CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155532	B. WING		12/18/2023
		100002	<u> </u>		12/10/2020
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTE	120 E I	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
			I	1	
(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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the In accordance with 42 Survey Date: 12/18 Facility Number: 0 Provider Number: 1002 At this Emergency I Bloomington Nursin was found not in co Preparedness Requi Medicaid Participat CFR 483.73 The facility has a care	2723 00460 155532 290620 Preparedness survey, ng and Rehabilitation Center mpliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 upacity of 38 certified beds and at the time of this visit.	E 0000	1 K000 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 of any proceedings and submit to the regulatory obligations. The fact requests the Plan of Correction considered our allegation of compliance effective January 2024 for the Annual Life Safet Code Recertification and State Licensure Emergency Preparedness Survey.	. We e of hese cility on be 6th,
E 0037 SS=F Bldg	441.184(d)(1), 482 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 497 EP Training Progr. §403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §48 §485.68(d)(1), §4 (1), §485.920(d)(1) §491.12(d)(1).	am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)			

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

TITLE (X6) DATE

Faith Arvin Administrator 01/08/2024

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	r í	UILDING	NSTRUCTION 	CON	TE SURVEY MPLETED 18/2023	
	E OF PROVIDER OR SUPPLIE	ER B AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401					
(X4) PREI	IX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION	
TA	HHAs at §484.10 §485.727, OPOs at §491.12:] (1) Training prog all of the followin (i) Initial training policies and proc existing staff, ind under arrangeme consistent with the (ii) Provide emerat least every 2 y (iii) Maintain doc preparedness training policies and procedures are facility] must con updated policies *[For Hospices and procedures are facility] must con updated policies *[For Hospices and procedures are facility] must concent with the hospice must (i) Initial training policies and procedures and procedures are providing services consistent with the (ii) Demonstrate emergency procedures are least every 2 y (iv) Periodically remergency preparently procedures are must be procedures and others.	in emergency preparedness redures to all new and dividuals providing services rent, and volunteers, heir expected roles. gency preparedness training rears. umentation of all emergency redures. Incy preparedness policies rear significantly updated, the reduct training on the reduct training or the reduct training or the reduct training or the reduct training reducts to all new and remain employees, and individuals resunder arrangement, heir expected roles. Staff knowledge of reduces. In the reduct training reducts to all new and replayers training rears. In the reduction of the reduction of the reducts training rears. In the reduction of the reduction of all emergency or reduction of all emer		TAG			DATE	

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Event ID:

QLC921 Facility ID: 000460

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532		UILDING	NSTRUCTION	COM	E SURVEY PLETED 8/2023
	PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER	₹	120 E N	DDRESS, CITY, STATE, ZIP CO IILLER DR IINGTON, IN 47401	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ECTION OULD BE PROPRIATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and procedures a	ncy preparedness policies re significantly updated, the duct training on the and					
	-	141.184(d):] (1) Training TF must do all of the					
	(i) Initial training in policies and proce existing staff, indirunder arrangement consistent with the (ii) After initial train preparedness train (iii) Demonstrate semergency proce	n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ning, provide emergency ning every 2 years. staff knowledge of dures.					
	preparedness trai (v) If the emergen and procedures a	ning. acy preparedness policies re significantly updated, the act training on the updated					
	organization musi (i) Initial training in policies and proce existing staff, indi- services under an	60.84(d):] (1) The PACE to do all of the following: in emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with es.					
	at least every 2 ye (iii) Demonstrate s emergency proce participants of wh whom to contact i	ency preparedness training ears. staff knowledge of dures, including informing at to do, where to go, and n case of an emergency. Imentation of all training.					

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Event ID:

QLC921 Facility ID: 000460

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 12/18/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTE	120 E N	ADDRESS, CITY, STATE, ZIP C MILLER DR MINGTON, IN 47401	OD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		(X5) COMPLETION
TAG	(v) If the emerger and procedures a PACE must condition policies and procedures and procedures and procedures and procedures and procedure and program of the following: (i) Initial training in policies and procedure arrangement consistent with the (ii) Provide emergency at least annually. (iii) Maintain docupreparedness trait (iv) Demonstrate emergency procedure and existing services under and existing services under and consistent with the (ii) Provide emergency procedure) Provide emergency at least every 2 yes (iii) Maintain document (iv) Demonstrate emergency procedure emergency procedure the provided responsibilities respon	es at §483.73(d):] (1) The LTC facility must do all emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected role. ency preparedness training mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The l of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. lency preparedness training	TAG	DEFICIENCY		DATE
	equipment.		1			

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(v) If the emergency preparedness policies

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532		ILDING	NSTRUCTION	(X3) DATE COMPL 12/18/	ETED
	PROVIDER OR SUPPLIEI NGTON NURSING	AND REHABILITATION CENTER	?	120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	re significantly updated, the uct training on the updated edures.					
	*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:						
	.,	n emergency preparedness edures, including prompt nguishing of fires,					
	protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and						
		viduals providing services					
	_	nt, and volunteers, eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
	, ,	mentation of the training.					
	` '	staff knowledge of					
	emergency proce						
	` '	ncy preparedness policies re significantly updated, the					
		ct training on the updated					
	policies and proce	_					
	*[For CMHCs at §	485.920(d):] (1) Training.					
		provide initial training in					
	emergency prepa	redness policies and					
	•	new and existing staff,					
		ng services under					
	-	volunteers, consistent with					
	their expected role	es, and maintain the training. The CMHC					
		staff knowledge of					
		dures. Thereafter, the					
	CMHC must provi						
		ning at least every 2 years.					
		view and interview, the facility	E 00)37	E037		01/06/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/18/2023		
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
E 0039	failed to conduct an Emergency Prepare LTC facility must d training in emergency procedures to all ne individuals providir and volunteers, controles; (ii) Provide entraining at least ann documentation of all training; (iv) Demonstrate procedures all residents in the findings include: Based on review of plan on 12/18/23 be with the Administration of annual emergency no documentation to demonstrate knowled preparedness plan won an interview at the Administrator stated policies when drills there was no documentation to sk knowledge of the enwas available for read the annual emergency procedures and Maintenance D conference.	nual training for the dness Program (EPP). The o all of the following: (i) Initial cy preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain all emergency preparedness instrate staff knowledge of res in accordance with 42 CFR deficient practice could affect facility. the emergency preparedness artween 10:35 a.m. and 12:45 p.m. and preparedness training and on show staff could edge of the emergency was available for review. Based the time of record review, the did that staff review individual are conducted, and confirmed the are to determine the area of the emergency raining, as well as no now staff could demonstrate mergency preparedness plan view. Viewed with the Administrator irrector during the exit		TAG	The facility ensures the training for Emergency Preparedness completed at least annually and documentation is maintained. Maintenance Director in service on the importance of Emergent Preparedness and the importation of maintaining documentation. All staff in serviced on the emergency preparedness bind as well as their locations. All residents have the potential be affected by this finding. All staff have been trained on emergency preparedness and training documented, including demonstration from staff, show their understanding of the EP training. Maintenance Director will audit monthly x6 months to ensure the facility is in compliance with the EP Training Program and documentation. Any concerns be addressed as discovered. It patterns are identified, an action plan will be written at the month 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 1/6/2024	eed acy ince ler l to a wing the e will fany on the chily	DATE
E 0039 SS=F Bldg	441.184(d)(2), 482	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2),					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /		ONSTRUCTION	(X3) DATE SURVEY	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155532	B. W	ING		12/18/	2023
	F PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
IAU	485.68(d)(2), 485.486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4 §485.625(d)(2), §4 OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [frexercises to test treatment and the community-based (A) When a community-based (A) When a community-based (A) When a community-based (B) If the [factional exercises to test treatment activation of the exercise (B) If the [factional ex	727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d), §494.62(d)(2). 16.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: 16.51 Facilities at §494.62]: 17.		IAU			DATE
	(B) A mock disast	er drill. Or	1				I

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/09/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	l í	JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 12/18/2023	
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	₹	120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR IINGTON, IN 47401		
	SUMMARY (EACH DEFICIENT REGULATORY OF ICO) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an erection (iii) Analyze the [famaintain documer exercises, and emaintain documer exercises, and emaintain the [facility's] emeans at (2) Testing for hoo the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a communicy of the patient's conduct exercises plan at least annual the following: (ii) Participate in a community based (A) When a communicy conduct exercises plan at least annual the following: (iii) Participate in a community based (A) When a communicy based (A) When a communicy based (A) Conduct exercises (A) When a communicy based (A) Conduct exercises (A) Conduct exe	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION PERCISE OF WORKShop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do	2	120 E M	IILLER DR	BE	(X5) COMPLETION DATE
	(B) If the hospice man-made emerg of the emergency exempt from engascale community-facility-based functionset of the emer (ii) Conduct an act years, opposite the functional exercise of this section is conclude, but is not (A) A second full-	experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Editional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based					

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(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is

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	OF CORRECTION	IDENTIFICATION NUMBER 155532	 JILDING	NSTRUCTION	COMPL 12/18/	ETED
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E M	NDDRESS, CITY, STATE, ZIP COD TILLER DR IINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
TAG	led by a facilitator discussion using a clinically-relevant a set of problem star messages, or prepto challenge an enditor of the exercises to test the per year. The hose (i) Participate in a that is community-(A) When a community-(A) When a community-(B) If the hospice of the emergency exempt from engate full-scale community-tonal exercises emergency event. (ii) Conduct an action of the emergency event. (iii) Conduct an action of the emergency event. (iiii) Conduct an action of the emergency event. (iiii) Conduct an action of the emergency event.	and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct me emergency plan twice spice must do the following: m annual full-scale exercise shased; or unity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem	TAG		ME.	DATE
	questions designe emergency plan. (iii) Analyze the h maintain documer	ed messages, or prepared and to challenge an ospice's response to and atation of all drills, tabletop bergency events and revise				

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	OF CORRECTION	IDENTIFICATION NUMBER 155532	A. BUILDING B. WING		COMPI 12/18	LETED
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	*[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [For conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community-(A) When a community-(A) When a community-based function (B) If the [PRTF, Hearn actual natural of that requires active plan, the [facility] is its next required for individual, facility following the onse (ii) Conduct at exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A mo (C) A tabletop is led by a facilitate discussion, using a clinically-relevant set of problem star messages, or prepto challenge an endition (iii) Analyze the and maintain docutabletop exercises	PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital, following: n annual full-scale exercise based; or unity-based exercise is not ct an annual individual, tional exercise; or dospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency exempt from engaging in sull-scale community based by-based functional exercise to f the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155532	B. WI	NG		12/18/	2023
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	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	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conduct exercises plan at least annual organization must (i) Participate in a that is community-(A) When a community-based functional exercise of the emerging (ii) Conduct a 2 years opposite the functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercise of the exemption of the emerging (ii) Conduct a 2 years opposite the functional exercise of this section is cobut is not limited to (A) A second full-community-based based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem star messages, or prepto challenge an erecision of the exercises, and emergence in the second of the exercises of the exercises in the second of the exercises of the exercises in the exercises of the exercises of the exercises in the exercises of the exer	ACE organization must to test the emergency ally. The PACE do the following: In annual full-scale exercise abased; or annual individual, attional exercise; or aperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required atty based or individual, attional exercise following the gency event. In additional exercise every the year the full-scale or a under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or the dill; or ercise or workshop that is and includes a group an anarrated, emergency scenario, and a tements, directed cared questions designed mergency plan. PACE's response to and anatom of all drills, tabletop mergency events and revise gency plan, as needed.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	l í	UILDING	NSTRUCTION	(X3) DATE COMPL 12/18/	ETED
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER		120 E N	DDRESS, CITY, STATE, ZIP COD IILLER DR IINGTON, 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)	ATE	(X5) COMPLETION DATE
	to test the emerge year, including un the emergency pro ICF/IID] must do to to Participate in a that is community. (A) When a commaccessible, conduct facility-based functions (B) If the [LTC factual natural or requires activation LTC facility is exerequired a full-scalindividual, facility-following the onse (ii) Conduct an actual may include, following: (A) A second full-community-based based functional of the community-based based functiona	an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual, stional exercise. ility] facility experiences an nan-made emergency that n of the emergency plan, the mpt from engaging its next alle community-based or based functional exercise et of the emergency event. diditional annual exercise but is not limited to the escale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.					
	(2) Testing. The I	CF/IID must conduct he emergency plan at least					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/18/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•	
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER	₹		IINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne ICF/IID must do the					
	following:						
	that is community	n annual full-scale exercise					
	1	nunity-based exercise is not					
	1 ' '	ict an annual individual,					
		ctional exercise; or.					
		experiences an actual					
	` '	ade emergency that requires					
		mergency plan, the ICF/IID					
	is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the						
	onset of the emergency event.						
		lditional annual exercise					
	· ·	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mock disast	er drill; or ercise or workshop that is					
		and includes a group					
	discussion, using	.					
		emergency scenario, and a					
	I	atements, directed					
	· ·	pared questions designed					
	to challenge an e	·					
	(iii) Analyze the I0	CF/IID's response to and					
	maintain docume	ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	84.102]					
	-	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	l; or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/18/2023		
	PROVIDER OR SUPPLIER		<u> </u>	120 E M	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401		
			ı	L	,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION ommunity-based exercise		TAG	DEFICIENCY		DATE
	is not accessible, individual, facility-levery 2 years; or. (B) If the HH, natural or man-ma activation of the elexempt from enga full-scale commun facility based functionset of the emergical Conduct an advears, opposite the	conduct an annual based functional exercise A experiences an actual ade emergency that requires mergency plan, the HHA is aging in its next required aity-based or individual, tional exercise following the gency event. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i)					
	include, but is not	limited to the following: full-scale exercise that is					
	is led by a facilitate discussion, using	saster drill; or o exercise or workshop that or and includes a group a narrated,					
	set of problem star messages, or prep to challenge an en (iii) Analyze the HI maintain document exercises, and em	pared questions designed					
	exercises to test the OPO must do the (i) Conduct a pape or workshop at lease exercise is led by	e OPO must conduct ne emergency plan. The					

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CENTERS FOI	ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	lì í	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155532	B. W			12/18/	
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTE	₹	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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
	relevant emerger problem statement prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing of the emergency (ii) Analyze the Omaintain docume exercises, and enthe [RNHCI's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCI must do to (i) Conduct a papart least annually. Group discussion narrated, clinically scenario, and a solirected message designed to challe (ii) Analyze the Romaintain docume exercises, and entertion of the exercises, and entertion of the exercises.	ncy scenario, and a set of ants, directed messages, or ans designed to challenge an alf the OPO experiences and an another man-made emergency that an of the emergency plan, the some engaging in its next exercise following the onset of event. PO's response to and antation of all tabletop mergency events, and revise at OPO's] emergency plan, as 3.748]: The RNHCI must conduct the emergency plan. The					
	Based on record re failed to conduct en preparedness pland including unannou emergency procedu the following:	view and interview, the facility exercises to test the emergency (EPP) at least twice per year, need staff drills using the tures. The LTC facility must do	E 0	039	E039 The facility ensures exercise are conducted to test the emergency plan annually. Maintenance Director in service on the importance of the Emergency Plan and the		01/06/2024

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is community-based; or

a. When a community-based exercise is not

accessible, conduct an annual individual,

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importance of completed and

exercises done 2x's per year with

accurate documentation on

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155532		ľ í	UILDING	ONSTRUCTION	(X3) DATE COMPL 12/18/	ETED	
	OF PROVIDER OR SUPPLIED	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)	.ΤΕ	(X5) COMPLETION DATE
TAU	facility-based funct b. If the LTC facili or man-made emery of the emergency p from engaging its r community-based of full-scale functional the onset of the act (ii) Conduct an add include, but is not l a. A second full-sca community-based of functional exercise b. A mock disaster c. A tabletop exerc facilitator that inclu a narrated, clinicall and a set of probler messages, or prepa challenge an emerg (iii) Analyze the L7 maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice c Findings include: Based on review of Preparedness Manu 12/18/23 at 11:00 a A.) There was docu exercise on 09/20/2 documentation that response and revise if needed. B.) No documentat choice was availab	ional exercise. Ity experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a per individual, facility-based l exercise for 1 year following ual event. Ititional exercise that may imited to the following: ale exercise that is per an individual, facility-based desired agroup discussion, using y-relevant emergency scenario, an statements, directed red questions designed to gency plan. ICC facility's response to and action of all drills, tabletop regency events, and revise the regency plan, as needed in the CFR 483.73(d)(2). This could affect all occupants. In the facility's Emergency used with the Administrator on the country in the regency plan with the Administrator on analyzed the facility's emergency plan ion of a second exercise of			facilities response included. All staff in serviced on the emergency plan as well as stadrills. All residents have the potential be affected by this finding. The facility based exercise was repeated with documentation showing the analysis of the facility's response. The facility also run a second exercise (or their choice) with documentation showing the analysis of the facility's response. The emergency plan will be update needed, based on the findings the analysis. Maintenance Director will aud monthly x6 months to ensure facility is in compliance with the EP exercises and documentate. Any concerns will be addressed as discovered. If any patterns identified, an action plan will be written at the monthly QAPI meeting by the QAPI committed. Any written action plan will be monitored by the Admin and/or Designee monthly until resolv and substantial compliance is achieved. Completion Date 1/6/2024	aff all to as has fion ed if s of it the he tion. ed are he ee.	DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155532				UILDING	NSTRUCTION	CON	TE SURVEY MPLETED 18/2023
	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 CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	available to show a response of the facil documentation was conducted second end and Maintenance D 482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this section and in procedures plan so (ii) and (iii) of this section and in procedures plan so (iii) and (iii) of this section and in procedures plan so (iii) and (iii) of this section and in procedures plan so (ii) and (iii) of this section and in procedures plan so (ii) and (iii) of this section and in procedures plan so (ii) and (iii) of this section and in procedures plan so (ii) and (iii) of this section and in procedures plan so (iii) and (iii) of this section and (iii) of this section and in procedures plan so (iii) and (iii) of this section and in procedures plan so (iii) and (iii) of this section and in procedures plan so (iii) and (iii) of this section and iii)	viewed with the Administrator irector at the exit conference. (e), 485.625(e) LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection. 625(e) d standby power systems. and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with rements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new rish when an existing					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2023
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATI	CROSS-REFERENCED TO THE APPR	TION (X5) D BE COMPLETION DATE
482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAH and LTC facilities] that maintain an onsite fu source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation b reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below.	N TAG DEFICIENCY)	
You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/cood_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. BUILDING COMP			(X3) DATE (COMPL 12/18/	ETED		
		ROVIDER OR SUPPLIER	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 CY MUST BE PRECEDED BY FULL LISC 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
		2012 edition, issued (ii) Technical interination NFPA 99, issued A (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Life edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to a 2009 Based on record reversible to implement inspection, testing, a found in the Health 110, and Life Safety CFR 483.73(e)(2). 1. Based on record of facility failed to ma of monthly generated 12 months. Chapter 12 months. Chapter 12 months. Chapter 13 to NFPA 12 months. Chapter 14 months. Chapter 15 months.	th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012	E 00)41	E041 The facility ensures the emergency power system inspection, testing, and maintenance requirements at completed. Maintenance Director in service on the importance of the record the monthly generator load testion a min. of 30 mins. Maintenance Director in service on the importance of maintaining	ed d of sting	01/06/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/18/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E N	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	the emergency elect accordance with NF Emergency and States. NFPA 110 8.4.2 service to be exercise minimum of 30 min 99 requires a writter performance, exercing generator to be regular for inspection by the jurisdiction. This decocupants. Findings include: Based on record reversity 12/18/23 at 12:00 performance and testing 2023 was not available interview at the time and Mainterview at the time Administrator confirmates for August and available for review. This finding was rear and Maintenance December 2. Based on record facility failed to ensemergency generated down period after a to the alternate power supservice within 10 second 10 s	rical system to be in FPA 110, the Standard for andby Powers Systems, Chapter requires diesel generator sets in sed at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA in record of inspection, sing period, and repairs for the alarly maintained and available end authority having efficient practice could affect all riew with the Administrator on a.m., documentation monthlying for August and November ble for review. Based on an end of record review, the remed documentation of a load November 2023 was not	TAG	documentation as well as completed documentation, no limited to the cool down time being on the logs as well as transfer time. All residents have the potential be affected by these findings. Written documentation of mor load testing is now done every month. Monthly load testing completed for January 2024 of January 5th, with a written remade of the testing. This includes documentation of a 5-minute cool down period, pl transfer time to the alternate power source to ensure the alternate power supply is cappof supplying service within 10 seconds. This will be complet with each monthly load test moving forward. Maintenance Director will aud monthly x6 months to ensure facility is in compliance with the Emergency Power System and documentation including the completed of the second service of the generators. Any concerns the generators. Any concerns the generators are identified, an action plan will be written at the month 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 1/6/2024	t DATE It all to onthly y on cord us a lable led lit the line lid cool of will lif any ion withly lift on this lift on t

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		A. BUI B. WIN	LDING	NSTRUCTION	(X3) DATE S COMPL 12/18/	ETED	
	PROVIDER OR SUPPLIEF	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 CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IK 0000	delay of 5 minutes or running of the Eme prior to shutdown. engine cool down. required on small (1 movers. This defic residents, as well as facility. Findings include: Based on record rew with the Administratedocumented the ger under load, however on the form that she down time following 2023. Additionally, September and Octodocumentation of a power to emergency review, the Adminitedocumentation of a time on the generate the aforementioned.	transfer time from normal y power. At the time of record strator confirmed there was no cool down time or transfer or monthly load test form for					
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR	K 00	00	1 K000 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 or	We	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/18/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	120 E I	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Facility Number: 0 Provider Number: 1000 At this Life Safety 0 Nursing and Rehabi in compliance with in Medicare/Medica Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa This one story facilit Type II (111) constr sprinklered. The fac with hard wired smand spaces open to a operated smoke alar rooms. The facility census of 27 at the t All areas where resi were sprinklered an	200460 155532 290620 Code survey, Bloomington dilitation Center was found not Requirements for Participation and, 42 CFR Subpart 483.90(a), are and the 2012 edition of the etion Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2. At was determined to be of ruction and was fully editity has a fire alarm system as the corridors, plus battery arms in all resident sleeping has a capacity of 38 and had a sime of this survey. dents have customary access d all areas providing facility selered, except two detached ity storage.		any proceedings and submit to responses pursuant to our regulatory obligations. The far requests the Plan of Correctic considered our allegation of compliance effective January 2024 for the Annual Life Safe Code Recertification and Stat Licensure Emergency Preparedness Survey.	hese cility on be 6th,
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lightir Emergency Lightir Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour ed automatically in			
	Based on records re failed to maintain it inspections and test	view and interview, the facility emized records of the s for all battery backup lights.) requires functional testing	K 0291	K291 The facility ensures that records are reviewed and itemized records of the	01/06/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE COMPL 12/18/	ETED
	PROVIDER OR SUPPLIEF NGTON NURSING	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 CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	weeks and a maxim for not less than 30 testing shall be cond of 1 1/2 hours if the battery powered and inspections and test for inspection by the jurisdiction. This does residents in the faci. Findings include: Based on records red on 12/18/23 between battery operated employers documentation indivigibles were tested in form was not itemize emergency light in on an interview at it. Administrator confit testing did not documentation individual light. This finding was residued.	eficient practice could affect all			inspections are maintained all battery back up lights are tested. Maintenance Director in serving on the importance of itemizin records of the emergency light Maintenance Director to immediately start implementing itemization in TELS tasks. All residents have the potential be affected by these findings. The battery operated lights were tested with documentation itemized, to show the location results of testing, for each individual light. Maintenance Director will aud weekly x6 months to ensure a facility is in compliance with the Emergency Lighting regs as a shaving itemized lists. Any concerns will be addressed a discovered. If any patterns are identified, an action plan will written at the monthly QAPI meeting by the QAPI committed. Any written action plan will be monitored by the Admin and/Designee monthly until resolution and substantial compliance is achieved. Completion Date 1/6/2024	iced g inting. ing al to ere and dit the he well s e o o r ved	
K 0300 SS=C Bldg. 01	Section 18.3 and requirements that	RKS section any LSC					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
		155532	B. WI	NG		12/18	/2023
			ь ,				
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
51.00141		AND DELLARU ITATION OFFITED	120 E MILLER DR				
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER		BLOOM	IINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
	information, along	with the applicable Life					
	_	FPA standard citation,					
	,	d on Form CMS-2567.					
		view, interview, and	K 03	200	K300		01/06/2024
		cility failed to ensure	I K U.	300	The facility ensures that		01/00/2024
		the preventative maintenance			documentation on the		
		-					
		ted smoke alarms in resident			preventative maintenance of		
	_	e. NFPA 101 in 4.6.12.3 states			the battery-operated smoke		
	-	features obvious to the public,			detectors in resident rooms	IS	
		ne Code, shall be maintained.			completed.		
	·	aintenance and Tests.			Maintenance Director in service		
		ment shall be maintained and			on the importance of preventa		
		e with the manufacturer's			maintenance as well as on the		
	_	ons and per the requirements			battery-operated smoke detec		
	_	A 72, 14.2.1.1.1 Inspection,			including battery replacement.		
	_	nance programs shall satisfy			Maintenance Director in service	ced	
	the requirements of	this Code and conform to the			on the importance of not only		
	equipment manufac	cturer's published instructions.			documenting this, but being su	ure	
	This deficient pract	ice could affect all residents,			the list is itemized.		
	staff, and visitors.				Maintenance Director to		
					immediately start implementin	g	
	Findings include:				itemization in TELS tasks.	-	
	-				All residents have the potentia	al to	
	Based on records re	eview on 12/18/23 between			be affected by these findings.		
		5 p.m. with the Administrator, no			The testing of all battery opera	ated	
		l list for preventative			smoke detectors has been		
	-	attery replacement of resident			itemized to include location an	nd	
		ted smoke alarms was available			results of each, individual unit		
		on interview at the time of			preventative maintenance and		
		Administrator confirmed that			of battery change.	· date	
	· ·	y operated smoke detectors in			Maintenance Director will audi	it	
		t itemized. During the facility					
		enance Director, battery			weekly x6 months to ensure the		
					facility is in compliance with th		
	_	ectors were observed in each			Emergency Lighting regs as w	/ell	
	resident room.				as having itemized lists. Any		
	TELL: C: 1:	t dad Attitue			concerns will be addressed as		
		viewed with the Administrator			discovered. If any patterns are		
	and Maintenance D	rirector at the exit conference.			identified, an action plan will b	е	
			1		written at the monthly QAPI		1

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3.1-19(b)

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meeting by the QAPI committee.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/18/2023	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER		STREET 120 E I	ADDRESS, CITY, STATE, ZIP COD MILLER DR MINGTON, IN 47401	12/10/	2023	
BLOOM		AND REHABILITATION CENTER	\ BLOOM			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
				Any written action plan will be monitored by the Admin and/or Designee monthly until resolve and substantial compliance is achieved. Completion Date 1/6/2024		
K 0914 SS=C Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visually LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, recesults. 6.3.4 (NFPA 99)	s - Maintenance and s - Maintenance and ceptacles at patient bed are deep sedation or general ainistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not anoths. Line isolation monitors are tested at intervals of to 1 month by actuating an per 6.3.2.6.3.6, which all and audible alarm. For automated self-testing, this formed at intervals less 2 months. LIM circuits are all after any repair or electric distribution system. tained of required tests and so or modifications, com or area tested, and	K 0914	K914		01/06/2024

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interview, the facility failed to ensure testing of

rooms was complete. NFPA 99, Health Care

Facilities Code 2012 Edition, Section 6.3.4.1.3

electrical receptacles at 18 of 18 resident sleeping

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The facility ensures that

receptacle testing is being

done by itemization as each

care room requires physical

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155532		(X2) MULTIPLE C A. BUILDING B. WING	<u> </u>				
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	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)			
TAG	states receptacles no patient bed location sedation or general shall be tested at immonths. Additional Testing in Patient C physical integrity of confirmed by visual the grounding circuits shall be verified. Concutral connections shall be confirmed; grounding blade of (except locking-typthan 115 grams (4 could affect all residual shall be confirmed; grounding blade of (except locking-typthan 115 grams (4 could affect all residual shall be confirmed; grounding blade of (except locking-typthan 115 grams (4 could affect all residual affect all residual from the maintenant of the maintenant of the properties of the maintenant of the maintenance of the mai	ot listed as hospital-grade, at as and in locations where deep anesthesia is administered, tervals not exceeding 12 ly, Section 6.3.3.2, Receptacle Care Rooms requires the f each receptacle shall be l inspection. The continuity of the intime ach electrical receptacle correct polarity of the hot and in each electrical receptacle and retention force of the each electrical receptacle are receptacles) shall be not less bunces). This deficient practice dents. Ons during a tour of the facility ce Director on 12/18/23 and 1:35 p.m., the facility's soms contained four to six es with a mix of non-hospital grade receptacles. Based on interview with the 15 p.m., the resident room sted in October 2023 after the Director was hired, and	TAG	integrity of each receptacle be verified. Maintenance Director in serv on the importance of testing e electrical receptacles. Maintenance Director in serv on the importance of not only documenting this, but being se the list is itemized. Maintenance Director to immediately start implementi itemization in TELS tasks. All residents have the potenti be affected by these findings. The resident room receptacle were retested on January 5th now includes itemized documented results of each individual receptacle, includir confirmation of the physical integrity, the continuity of the grounding circuit, correct pola of the hot and neutral connect and retention force of the grounding blade. Maintenance Director will aud weekly x6 months to ensure facility is in compliance with the Electrical Systems-Maint. and Testing as well as having iter lists. Any concerns will be addressed as discovered. If a patterns are identified, an act plan will be written at the mod QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monity until resolved and substantia	iced of iced o		
I				compliance is achieved.			

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AND PLAN OF CORRECTION IDENTIFIE		IDENTIFICATION NUMBER 155532		ILDING	01	COMPL 12/18/	ETED	
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 E MILLER DR BLOOMINGTON, IN 47401					
(X4) ID PREFIX TAG	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 APPROPRIAT DEFICIENCY)	ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE		
					Completion Date 1/6/2024			
K 0918 SS=F Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL							
	NFPA 111, 700.10	(NFPA 70)						

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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. BUILDING <u>01</u>		COMPLETED		
155532		B. WING 12/1			12/18/	2023	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			MILLER DR		
BLOOMINGTON NURSING AND REHABILITATION CENTER					MINGTON, IN 47401		
			1		1	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	177.0	TAG	DEFICIENCY)		DATE
		review and interview, the	K 0	918	K918		01/06/2024
		intain a complete written record			The facility ensures the		
	of monthly generator load testing for 2 of the last				emergency power system		
	-	6.4.4.1.1.4(a) of 2012 NFPA 99			inspection, testing, and		
		sting of the generator serving			maintenance requirements a	re	
		trical system to be in			completed.		
		FPA 110, the Standard for			Maintenance Director in service		
		ndby Powers Systems, Chapter			on the importance of the recor		
		requires diesel generator sets in			the monthly generator load tes	sting	
		sed at least once monthly, for a			for a min. of 30 mins.		
		nutes. Chapter 6.4.4.2 of NFPA			Maintenance Director in service		
	99 requires a written record of inspection,				on the importance of maintain	ing	
	performance, exercising period, and repairs for the				documentation as well as		
	generator to be regularly maintained and available				completed documentation, no	t	
	for inspection by the authority having				limited to the cool down time		
		eficient practice could affect all			being on the logs as well as		
	occupants.				transfer time.		
	TO 11 1 1 1				All residents have the potentia	al to	
	Findings include:				be affected by these findings.		
					Written documentation of mon	-	
	Based on record review with the Administrator on				load testing is now done every	/	
	12/18/23 at 12:00 p.m., documentation of monthly				month. Monthly load testing		
	generator load testing for August and November				completed for January 2024 o		
	2023 was not available for review. Based on an			January 5th, with a written record			
	interview at the time of record review, the				made of the testing. This inclu		
	Administrator confirmed documentation of a load				documentation of a 5-minute of		
	test for August and November 2023 was not		1		down period, plus a transfer til		
	available for review.		1		to the alternate power source		
	This finding was reviewed with the Administrate				ensure the alternate power su		
	This finding was reviewed with the Administrator				is capable of supplying service		
	and Maintenance Director at the exit conference.		1		within 10 seconds. This will be		
	2 Passed on record review and intermitary the				completed with each monthly	เบลน	
	2. Based on record review and interview, the			test moving forward.		i+	
	facility failed to ensure documentation for 1 of 1		1	Maintenance Director will audit			
	emergency generators included a 5 minute cool				monthly x6 months to ensure		
	down period after a load test, plus a transfer time				facility is in compliance with the	ie	
	to the alternate power source on the monthly load				Electrical System-Essential		
	tests for all of the past 12 months to ensure the		1		Electric System and		
		ply was capable of supplying			documentation including the c		
service within 10 seconds. Chapter 6.4.4.1.1.4(a) of					down time and transfer times	of	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPI	COMPLETED	
		155532	B. WING 12/18/20		/2023		
			12/10/2020				
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					MILLER DR		
BLOOMI	NGTON NURSING	AND REHABILITATION CENTER		BLOOM	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DD OVIDERNO SV. VV. OF GOVERN		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		aires monthly testing of the			the generators. Any concerns	will	
	_	ne emergency electrical system			be addressed as discovered.		
	-	with NFPA 110, the Standard			patterns are identified, an activ	•	
		Standby Powers Systems,		plan will be written at the monthly			
		10, 6.4.2.1.5.9 Time Delay on			QAPI meeting by the QAPI	y	
	_	equires that a minimum time			committee. Any written action		
	_	shall be provided for unloaded			plan will be monitored by the		
	-	rgency Power Supply (EPS)			Admin and/or Designee month	nlv	
	•	This delay provides additional			until resolved and substantial	y	
	*	This time delay shall not be			compliance is achieved.		
	_	15 kW or less) air-cooled prime			Completion Date 1/6/2024		
		ient practice could affect all			Completion Date 1/0/2024		
		s staff and visitors in the					
	facility.	suit and visitors in the					
	idenity.						
	Findings include:						
	i manigs merade.						
	Based on record rev	view on 12/18/23 at 10:50 a.m.					
		ator, the generator log form					
		nerator was tested monthly					
	_	r, there was no documentation					
		owed the generator had a cool					
		g its load test in September					
		the monthly load testing for					
	September and Octo						
	_	transfer time from normal					
		y power. At the time of record					
		strator confirmed there was no					
		cool down time or transfer					
		or monthly load test form for					
	the aforementioned	-					
	uie atorementioned	monuis.					
	This finding was ==	viewed with the Administrator					
		viewed with the Administrator irector at the exit conference.					
	and Maintenance D	nector at the exit conference.					
	2 1 10/1						
	3.1-19(b)						
			l				1

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