., Resident 23's clinical record was reviewed. The diagnoses included, but			

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	were not limited to, cognitive impairment and muscle weakness. The dehydration care plan, dated 10/25/23, indicated the staff were to encourage good fluid intake with dietary parameters. 5. During an observation on 11/13/23 at 11:31 a.m., Resident 29 indicated he would only get ice water if he asked for it. At that time, Resident 29 did not have a water pitcher at bedside. During an observation on 11/14/23 at 9:11 a.m., Resident 29 was observed to have a clear medication cup at bedside, but no water pitcher was observed to be at bedside. On 11/16/23 at 12:20 p.m., Resident 29's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and muscle weakness. The dehydration care plan, dated 4/27/23, indicated the staff were to encourage good fluid intake with dietary parameters. During the Resident Council Meeting on 11/14/23 at 2:16 p.m., the Resident Council President indicated they only get fresh ice or water if they ask for it. During an interview on 11/16/23 at 3:10 p.m., Certified Nursing Assistant (CNA) 1 indicated some days they do not have enough time to complete all their required task. Some of the tasks they can't complete was ice pass. The ice pass was at the "bottom of the list". On 11/16/23 at 6:06 p.m., the Administrator provided the facility's policy, "Resident Rights,"			

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	revised date of 12/2016, and indicated it was the policy being used by the facility. A review of the policy indicated, "...Federal and state laws guarantee certain basic rights to all residents...a. a dignified existence..." 3.1-46(b)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored and served in a sanitary manner for 3 of 3 kitchen observations. The hand washing station did not have hot water, the air conditioning unit was dirty, items in the refrigerator and freezer were unlabeled, and the chemical strips used for the 3	F 0812	F812 **The facility will ensure we store, prepare, and distribute and serve food in accordance with professional standards for food service safety.** Heflin Industries came in on 11/28	12/08/2023

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	compartment sink were expired. This had the potential to impact 30 of 30 residents residing in the facility. Findings include: 1. During an initial tour of the facility kitchen on 11/13/23 at 10:15 a.m., the following was observed: - The hot water in the handwashing sink would not get hot. The Dietary Manager (DM) indicated at that time to use the 3 compartment sink because the water from that pipe would get hot. - The tubing around the wall air conditioning (A/C) unit was dirty with dust and debris and the vent slabs were observed to be dirty with a dark black substance. - The freezer was observed to have 5 packages of frozen meats that were unlabeled. The DM indicated at that time they were hamburger. - The refrigerator was observed to have a pitcher of a red liquid, a gallon of tea that that was almost gone and a gallon of milk that was almost gone with no open or use by date. The DM indicated at that time the red liquid had just been made this morning and the tea and milk would be gone by noon today. 2. During a follow up visit to the kitchen on 11/16/23 at 11:30 a.m., the following was observed: - The hot water in the handwashing sink would not get hot. - The tubing around the wall air conditioning unit was dirty with dust and debris and the vent slabs were observed to be dirty with a dark black		to repair Hot Water Boiler and Valve, allowing hot water temps to return back to required temperatures. The Maintenance Director immediately cleaned the A/C unit in the kitchen as well as tubing, and vent slabs. Both Maint. and DM in-serviced on the importance of this. The Dietary Manager immediately audited the kitchen and fixed all deficiencies from undated and/or expired labeled food, drinks, and chemicals, test strips. All Dietary staff were in-serviced on the importance of food storage and labeling and dating food. Dietary Manager in-serviced by Admin. on importance of proper storage and labeling. All residents have the potential to be affected by this finding. Dietary Manager and/or Designee will audit food storage and labeling 2x a Week x6 months at Week Begin and Week End. Maint. Director will audit hot water temps (hand washing sink) weekly x6 months to ensure temps stay consistent to regs. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is	

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	substance. - The freezer was observed to have 5 packages of frozen meats that were unlabeled. - The refrigerator was observed to have 2 containers of cottage cheese bowls undated. - The chemical strips used to test the 3 compartment sink had expired on 4/24/13. During an interview on 11/16/23 at 11:31 a.m., the DM indicated the A/C unit was dirty, the hand washing sink would not produce hot water, the test strips were expired, the cottage cheese bowls were being used today and the hamburger in the freezer was unlabeled. 3. During a follow up visit to the kitchen on 11/16/23 at 3:29 p.m., the following was observed: - The handwashing sink hot water measured with a thermometer to be 70.5 degrees. Cook 1 indicated at that time the hot water had never been hot in the sink. They had reported it but it never had been fixed. During an interview on 11/16/23 at 3:45 p.m., the Administrator indicated they have had the main water line replaced and they were still working on the hot water issues in the facility. On 11/26/23 at 6:06 p.m., the Administrator provided the facility policy titled, "Sanitization" with a revised date of October 2008, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Policy Interpretation and Implementation ... 2. All ... equipment shall be kept clean ..."		achieved. Completion Date 12/8/2023	

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	On 11/26/23 at 6:06 p.m., the Administrator provided the facility policy titled, "Food Receiving and Storage" with a revised date of July 2014, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Policy Interpretation and Implementation ... 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated [use by date] ..." A review of the above policies did not indicated having hot water in the hand washing sink and the expired chemical test strips. On 11/20/23 at 1:00 p.m., a review of the Indiana State Department of Health Retail Food Establishment Sanitation Requirements manual, effective date November 13, 2004 indicated, "...410 IAC 7-24 ... Handwashing: ...Sec. 128 a. Food employees shall ... clean their hands and exposed portions of their arms ... at a hand washing sink ... in water having a temperature of at least one hundred (100) degrees Fahrenheit and thoroughly rinsing with clean water ... Food Labels: Sec. 146. a. Food packaged in a retail food establishment shall be labeled as specified in law ... b. Label information shall include the following: 1. The common name of the food or, absent a common name, an adequately descriptive identity statement ..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically			

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	submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff.			

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	When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to electronically submit to the Centers for Medicare and Medicaid (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for Quarter 3 (April 1 to June 30) of fiscal year 2023. Findings include: On 11/13/23 at 11:30 a.m., the facility's Payroll Based Journal (PBJ) Staffing Data Report was reviewed. The report indicated the facility had no RN Hours for 4/2/23, 4/9/23, 5/7/23, 5/21/23, 6/4/23, and 6/18/23. The report further indicated the facility failed to have Licensed Nursing Coverage 24 hours per day on 4/2/23, 4/4/23, 4/8/23, 4/14/23, 4/15/23, 4/16/23, 4/21/23, 4/22/23, 4/30/23, 5/2/23, 5/6/23, 5/7/23, 5/8/23, 5/10/23, 5/11/23, 5/12/23, 5/14/23, 5/15/23, 5/16/23, 5/20/23, 5/21/23, 5/22/23, 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, 6/3/23, 6/4/23, 6/5/23, 6/8/23, 6/10/23, 6/11/23, 6/18/23, 6/19/23, 6/22/23, 6/23/23, 6/24/23, 6/25/23, 6/26/23.	F 0851	F851 **Mandatory submission of staffing information based on payroll data in a uniform format to CMS.** All staff in-serviced on the importance of using OnShift including Dep. Heads uploading their schedules each month. Admin, DON, ADON/MDS in-serviced on submitting payroll based staffing information to CMS by RDO. All residents have the potential to be affected by this finding. IDT in-serviced on the importance of RN coverage. Admin, DON, ADON/MDS in-serviced on the importance of RN coverage by RDO. Exempt Nursing employees in-serviced on the importance of completing a time sheet to turn in to Payroll clerk when the schedule has been altered from Monday –	12/08/2023

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	Lastly, the facility received a 1 star staffing rating during the third quarter. On 11/15/23 at 11:46 a.m., a review of the third quarter staffing schedules indicated the facility had no RN hours on 4/2/23, 4/9/23, 5/7/23, and 6/24/23. An additional review of the last thirty days of schedules indicated there were no RN hours for 10/21/23 and 10/22/23. During an interview on 11/16/23 at 12:00 p.m. the Administrator (ADM) indicated staff was late updating the schedule into a program accessible by computer and thought that may be why the PBJ report triggered so many days. She was unsure, but thought the staff included agency staff into the PBJ numbers. During an interview on 11/16/23 at 4:38 p.m., the ADM indicated during the third quarter of 2023, corporate staff was responsible for inputting the PBJ data to CMS. They had performed a schedule audit and are trying to hire a RN. On 11/16/23 at 6:07 p.m., the ADM provided the facility policy, "Reporting Direct-Care Staffing Information (Payroll-Based Journal)," revised July, 2006, and indicated it was the policy currently being used. A review of the policy indicated, "... 2. Direct-care staffing information will include those hired through an agency, and contract employees ... 9. Staffing information will be collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter ... Fiscal Quarter 3 ... Date Range April 1 - June 30 ... Submission Deadline August 14 ..."		Friday (null punch). This will enable the actual time to be captured to ensure licensed staff are documented for 24 hours per day. Facility continues to recruit and hire staff to assist with staffing needs. Facility continues to raise star rating by ensuring RN coverage is being followed. An audit of RN coverage will be done by ADON/MDS (staffing) daily x6 months to ensure the facility is meeting the requirements of RN coverage. Admin will verify upon doing daily staffing sheet audit. An audit will be conducted to ensure the licensed nursing hours have been captured and will continue to audit going forward weekly x6 months, to make sure the hours have been documented for all nursing staff. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a clean and sanitary environment for 6 of 11 resident rooms and 4 of 4 bathrooms observed. Water temperatures in resident room sink faucets were not hot, floor tiles were not in place and clean, and toilet bases were not clean. (Room 5, Room 7, Room 9, Room 11, Room 12, Room 6, Northeast Bathroom, Northwest Bathroom, Southeast Bathroom, Southwest Bathroom) Findings include: 1. On the following dates and times, the hot water temperature for each resident room sink faucet was measured for a period of 3 minutes, with the temperature results documented: - On 11/16/23 from 11:00 A.M. to 11:03 A.M., Room 5's hot water temperature was 77.1 degrees Fahrenheit. - On 11/16/23 from 11:06 A.M. to 11:09 A.M., Room 7's hot water temperature was 64.8 degrees Fahrenheit. - On 11/16/23 from 11:12 A.M. to 11:15 A.M., Room 9's hot water temperature was 76.2 degrees Fahrenheit. 2. On 11/15/23 between 11:15 A.M. and 11:45 A.M., the following resident rooms were observed to have floor covering of vinyl planks which were loose, missing, and with black and brown substances in the spaces between the planks: Room 9, Room 11, Room 12, Room 6, and Room 7.	F 0921	F921 **The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.** Rms 5, 6, 7, 9, 11, and 12 were all deep cleaned and added to the list to review flooring upon our Maint. Director continuing with replacing floors as facility has been doing. Facility will maintain replacing one resident room floor a month as able until all effected areas have been replaced and/or repaired. Progress and other room needs to be monitored by Admin. Projected completion date May 2024. Heflin Industries came in on 11/28 to repair Hot Water Boiler and Valve, allowing hot water temps to return back to required temperatures in effected areas. South East, South West, North East, and North West bathrooms were sealed, cleaned and caulked around the toilets and bases as well as the wall floor joints. All residents have the potential to be affected by these findings. Maint. Director will audit hot water temps (including hand washing sink in kitchen) weekly x6 months to ensure temps stay consistent to regs. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly	12/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155532	A. BUILDING 00 B. WING	11/16/2023

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	3. On 11/15/23 at 11:50 A.M., the southeast resident bathroom was observed to have a toilet with a dark brown colored substance around the base as well as brown staining along the wall to floor joints. 4. On 11/15/23 at 11:53 A.M., the northeast resident bathroom was observed to have a toilet with a dark brown colored substance around the base. 5. On 11/15/23 at 11:56 A.M., the southwest resident bathroom was observed to have a toilet with a dark brown colored substance around the base. 6. On 11/15/23 at 11:58 A.M., the northwest resident bathroom was observed to have a toilet with a dark brown colored substance around the base. During an interview on 11/16/23 at 3:00 P.M., the Maintenance Director indicated the hot water boiler which went to several resident rooms was in need of repair in order to heat the water to the proper temperature, the floor tiles were not staying in place and contained stains under them and between the seams, and the toilet bases of the restrooms were in need of cleaning and sealing, 3.1-19(f)		QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved. Completion Date 12/8/2023	