12/07/2023

			TRINIED.
PARTMENT OF HEALTH AND HUN	FORM APPROVED		
NTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155532		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIER NGTON NURSING	AND REHABILITATION CENTER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG F 0000	(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
F 0567 SS=D Bldg. 00	Licensure Survey. Survey dates: Nove Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type Medicare: 1 Medicaid: 28 Other: 1 Total: 30 These deficiencies accordance with 41 Quality review com 483.10(f)(10(i)(ii) Protection/Manag §483.10(f)(10) The manage his or her includes the right charges a facility resident's persona (i) The facility must deposit their persona a resident choose with the facility, up a resident, the face	reflect State Findings cited in 0 IAC 16.2-3.1. Impleted November 21, 2023. ement of Personal Funds e resident has a right to r financial affairs. This to know, in advance, what may impose against a	F 00	000	1 F000 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific binding or allegations reserve the right to contest the finding or allegations as part any proceedings and submit responses pursuant to our regulatory obligations. The farequests the Plan of Correctic considered our allegation of compliance effective December 8th, 2023, for the annual recertification and state licen	s. We ne of these acility on be	

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

TITLE (X6) DATE

Faith Arvin Administrator 12/04/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: QLC911 Facility ID: 000460 If continuation sheet Page 1 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 11/16				
	PROVIDER OR SUPPLIEF NGTON NURSING	AND REHABILITATION CENTER		120 E M	NDDRESS, 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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	of the resident de specified in this se (ii) Deposit of Fun (A) In general: Ex (f)(10)(ii)(B) of this deposit any reside excess of \$100 in (or accounts) that facility's operating all interest earned account. (In poole a separate account share.) The facility personal funds the non-interest bearing account, or petty (B) Residents who Medicaid: The fact residents' personal in separate from a accounts, and that on resident's fund accounts, there maccounting for ear facility must maintinot exceed \$50 in account, interest-cash fund.	ds. cept as set out in paragraph s section, the facility must ents' personal funds in an interest bearing account is separate from any of the accounts, and that credits I on resident's funds to that ed accounts, there must be enting for each resident's y must maintain a resident's at do not exceed \$100 in a ng account, interest-bearing cash fund. cose care is funded by cillity must deposit the eal funds in excess of \$50 in g account (or accounts) that any of the facility's operating at credits all interest earned s to that account. (In pooled cust be a separate ch resident's share.) The tain personal funds that do a noninterest bearing bearing account, or petty					
	failed to ensure resi facility managed pe	and record review, the facility idents had full access to their ersonal funds account during for 1 of 16 residents reviewed (Resident 5)	F 05	567	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	nt	12/08/2023
	Findings include:	y on 11/13/23 at 3:40 n m			charges a facility may impos against a resident's personal		
	_	v on 11/13/23 at 3:49 p.m., d he was unable to get the full			funds. BOM followed up with R 5 to		

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Event ID:

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PRINTED: 12/07/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	•			OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155532	B. WING	·	11/16/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				MILLER DR		
BLOOM	INGTON NURSING	AND REHABILITATION CENTE	R BLOOM	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	N
TAG	` `	R LSC IDENTIFYING INFORMATION	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	 	rom his personal funds account		ensure he was good and satis		
	1	The facility limited him on how		with funds currently.	licu	
	much he could have	_		All residents have the potentia	ul to	
	much he could have	С.			110	
	D - : 1 4 1 - 1 - 1 - 1	l record was reviewed on		be affected by this finding.		
	-			All staff in-serviced on residen		
		.m. The diagnosis included, but		funds on Evenings and Weeke	nas	
		chronic obstructive pulmonary		as well as the lock box with		
	disease.			resident funds in Med Room.		
				BOM in-serviced by Admin. or	1	
		imum Data Set (MDS)		important of resident funds.		
		9/4/23, indicated Resident 5		Reminders posted at Nurses		
	was cognitively int	act.		Station and in Med Room on L		
				Box to call BOM and/or Admin	i. if	
	During an interview	v on 11/16/23 at 4:08 p.m., the		insufficient funds to meet		
	Business Office Ma	anager (BOM) indicated the		residents needs.		
	residents would line	e up outside her office on		BOM and/or Designee will aud	lit on	
	Friday because they	y were only allowed to get		working days before EOS x6		
	between \$5.00 and	\$10.00 out of their personal		Months as well as on Fridays		
	funds account on the	ne weekend. She only kept		before the Weekend to ensure	;	
	\$40.00 on hand.			sufficient funds are left and give	/en	
				to residents. BOM will audit 1		
	On 11/16/23 at 4:00	0 p.m., the BOM provided the		Resident a Week x 6 Months t	io l	
		esident Facility Trust Fund		ensure residents are satisfied		
		re" undated, and indicated it		how they are receiving their fu		
	1	tly being used by the facility.		as well as receiving them on	,	
		licy indicated, " Normal		Evenings and Weekends. Any	,	
	-	g Resident Trust 3. The		concerns will be addressed as		
		equest and receive funds from		discovered. If any patterns are		
		time 4 The resident can		identified, an action plan will b	•	
	-	do what they choose with"		1		
	withdrawar cash to	do what they choose with		written at the monthly QAPI meeting by the QAPI committee		
	3.1-6				. c .	
	3.1-0			Any written action plan will be	_	
				monitored by the Admin and/o		
				Designee monthly until resolve	3G	
				and substantial compliance is		
				achieved.		
				Completion Date 12/8/2023		
F 0656	483.21(b)(1)(3)					

FORM CMS-2567(02-99) Previous Versions Obsolete

SS=D

Event ID:

Develop/Implement Comprehensive Care Plan

QLC911

Facility ID: 000460

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155532	B. WI	NG		11/16/	/2023
				CTDEET A	DDDEGG GITY GTATE TIR COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DI OOMIN	NOTON NILIDOING	AND DELIABILITATION CENTED			MILLER DR MINGTON, IN 47401		
BLOOMINGTON NURSING AND REHABILITATION CENTER			BLOOM	IING FON, IN 4740 I			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	§483.21(b) Compr	rehensive Care Plans					
	§483.21(b)(1) The	facility must develop and					
	implement a comp	rehensive 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 tim	eframes to meet a					
	resident's medical	, nursing, and mental and					
	psychosocial need	ds that are identified in the					
	comprehensive as	sessment. The					
	comprehensive ca	re plan must describe the					
	following -						
	(i) The services the	at are to be furnished to					
	attain or maintain	the resident's highest					
	practicable physic	al, mental, and					
	psychosocial well-	being as required under					
	§483.24, §483.25	or §483.40; and					
	(ii) Any services th	nat would otherwise be					
	required under §4	83.24, §483.25 or §483.40					
	but are not provide	ed due to the resident's					
	exercise of rights (under §483.10, including					
	the right to refuse	treatment under §483.10(c)					
	(6).						
	(iii) Any specialize	d services or specialized					
	rehabilitative servi	ces the nursing facility will					
	provide as a result	t 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 represe	ntative(s)-					
	(A) The resident's	goals for admission and					
	desired outcomes						
	(B) The resident's	preference and potential for					
	future discharge. F	acilities must document					
	whether the reside	ent's desire to return to the					
	community was as	ssessed and any referrals					
	-	encies and/or other					
	_	s, for this purpose.					
		ns in the comprehensive					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/16/2023 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 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 F 0656 F656 12/08/2023 failed to ensure a care plan was developed for a The facility develops and resident with a surgical wound who was on a long improvements a term antibiotic for 1 of 1 residents reviewed for comprehensive personantibiotic use. (Resident 9) centered care plan for each resident that is consistent with Findings include: the resident's rights that includes measurable objectives Resident 9's clinical record was reviewed on and timeframes to meet a 11/16/23 at 9:45 a.m. The diagnoses included, but residents medical, nursing, were not limited to, acquired absence of mental and psychosocial unspecified hip joint and acquired absence of left needs. leg above knee. R9 was reviewed. The clinical record now contains Current physician orders, dated 11/16/23, documentation of long-term indicated Resident 9's orders included, but were antibiotics for surgical wound. not limited to: clindamycin HCL (an antibiotic) 150 All residents have the potential to mg (milligrams) give 1 capsule by mouth one time be affected by this finding. a day related to infection and inflammatory An in-service was conducted with reaction due to internal left hip prosthesis. There the IDT in effort to provide a was no stop dated listed for the antibiotic. comprehensive care plan on all residents The Quarterly Minimum Data Set (MDS) An audit of all care plans has been assessment, dated 8/21/23, assessed Resident 9 as conducted to review for accuracy. taking an antibiotic 7 out of 7 days during the DON and/or Designee will audit 3 lookback period. residents weekly x6 months. Any concerns will be addressed as A care plan, initiated on 3/21/14, for Resident 9 discovered. If any patterns are indicated: FOCUS: "... Is at risk for skin identified, an action plan will be breakdown related to: The resident has impaired written at the monthly QAPI physical mobility r/t [related to] AKA [above knee meeting by the QAPI committee.

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amputation] ... Has surgical open area left hip ...

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Any written action plan will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155532	B. WI	NG		11/16/	2023
NAME OF P	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD		
					MILLER DR		
BLOOMII	NGTON NURSING	AND REHABILITATION CENTER		BLOOM	IINGTON, IN 47401		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION nt will demonstrate the		TAG		r	DATE
		adaptive devices to increase			monitored by the Admin and/o Designee monthly until resolve		
	mobility through th	-			and substantial compliance is	Ju	
		S: Invite the resident to activity			achieved.		
		urage activity, physical			Completion Date 12/8/2023		
		ercise group The resident					
	•	or locomotion Provide					
	supportive care, ass	sistance with mobility as					
	needed PT [phys	ical therapy] OT [occupational					
	therapy] referrals as	s ordered"					
	TI 1 C D	1. (01.1.1					
	The care plan for R	he resident being on a long					
		treatment of the infection in the					
	surgical wound.	reaument of the infection in the					
	surgical would.						
	During an interview	v on 11/16/23 at 10:47 p.m., the					
	_	Coordinator indicated Resident					
	9 was on a long terr	m antibiotic for the surgical					
	wound on his left h	ip and there was no care plan					
	for it.						
	On 11/16/22 -+ 6:00	0 41 - 4 4					
		0 p.m., the Administrator y's policy, "Care Plans -					
		ith a revised date of September					
	•	l it was the one currently being					
		. A review of the policy					
		adividualized comprehensive					
	· ·	des measurable objective and					
	*	the resident's medical, nursing					
		ogical needs is developed for					
	each resident"	-					
	3.1-35(a)						
F 0727	483.35(b)(1)-(3)						
SS=E	. , . , . ,	Wk, Full Time DON					
Bldg. 00	§483.35(b) Regist						
-	. , , -	cept when waived under					
	- , , , ,	f) of this section, the facility					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155532	B. WING		11/16/2023	
			CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD MILLER DR		
DI OOMI	NOTON NUIDOINO	AND DELIABILITATION CENTER				
BLOOMINGTON NURSING AND REHABILITATION CENTER			BLOOI	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	must use the serv	rices of a registered nurse				
	for at least 8 cons	ecutive hours a day, 7 days				
	a week.	•				
	§483.35(b)(2) Exc	cept when waived under				
	- ' ' ' '	f) of this section, the facility				
		registered nurse to serve				
	_	nursing on a full time basis.				
		3				
	§483.35(b)(3) The	e director of nursing may				
	- ' ' ' '	nurse only when the facility				
has an average daily occupancy of 60 or						
	fewer residents.					
		and record review, the facility	F 0727	F727	12/08/2023	
		ces of a registered nurse for at	1 0/2/	The facility ensures that the		
		hours a day, 7 days a week for		is RN coverage 8 consecutiv		
	6 of 120 days review			hours a day, 7 days a week		
	0 01 120 days levie	wed.		except when waived.		
	Findings include:			All residents have the potential	al to	
	i mangs merade.			be affected by this finding.	ai to	
	On 11/13/23 at 11:3	30 a.m., the facility's Payroll		IDT in-serviced on the importa	ance	
		Staffing Data Report was		of RN coverage.	alloc	
		rt indicated the facility had no		Admin, DON, ADON/MDS		
	_	3, 4/9/23, 5/7/23, 5/21/23, 6/4/23,			of	
	and 6/18/23.	.5, 4/3/25, 5///25, 5/21/25, 6/4/25,		in-serviced on the importance	OI	
	and 0/16/23.			RN coverage by RDO. Facility continues to recruit ar		
	On 11/15/22 of 11./	46 a.m., the third quarter staffing		hire staff to assist with staffing		
		5/30/23) were reviewed. The		,	9	
	· ·	ndicated the facility had no		needs.		
	_	/2/23, 4/9/23, 5/7/23, and 6/4/23.		An audit of RN coverage will I		
				done by ADON/MDS (staffing	′ I	
		the last thirty days of staffing		daily x6 months to ensure the		
		there were no RN scheduled		facility is meeting the	,	
	for 10/21/23 and 10	0/22/25.		requirements of RN coverage	· I	
	D	11/16/22 + 12.00		concerns will be addressed as		
		v on 11/16/23 at 12:00 p.m. the		discovered. If any patterns are		
		y were late updating the		identified, an action plan will b	oe	
		gram accessible by computer		written at the monthly QAPI		
	_	ay be why the PBJ report		meeting by the QAPI committ		
	triggered so many d	lays. She further indicated the	1	Any written action plan will be		

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facility did not have any RN coverage on 4/2/23,

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monitored by the Admin and/or

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

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155532		ì í	JILDING	nstruction 00	(X3) DATE COMPL 11/16/	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 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)	ΓE	(X5) COMPLETION DATE
	During an interview ADM indicated dur (4/1/23-6/30/23), co for inputting data in performed a schedu a RN.	23, 10/21/21 and 10/22/23. y on 11/16/23 at 4:38 p.m. the ring the third quarter of 2023 priporate staff was responsible into the PBJ. They had alle audit and were trying to hire			Designee monthly until resolve and substantial compliance is achieved. Completion Date 12/8/2023	ed	
	provided the facility Supervision," revise was the policy curre the policy indicated Licensed Practical/\(^1\) twenty-four hours p	7 p.m., the Administrator y policy, "Departmental ed April, 2006, and indicated it ently being used. A review of l, " 1. A Registered or Vocational Nurse is on duty per day, seven days per week evailable in the facility, daily, for seach day"					
F 0732 SS=C Bldg. 00	§483.35(g)(1) Dat must post the follo basis: (i) Facility name. (ii) The current da (iii) The total numl worked by the follo licensed and unlice responsible for rese (A) Registered num (B) Licensed prace	Staffing Information. a requirements. The facility owing information on a daily te. ber and the actual hours owing categories of tensed nursing staff directly sident care per shift: rses. tical nurses or licensed (as defined under State					

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Event ID:

QLC911 Facility ID: 000460

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

IDENTIFICATION NUMBER 156322 NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER BLOOMINGTON NURSING AND REHABILITATION CENTER REAL EACH DEPTRICES OF MEST REPRECIDED BY FULL TAG REGILATORY OR IS IDENTIFIVEN NURSINGMAND (A) IDENTIFICATION STREET PROCEDURE BY FULL TAG REGILATORY OR IS IDENTIFIVEN NURSINGMAND (B) The facility must post the nurse staffing data specified in paragraph (g/ft) 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/4) Facility must will, 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 aniatian the posted daily nurse staffing data available on the public for review at a cost not to exceed the community standard. \$483.35(g/4) Facility data retention requirements. The facility must paster. 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 sheet had the actual hours worked by 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 unificensed in licensed and unificensed in licensed and unificensed in licensed and unificensed in licensed in license	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
BLOOMINGTON NURSING AND REHABILITATION CENTER BLOOMINGTON NURSING AND REHABILITATION CENTER (AACH DEPICIENCY MUST BE PRECEDED BY PULL TAG: RECILIATORY OF IXE INDIREPTIVES MINORMATION S483.35(9)(2) Posting requirements. (i) The facility must boots 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 filled to ensure the daily posted murse staffing shect had the actual hours worked by staff for 4 days of daily pested murse staffing reviewed. Findings include: During an observation on 11/13/23 at 11:39 a.m., the daily posted mursing 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 mursing staff sheet lacked the daily posted mursing staff sheet lacked were reviewed. The Administrator indicated the daily posted on the importance of daily staffing information being of daily staffing information being	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
BLOOMINGTON NURSING AND REHABILITATION CENTER IXA ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG S483.35(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)(2) Public access to posted 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 reviewed. Findings include: During an observation on 11/13/23 at 11:39 a.m., the daily posted mursing staff sheet lacked the the actual hours saff worked. During an interview on 11/16/23 at 3:57 p.m., the Administrator provided the daily posted dursing staff sheet sked dily posted dursing staff sheet sked by dupset dursing staff sheet sked by dupset dursing staff sheets were reviewed. The Administrator indicated the daily posted mursing staff sheets deed of 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 sheets were reviewed. The Administrator indicated the daily posted nursing staff sheets deed of the daily posted of the provided the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted on the daily posted on the daily posted nursing staff sheets deed of the daily posted on the			155532	B. WING 11/16/2023			2023	
PREFIX TAG RECULATORY OR ISC IDENTIFYING INFORMATION TAG SASSASS(QIC) 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 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 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 sheet lacked the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheet lacked the daily posted nu					120 E M	IILLER DR		
TAG REGULATORY OR LSC IDENTETRINO INFORMATION \$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 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. 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 2:57 p.m., the Administrator provided the daily posted nursing staff sheet lacked the daily posted nursing staff sheet lacked the daily posted nursing staff sheet work of the facility were immediately modified to include the required information for each daily posted nursing staff sheets lacked the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheet lacked the daily p	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
### RECOLLATORY OR INCE IDENTIFYING INFORMATION \$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 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. Enindings 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 were reviewed. The Administrator indicated the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheets decked the daily posted nursing staff sheets decked the daily posted nursing staff sheets decked the daily posted nursing staff sheet lacked to include the required information of each daily posted nursing staff sheet lacked to include the required information of each daily posted nursing staff sheet lacked to include the required information of each daily posted nursing staff sheet lacked to include the required information being the actual hours worked? DIT in-serviced on the importance of daily staffing information being the actual hours worked? DIT in-serviced on the importance of daily staffing informatio	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
(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 reviewed. Based on observation on 11/13/23 at 11:39 a.m., the daily posted nursing staff sheet lacked the the actual hours worked. 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 were reviewed. The Administrator indicated the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheets were reviewed. The Administrator indicated the daily posted nursing staff sheets acked to the importance of daily staffing information being	TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		§483.35(g)(2) Pose (i) The facility must data specified in proceed on a daily each shift. (ii) Data must be proceed (B) In a prominent residents and visit §483.35(g)(3) Pubstaffing data. The written request, may available to the public exceed the composite of the public exceeds the composite of the public exceeds the composite of the public exceeds	sting requirements. It post the nurse staffing paragraph (g)(1) of this basis at the beginning of posted as follows: It place readily accessible to toors. It place readily a	F 07	732	The facility must post the following information on a daily basis: Facility name, current date, total number, at the actual hours worked by t following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The staffing sheets for the faci were immediately modified to include the required informatic each day including the "actual hours worked". IDT in-serviced on the importat of daily staffing information be	lity on for	12/08/2023

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Event ID: QLC911 Facility ID: 000460

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/07/2023 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			0	MB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 11/16/2023	
	ROVIDER OR SUPPLIEF	AND REHABILITATION CENTE	12	REET ADDRESS, CITY, STATE, ZIP C 10 E MILLER DR LOOMINGTON, IN 47401	COD		
(X4) ID PREFIX	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREI	PROVIDER'S PLAN OF COR FIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION	
TAG	staff.	R LSC IDENTIFYING INFORMATION	TA	information, and readil Admin, DON, ADON/M in-serviced on the impudaily staffing information, and readil An audit of daily staffir will be done by Admin months to ensure the fineeting the requirement posted information. An will be addressed as divided any patterns are identification plan will be writt monthly QAPI meeting QAPI committee. Any action plan will be more the Admin and/or Desimonthly until resolved substantial compliance achieved. Completion Date 12/8/	AIDS ortance of on being t ly available. ng sheets . daily x6 facility is ents of ny concerns liscovered. If iffed, an ten at the g by the written nitored by ignee and e is	DATE	
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unned Each resident's dr from unnecessary drug is any drug v §483.45(d)(1) In eduplicate drug the	excessive dose (including erapy); or					
	l §483.45(d)(2) For	excessive duration: or					

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§483.45(d)(3) Without adequate monitoring;

§483.45(d)(4) Without adequate indications

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Facility ID: 000460

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Cl	ENTERS FOR	MEDICARE & MEDIC				OMB NO. 0938-039	
		T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155532	A. BUILDING B. WING	00	COMPLETED	
			199992	<u> </u>		11/16/2023	
	NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD		
	DI OOMII	NOTON NUIDOINO	AND DELIABILITATION CENTER		MILLER DR		
BLOOMINGTON NURSING AND REHABILITATION CENTE				BLOOM	MINGTON, IN 47401		
	(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
	PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
	TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		for its use; or					
		8483 45(d)(5) In t	he presence of adverse				
		- , , , ,	nich indicate the dose				
		•	d or discontinued; or				
			a e. a.e.eaea, e.				
		§483.45(d)(6) Any	combinations of the				
		reasons stated in	paragraphs (d)(1) through				
		(5) of this section.					
			and record review, the facility	F 0757	F757	12/08/2023	
			resident with a new medication		Each residents drug regimen		
		order for 1 of 5 resi			must be free from unnecessa	ry	
			ations. Blood sugars were not		drugs.		
		obtained.(Resident	11)		R 11's drug regimen was		
		F' 1' ' 1 1			immediately reviewed to ensur	e	
		Findings include:			there were no longer any		
		On 11/16/23 at 10:3	36 a.m., Resident 11's clinical		unnecessary drugs.	l to	
			ed. The diagnoses included, but		All residents have the potential be affected by this finding.	110	
			, diabetes mellitus and		R 11's MAR's lacked		
			ease with left hemiplegia		documentation of blood sugars		
			sis on one side of the body).		R 11's diabetes mellitus care p		
			•		lacked any monitoring of blood		
		The diabetes mellit	us care plan, dated 8/23/22,		sugar as interventions.		
		lacked any monitor	ing of blood sugar as		All nursing staff in-serviced on	the	
		interventions.			importance of documentation a	as	
					well as refusals.		
		_	ers included, but were not		DON, ADON/MDS in-serviced		
		limited to:			the importance of documentation	on	
			morning and every bedtime		as well as refusals, and on		
			sician if blood sugar less than		interventions being added for		
		_	500 (start date 10/3/23).		resident's care plans when not		
		·	medication used to treat inject 10 units, in the evening		being followed by resident. An audit of all drug regimens h	20	
		(start date 10/3/23).			been conducted to review for	as	
		(start date 10/3/23).	•		accuracy. DON and/or Designe	26	
		The October 2023 !	Medication Administration		will audit 3 residents weekly x6		
			umentation of blood sugars.		months. Any concerns will be		
		110001a laonea doct	and the second sugars.		addressed as discovered. If an	v	
				i	I man occor as allocatorea. If all	· J	

The November 2023 Medication Administration

patterns are identified, an action

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CENTERS FOR	R MEDICARE & MEDIC.		_		OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155532	B. WING		11/16/2023
	PROVIDER OR SUPPLIER	I : AND REHABILITATION CENTER	120 E	T ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Record lacked docu On 11/16/23 at 4:10 Nursing indicated the documentation of bital Administration Record On 11/16/23 at 6:06 provided the facility Protocol," revised downs the policy being review of the policy will order appropriate periodic finger stick based on these result receiving insulin which blood glucose levels 3.1-48(a)(3)	p.m., the Assistant Director of the clinical record lacked lood sugars on the Medication		plan will be written at the mon QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee montl until resolved and substantial compliance is achieved. Completion Date 12/8/2023	thly
F 0807 SS=E Bldg. 00	§483.60(d) Food a Each resident reco provides- §483.60(d)(6) Drir other liquids consi and preferences a resident hydration	eives and the facility nks, including water and stent with resident needs and sufficient to maintain	F 0807	F807	12/08/2023
	review, the facility provided with fresh out of 5 residents re	on, interview and record failed to ensure residents were water on a routine basis for 5 eviewed for hydration. dent 25, Resident 22, Resident	F 0807	The facility ensures that they provide, and each resident receives drinks, including water and other liquids consistent with resident nee and preferences sufficient to maintain resident hydration. R 25, 13, 22, 29 and 23 were	ds)

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1. During an interview on 11/13/23 at 11:33 a.m.,

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If continuation sheet

passed fresh Ice Water as well as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155532	B. W	ING		11/16/	2023
N. 1	NOVEMBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	K			MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER		BLOOM	MINGTON, IN 47401		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		ated she was not getting			the remainder of residents who)	
	_	cause the facility did not pass sobserved to be at the			may be affected by this		
	residents bedside du				deficiency. All residents have the potentia	l to	
	residents bedside di	aring that time.			be affected by this finding.	110	
	During an observati	ion on 11/14/23 at 1:59 p.m.,			All staff in-serviced on the		
		bserved to be lying in her bed			importance of hydration and		
		gray pitcher with a straw			passing Ice Water on all shifts		
		ck dresser that was undated			DON and/or Designee will aud		
	and 3/4 full of warn	n water with no ice.			Ice Water Pass Each Shift on		
					working days, Days and Night	s to	
	_	v on 11/14/23 at 3:16 p.m.,			ensure residents are receiving		
		ated she had not known there			proper hydration. This audit w		
		tcher on the dresser next to the			be completed Daily Each Shift	x 6	
		have only noticed it if it had			Months. Any concerns will be		
	been on the bedside	e table.			addressed as discovered. If ar	-	
	.	11/15/22 + 0.45			patterns are identified, an action		
	1	ion on 11/15/23 at 9:45 a.m.,			plan will be written at the mon	inly	
		ut of the room attending PT			QAPI meeting by the QAPI		
		There was a gray pitcher with the bedside table that was			committee. Any written action		
		of warm water with no ice.			plan will be monitored by the Admin and/or Designee month	dv	
	undated and 1/4 fur	i oi waim water with no icc.			until resolved and substantial	пу	
	During an observati	ion on 11/15/23 at 11:38 a.m.,			compliance is achieved.		
	1	ut sitting in her room in a			Completion Date 12/8/2023		
		vas a gray pitcher with a straw			Sempledien Bate 12,6,2020		
		Iside table that was undated					
		water. The resident indicated at					
		was the first day she had seen					
	the facility pass was	-					
	During on absor	ion on 11/16/22 at 0:40 a					
		ion on 11/16/23 at 9:40 a.m.,					
		ut of the room sitting at the rwheelchair. There was a gray					
		observed on the bedside table					
	_	ad 3/4 full of warm water with					
	no ice.	a Si i full of warm water with					
	110 100.						
	Resident 133's clini	cal record was reviewed on					
	11/16/23 at 11:38 a	.m. The diagnoses included, but	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155532	B. W	ING		11/16/2023		
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R			MILLER DR			
	NGTON NURSING	AND REHABILITATION CENTER			MINGTON, IN 47401			
		, and the model in the control of th		DECON			•	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		, type II diabetes mellitus and						
	hypertension.							
	7E1 A 1 ' ' NA'	· D · C · (MDC)						
		nimum Data Set (MDS)						
		1/14/23, was still in progress						
	and had not assessed Resident 133's cognitively status at that time.							
	status at that time.							
	2 During an intervi	iew on 11/13/23 at 12:27 p.m.,						
	Resident 25 indicated she was not getting enough							
		e facility did not pass water.						
		rved to be at the residents						
	bedside during that time.							
	During an observati	ion on 11/14/23 at 1:56 p.m.,						
	_	oserved to be out of her room.						
	No water was obser	rved to be at the bedside.						
	During an observat	ion on 11/16/23 at 9:44 a.m.,						
	Resident 25 was ob	served to be asleep in bed. No						
	water was observed	I to be at the bedside.						
	_	ion on 11/15/23 at 11:39 a.m.,						
		oserved to be out of her room.						
	No water was obsei	rved to be at the bedside.						
	Daning 1	:						
	_ ~	ion on 11/15/23 at 2:51 p.m.,						
		served to be out of her room.						
		itcher with a straw observed on at was undated and 3/4 full of						
	warm water with no							
	waim water with he							
	During an observat	ion on 11/16/23 at 10:39 a.m.,						
		eserved to be lying in bed						
		ar cup of water 3/4 full used for						
	_	rved at bedside however, no						
	water pitcher with i							
	Resident 25's clinic	cal record was reviewed on						
		.m. The diagnoses included, but						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155532	B. W	NG		11/16/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER	:		IINGTON, IN 47401		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID			(V.5)
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		, hemiplegia and hemiparesis		IAG			DATE
		natic intracerebral hemorrhage					
		nant side and hypertension.					
	arrecting left domin	iant side and hypertension.					
	The Quarterly Mini	imum Data Set (MDS)					
		3/21/23, indicated Resident 25					
		act. 3. On 11/13/23 at 3:07 p.m.,					
		ed he only gets ice water if he					
		t time, Resident 22 had a clear					
	medication glass at	beside which was almost					
	empty.						
	O 11/14/02 + 2.04 B : 1 + 22						
	On 11/14/23 at 3:04 p.m., Resident 22 was						
	observed to have a clear medication cup on his						
	bedside table which	n was half full.					
	On 11/15/23 at 9:15	8 a.m., Resident 22 was					
		clear medication glass on his					
		was one quarter full.					
	bedside table willer	i was one quarter run.					
	On 11/16/23 at 11:0	06 a.m., Resident 22's clinical					
	record was reviewe	ed. The diagnoses included, but					
	were not limited to,	, dementia and muscle					
	weakness.						
	1 -	re plan, dated 5/8/23, indicated					
		courage good fluid intake with					
	dietary parameters.						
	4 During an observ	vation on 11/13/23 at 2:56 p.m.,					
		ot observed to have a water					
	pitcher at bedside.	to observed to have a water					
	phonor at bouside.						
	During an observat	ion on 11/15/23 at 9:49 a.m.,					
		served to have a clear water					
	glass at bedside wh	ich was one quarter full. A					
		ot observed to be at bedside.					
		5 a.m., Resident 23's clinical					
	record was reviewe	d. The diagnoses included, but					I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QLC911 Facility ID: 000460

If continuation sheet Page 15 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		120 E M	DDRESS, CITY, STATE, ZIP COD IILLER DR INGTON, 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)	SHOULD BE COMPLETIC APPROPRIATE	
IAU		cognitive impairment and		TAG			DATE
	The dehydration care plan, dated 10/25/23, indicated the staff were to encourage good fluid intake with dietary parameters.						
	Resident 29 indicat	vation on 11/13/23 at 11:31 a.m., ed he would only get ice water t that time, Resident 29 did not r at bedside.					
	Resident 29 was ob	ion on 11/14/23 at 9:11 a.m., served to have a clear bedside, but no water pitcher at bedside.					
	record was reviewe	20 p.m., Resident 29's clinical d. The diagnoses included, but diabetes mellitus and muscle					
		re plan, dated 4/27/23, were to encourage good fluid parameters.					
	at 2:16 p.m., the Re	t Council Meeting on 11/14/23 esident Council President get fresh ice or water if they					
	Certified Nursing A some days they do complete all their re	v on 11/16/23 at 3:10 p.m., assistant (CNA) 1 indicated not have enough time to equired task. Some of the tasks was ice pass. The ice pass of the list".					
		6 p.m., the Administrator y's policy, "Resident Rights,"					

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Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155532	A. BU B. WI		00	COMPL 11/16	
		100002	Б. 111			11/10/	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER			MINGTON, IN 47401		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	revised date of 12/2 policy being used b policy indicated, "	2016, and indicated it was the sy the facility. A review of theFederal and state laws asic rights to all residentsa. a					
F 0812 SS=F Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.					
	approved or consifederal, state or lot (i) This may included directly from local applicable State a regulations. (ii) This provision facilities from usin gardens, subject trapplicable safe gractices. (iii) This provision	de food items obtained producers, subject to					
	serve food in according standards for food Based on observation review, the facility stored and served in kitchen observation did not have hot was dirty, items in the standard serve for the serve food in according to the serve f	ore, prepare, distribute and ordance with professional diservice safety. on, interview, and record failed to ensure food was a a sanitary manner for 3 of 3 as. The hand washing station atter, the air conditioning unit the refrigerator and freezer were chemical strips used for the 3	F 08	312	F812 The facility will ensure we store, prepare, and distribute and serve food in accordance with professional standards food service safety. Heflin Industries came in on 1	e for	12/08/2023

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Event ID:

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STATEMENT OF DEFICIENCIES X13		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155532	B. WI	ING		11/16	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
BI OOMII	NCTON NUIDSING	AND REHABILITATION CENTER			MINGTON, IN 47401		
BLOOMII	DNIICHUN NUCSING	AND REHABILITATION CENTER		BLOOK			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	vere expired. This had the			to repair Hot Water Boiler and		
		30 of 30 residents residing in			Valve, allowing hot water temp	os to	
	the facility.				return back to required		
					temperatures.		
	Findings include:				The Maintenance Director		
					immediately cleaned the A/C เ		
	-	tour of the facility kitchen on			in the kitchen as well as tubing	•	
	11/13/23 at 10:15 a.m., the following was observed:				and vent slabs. Both Maint. ar		
					DM in-serviced on the importa	ince	
		he handwashing sink would			of this.		
		etary Manager (DM) indicated			The Dietary Manager immedia	-	
		ne 3 compartment sink because			audited the kitchen and fixed a		
	the water from that	pipe would get hot.			deficiencies from undated and		
					expired labeled food, drinks, a	ınd	
	_	I the wall air conditioning			chemicals, test strips.		
		with dust and debris and the			All Dietary staff were in-service		
		erved to be dirty with a dark			on the importance of food stor	age	
	black substance.				and labeling and dating food.		
					Dietary Manager in-serviced b	-	
		bserved to have 5 packages of			Admin. on importance of prope	er	
		ere unlabeled. The DM			storage and labeling.		
	indicated at that tim	ne they were hamburger.			All residents have the potentia	ıl to	
					be affected by this finding.		
		as observed to have a pitcher			Dietary Manager and/or Desig		
		llon of tea that that was almost			will audit food storage and lab	_	
	-	f milk that was almost gone			2x a Week x6 months at Weel	K	
	-	by date. The DM indicated at			Begin and Week End. Maint.		
		uid had just been made this			Director will audit hot water ter	•	
	_	and milk would be gone by			(hand washing sink) weekly x6	3	
	noon today.				months to ensure temps stay		
	.	t to a late t			consistent to regs. Any concer		
		ap visit to the kitchen on			will be addressed as discovered		
	11/16/23 at 11:30 a	.m., the following was observed:			any patterns are identified, an		
	TEN 1				action plan will be written at th	ie	
		he handwashing sink would			monthly QAPI meeting by the		
	not get hot.				QAPI committee. Any written		
	m · · · ·	ra no esta e			action plan will be monitored b	у	
		I the wall air conditioning unit			the Admin and/or Designee		
	-	and debris and the vent slabs			monthly until resolved and		
	L were observed to be	dirty with a dark black	ı		cubetantial compliance is		1

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/16/2023
	F PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER	120 E	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	substance. - The freezer was o frozen meats that w	bserved to have 5 packages of vere unlabeled.		achieved. Completion Date 12/8/2023	
	_	vas observed to have 2 ge cheese bowls undated.			
	- The chemical strip compartment sink h	os used to test the 3 nad expired on 4/24/13.			
	DM indicated the A washing sink would test strips were exp	y on 11/16/23 at 11:31 a.m., the A/C unit was dirty, the hand of not produce hot water, the ired, the cottage cheese bowls day and the hamburger in the ed.			
	_	up visit to the kitchen on m., the following was observed:			
	a thermometer to be indicated at that tin	sink hot water measured with e 70.5 degrees. Cook 1 he the hot water had never to They had reported it but it ad.			
	Administrator indic	ov on 11/16/23 at 3:45 p.m., the stated they have had the main and they were still working on in the facility.			
	provided the facility with a revised date it was the policy cut facility. A review of	of p.m., the Administrator y policy titled, "Sanitization" of October 2008, and indicated rrently being used by the f the policy indicated, " n and Implementation 2. All be kept clean"			

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Event ID:

QLC911

Facility ID: 000460

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 B. WING			COMPLETED	
		155532	B. W	ING		11/16	/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	₹	120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR IINGTON, IN 47401			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	D BE COMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE	
	On 11/26/23 at 6:06	p.m., the Administrator						
	provided the facility	y policy titled, "Food						
	_	age" with a revised date of July						
		it was the policy currently						
		acility. A review of the policy						
	indicated, " Policy	-						
		7. All foods stored in the						
		er will be covered, labeled and						
	dated [use by date]	···						
	A review of the abo	ove policies did not indicated						
		the hand washing sink and						
	the expired chemica							
	•	•						
	On 11/20/23 at 1:00	p.m., a review of the Indiana						
	_	f Health Retail Food						
		tation Requirements manual,						
		mber 13, 2004 indicated, "410						
		vashing:Sec. 128 a. Food						
		clean their hands and exposed						
	1 -	ns at a hand washing sink						
	1	emperature of at least one						
		ees Fahrenheit and thoroughly vater Food Labels: Sec. 146.						
	_	n a retail food establishment						
		specified in law b. Label						
		iclude the following: 1. The						
		ne food or, absent a common						
		y descriptive identity						
	statement"							
	3.1-21(i)(2)							
	3.1-21(i)(3)							
F 0851	492 70(a)(4) (F)							
SS=F	483.70(q)(1)-(5) Payroll Based Jou	ırnal						
Bldg. 00		atory submission of staffing						
D.49. 00	\ '.'	on payroll data in a uniform						
	format.	on payron data in a dimonii						
		cilities must electronically						

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Event ID:

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

PRINTED: 12/07/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	JILDING	nstruction 00	(X3) DATE COMPL 11/16/	ETED
	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	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)	TE	(X5) COMPLETION DATE
	care staffing inform for agency and copayroll and other vin a uniform formal specifications established by the care Staff at through interpersor or resident care mand services to all maintain the higher mental, and psychicare staff does no primary duty is man environment of the example, houseked \$483.70(q)(2) Subtraction of the example of the exampl	ect Care Staff. are those individuals who, onal contact with residents nanagement, provide care low residents to attain or est practicable physical, nosocial well-being. Direct of include individuals whose aintaining the physical e long term care facility (for eeping). Direct of include individuals whose aintaining the physical elong term care facility (for eeping). Direct of include individuals whose aintaining the physical elong term care facility (for eeping). Direct of include individuals whose aintaining the physical elong term care facility (for eeping). Direct of include individuals whose aintaining the physical electronically submit to ad accurate direct care on, including the following: f work for each person on including, but not limited to, dual is a registered nurse, nurse, licensed vocational ursing assistant, therapist, edical personnel as Direct care staff turnover in the hours of care provided of staff per resident per day at limited to, start date, end te), and hours worked for				

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Event ID:

QLC911 Facility ID: 000460

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/16/2023 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0851 F851 12/08/2023 failed to electronically submit to the Centers for Mandatory submission of Medicare and Medicaid (CMS) complete and staffing information based on accurate direct care staffing information, including payroll data in a uniform information for agency and contract staff, based format to CMS. on payroll and other verifiable and auditable data All staff in-serviced on the in a uniform format according to specifications importance of using OnShift established by CMS for Quarter 3 (April 1 to June including Dep. Heads uploading 30) of fiscal year 2023. their schedules each month. Admin, DON, ADON/MDS Findings include: in-serviced on submitting payroll based staffing information to CMS On 11/13/23 at 11:30 a.m., the facility's Payroll by RDO. Based Journal (PBJ) Staffing Data Report was All residents have the potential to reviewed. The report indicated the facility had no be affected by this finding. RN Hours for 4/2/23, 4/9/23, 5/7/23, 5/21/23, 6/4/23, IDT in-serviced on the importance and 6/18/23. The report further indicated the of RN coverage. facility failed to have Licensed Nursing Coverage Admin, DON, ADON/MDS 24 hours per day on 4/2/23, 4/4/23, 4/8/23, 4/14/23, in-serviced on the importance of 4/15/23, 4/16/23, 4/21/23, 4/22/23, 4/30/23, 5/2/23, RN coverage by RDO. 5/6/23, 5/7/23, 5/8/23, 5/10/23, 5/11/23, 5/12/23, **Exempt Nursing employees** 5/14/23, 5/15/23, 5/16/23, 5/20/23, 5/21/23, 5/22/23, in-serviced on the importance of 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, 6/3/23, completing a time sheet to turn in 6/4/23, 6/5/23, 6/8/23, 6/10/23, 6/11/23, 6/18/23, to Payroll clerk when the schedule

FORM CMS-2567(02-99) Previous Versions Obsolete

6/19/23, 6/22/23, 6/23/23, 6/24/23, 6/25/23, 6/26/23.

Event ID:

QLC911

Facility ID: 000460

If continuation sheet

has been altered from Monday -

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/16/2023 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Lastly, the facility received a 1 star staffing rating Friday (null punch). This will during the third quarter. enable the actual time to be captured to ensure licensed staff On 11/15/23 at 11:46 a.m., a review of the third are documented for 24 hours per quarter staffing schedules indicated the facility dav. had no RN hours on 4/2/23, 4/9/23, 5/7/23, and Facility continues to recruit and 6/24/23. An additional review of the last thirty hire staff to assist with staffing days of schedules indicated there were no RN needs. hours for 10/21/23 and 10/22/23. Facility continues to raise star rating by ensuring RN coverage is During an interview on 11/16/23 at 12:00 p.m. the being followed. Administrator (ADM) indicated staff was late An audit of RN coverage will be updating the schedule into a program accessible done by ADON/MDS (staffing) by computer and thought that may be why the daily x6 months to ensure the PBJ report triggered so many days. She was facility is meeting the unsure, but thought the staff included agency requirements of RN coverage. staff into the PBJ numbers. Admin will verify upon doing daily staffing sheet audit. An audit will During an interview on 11/16/23 at 4:38 p.m., the be conducted to ensure the ADM indicated during the third quarter of 2023, licensed nursing hours have been corporate staff was responsible for inputting the captured and will continue to audit PBJ data to CMS. They had performed a schedule going forward weekly x6 months, audit and are trying to hire a RN. to make sure the hours have been documented for all nursing staff. On 11/16/23 at 6:07 p.m., the ADM provided the Any concerns will be addressed facility policy, "Reporting Direct-Care Staffing as discovered. If any patterns are Information (Payroll-Based Journal)," revised July, identified, an action plan will be 2006, and indicated it was the policy currently written at the monthly QAPI being used. A review of the policy indicated, "... 2. meeting by the QAPI committee. Direct-care staffing information will include those Any written action plan will be hired through an agency, and contract employees monitored by the Admin and/or ... 9. Staffing information will be collected daily Designee monthly until resolved and reported for each fiscal quarter no later than and substantial compliance is 45 days after the end of the reporting quarter ... achieved. Fiscal Quarter 3 ... Date Range April 1 - June 30 ... Completion Date 12/8/2023 Submission Deadline August 14 ..." F 0921 483.90(i)

FORM CMS-2567(02-99) Previous Versions Obsolete

SS=E

Bldg. 00

Event ID:

Safe/Functional/Sanitary/Comfortable Environ

§483.90(i) Other Environmental Conditions

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/16/2023 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 F 0921 F921 12/08/2023 failed to ensure a clean and sanitary environment The facility must provide a for 6 of 11 resident rooms and 4 of 4 bathrooms safe, functional, sanitary, and observed. Water temperatures in resident room comfortable environment for sink faucets were not hot, floor tiles were not in residents, staff, and the public. place and clean, and toilet bases were not clean. Rms 5, 6, 7, 9, 11, and 12 were all (Room 5, Room 7, Room 9, Room 11, Room 12, deep cleaned and added to the list Room 6, Northeast Bathroom, Northwest to review flooring upon our Maint. Bathroom, Southeast Bathroom, Southwest Director continuing with replacing Bathroom) floors as facility has been doing. Facility will maintain replacing one Findings include: resident room floor a month as able until all effected areas have 1. On the following dates and times, the hot water been replaced and/or repaired. temperature for each resident room sink faucet Progress and other room needs to was measured for a period of 3 minutes, with the be monitored by Admin. Projected temperature results documented: completion date May 2024. Heflin Industries came in on 11/28 - On 11/16/23 from 11:00 A.M. to 11:03 A.M.. to repair Hot Water Boiler and Room 5's hot water temperature was 77.1 degrees Valve, allowing hot water temps to Fahrenheit. return back to required temperatures in effected areas. South East, South West, North - On 11/16/23 from 11:06 A.M. to 11:09 A.M., Room 7's hot water temperature was 64.8 degrees East, and North West bathrooms Fahrenheit. were sealed, cleaned and caulked around the toilets and bases as - On 11/16/23 from 11:12 A.M. to 11:15 A.M., well as the wall floor joints. Room 9's hot water temperature was 76.2 degrees All residents have the potential to Fahrenheit. be affected by these findings. Maint. Director will audit hot water 2. On 11/15/23 between 11:15 A.M. and 11:45 temps (including hand washing A.M., the following resident rooms were observed sink in kitchen) weekly x6 months to have floor covering of vinyl planks which were to ensure temps stay consistent loose, missing, and with black and brown to regs. Any concerns will be substances in the spaces between the planks: addressed as discovered. If any Room 9, Room 11, Room 12, Room 6, and Room 7. patterns are identified, an action

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Event ID:

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If continuation sheet

plan will be written at the monthly

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

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155532	B. WI	NG		11/16/2023	
BLOOMII	 I	AND REHABILITATION CENTER		120 E M BLOOM	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	•	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	resident bathroom with a dark brown of base as well as brown floor joints. 4. On 11/15/23 at 1 resident bathroom with a dark brown of base. 5. On 11/15/23 at 1 resident bathroom with a dark brown of base. 6. On 11/15/23 at 1 resident bathroom with a dark brown of base. During an interview Maintenance Direct boiler which went to need of repair in order proper temperature, staying in place and and between the sea	1:50 A.M., the southeast was observed to have a toilet colored substance around the wn staining along the wall to 1:53 A.M., the northeast was observed to have a toilet colored substance around the 1:56 A.M., the southwest was observed to have a toilet colored substance around the 1:58 A.M., the northwest was observed to have a toilet colored substance around the 1:58 A.M., the northwest was observed to have a toilet colored substance around the 1:59 A.M., the northwest was observed to have a toilet colored substance around the 1:59 A.M., the northwest was observed to have a toilet colored substance around the 1:59 A.M., the northwest was observed to have a toilet colored substance around the 1:59 A.M., the northwest was observed to have a toilet colored substance around the 1:50 A.M., the southwest was observed to have a toilet colored substance around the 1:50 A.M., the northwest was observed to have a toilet colored substance around the 1:50 A.M., the southwest was observed to have a toilet colored substance around the 1:50 A.M., the northwest was observed to have a toilet colored substance around the 1:50 A.M., the northwest was observed to have a toilet colored substance around the 1:50 A.M., the northwest was observed to have a toilet colored substance around the			QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee month until resolved and substantial compliance is achieved. Completion Date 12/8/2023	nly	
	3.1-19(f)						

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