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		A. BUILDING 00 B. WING	12/20/2023

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 19 and 20, 2023 Facility number: 011076 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 22, 2023.	R 0000	The following is the Plan of Correction for Brookdale Bloomington regarding the Statement of Deficiencies dated December 20, 2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meghan Berinati	Administrator	01/05/2024

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	telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record	R 0090		01/11/2024

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	review, the facility failed to ensure a notice was posted of the availability of the most recent annual State survey for 2 of 2 days of the survey. Findings include: On 12/19/23 at 10:35 a.m., during an initial tour of the facility, the most recent State survey results was unable to be located and a sign alerting residents to where the most recent survey was located was not observed. During an interview on 12/19/23 at 10:36 a.m., the Activities Director (AD) and the Business Office Manager (BOM) indicated there was no sign alerting residents to where the most recent State survey results were but the survey was usually on a desk in the lobby. On 12/19/23 at 10:40 a.m., the most recent State survey was located in a drawer inside the lobby desk by the AD and the BOM. During an interview on 12/20/23 at 12:18 p.m., the Administrator indicated they facility did not have a policy related to a sign which indicated where the most recent State survey was located but the facility followed the State rules.		No residents were affected by deficit practice. Administrator posted sign and survey results, accessible for residents and visitors, located on a table in south common area on 12/22/23. All residents have the potential to be affected by this deficiency. Administrator or designee will monitor the survey results binder and maintain a daily log for one month verifying the results are posted. Administrator or designee will document education with staff members regarding the requirement to have survey results available at all times and for the binder to remain in its designated location. This will be completed by 1/11/24 The Administrator and/or designee will complete weekly audits for 3 months to verify results are posted, and then periodically. Any issues identified during the audit will be addressed immediately by the Administrator and discussed in the Daily Stand	

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			Up Meeting Monday through Friday.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure references were completed for 1 of 5 employees' files reviewed. (QMA) 1) Finding includes: On 12/19/23 at 2:23 p.m., the Administrator presented the employees' files. QMA 1 was hired on 9/18/23. The file lacked any references. During an interview on 12/20/23 at 11:26 a.m., the Administrator indicated the employee's file lacked references. On 12/20/23 at 12:18 p.m., the Administrator indicated they did not have a policy on facility requiring references.	R 0116	No residents were affected by deficit practice. Administrator or designee will conduct audit of personnel files to determine if employee file holds reference checks. All residents have the potential to be affected by this deficiency. Administrator or designee will log all personnel that do not have reference checks, and will conduct reference check calls for individuals logged. The file audit and reference check completion will be completed by 1/19/24. The Administrator and/or designee will complete weekly audits for 3 months to verify employee files contain reference checks, and then periodically. Any issues identified during the audit will be addressed immediately by the Administrator and discussed in the Daily Stand Up Meeting Monday through Friday.	01/19/2024

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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff member with current cardiopulmonary resuscitation (CPR) and first aid (FA) certification worked onsite at all times for 7 of 7 days reviewed. Findings include: On 12/19/23 at 11:30 a.m., the Executive Directed provided the facility's schedule, dated 12/10/23 through 12/16/23, and all employees CPR and FA certification cards. A review of the schedule indicated the following:	R 0117	R117 - Personnel No residents were affected by deficit practice. Administrator or designee will conduct audit of clinical employees (LPNs, QMAs, CNAs, HHAs) to determine if individuals hold a CPR and FA certification. All residents have the potential to be affected by the deficiency. Administrator or designee will initiate completion of CPR and	02/05/2024

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	- On 12/10/23, the first shift did not have a FA certified staff member and the second shift did not have a FA or CPR certified staff member onsite. - On 12/11/23, the first shift not have a FA or CPR certified staff member onsite. - On 12/12/23, the first shift did not have a FA certified staff member onsite. - On 12/13/23, the first shift did not have a FA certified staff member onsite. - On 12/14/23, the first shift and second shift did not have a CPR or FA certified staff member onsite. - On 12/15/23, the first shift did not have a FA certified staff member onsite. - On 12/16/23, the first shift did not have a CPR or FA certified staff member onsite. On 12/20/23 at 9:45 a.m., the Executive Director (ED) indicated there were no additional current first aid certified staff members to cover the missing shifts in the schedule. On 12/20/23 at 12:15 p.m., the Executive Director provided the facility policy, "CPR Policy-States Requiring Certification," revised on January 2023, and indicated it was the policy currently being used. A review of the policy did not specify a staff member with current CPR certification should be onsite at all times. The ED indicated the facility follows the Indiana guidelines in regard to the requirements to have a CPR and FA certified staff member onsite at all times.		FA for clinical employees that do not have a current certification on file. The file audit and CPR/FA certification by clinical employees will be completed by 2/5/24. The Administrator and/or designee will complete weekly audits for 3 months to verify employees are CPR and FA certified, and then periodically. Any issues identified during the audit will be addressed immediately by the Administrator and discussed in the Daily Stand Up Meeting Monday through Friday.	

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight			

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	loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to obtain a 2-step tuberculin (TB) skin test for 1 out of 5 sampled employees who currently worked in the facility. (Cook 1) Findings include: On 12/19/23 at 10:00 a.m., the facility staff employee records were reviewed. The records indicated Cook 1 had a hire date of 5/25/23. The employee's record lacked documentation of receiving a first and second step TB skin testing. On 12/20/23 at 9:28 a.m., the Executive Director indicated Cook 1 did not have the TB skin tests and she did not know why. On 12/20/23 at 12:15 a.m., the Executive Director indicated they did not have a specific policy related to TB testing, however, they followed the Indiana guidelines and provided a reference guide, "Tuberculosis (TB) Associate Requirements by State - Reference," revised December 2023, and indicated it was the reference guide currently being used. The guide indicated, ".... IN (Indiana) 2-step > [greater than] 12 mos. [months] documented negative test at hire. 1-step < [less than] 12 mos. documented negative test at hire ..."	R 0121	No residents were affected by deficit practice. Administrator or designee will conduct audit of employee files to determine if TB testing is accurate and up to date, and will log employees not in compliance. All residents have the potential to be affected by the deficiency. Administrator or designee will notify employees of need for TB skin tests to be completed by all employees that are not within guidelines. The file audit and TBs for employees will be in compliance as of 2/5/23. The Administrator and/or designee will complete weekly audits for 3 months to verify employees are in compliance with TB tests, and then periodically. Any issues identified during the audit will be addressed immediately by the Administrator and discussed in the Daily Stand Up Meeting Monday through Friday.	02/05/2024
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record	R 0273	No residents were affected	02/05/2024

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	review, the facility failed to ensure pre-prepared beverages were labeled and dated and expired half and half was not discarded on or before the use-by date for 2 of 2 days of the survey. Findings include: On 12/19/23 at 10:20 a.m., the small refrigerator in the facility kitchen was observed to contain 2 unlabeled and undated pitchers of a brown liquid, 2 unlabeled and undated pitchers of an dark brown liquid, 1 unlabeled and undated pitcher of a light brown liquid, 1 unlabeled and undated pitcher of a pink liquid, 5 opened 1 quart containers of half and half with an expiration date of 12/16/23, and 7 unopened 1 quart containers of half and half with an expiration date of 12/16/23. On 12/20/23 at 10:00 a.m., the small refrigerator in the facility kitchen was observed to contain 2 unlabeled and undated pitchers of a brown liquid, 2 unlabeled and undated pitchers of an dark brown liquid, 1 unlabeled and undated pitcher of a light brown liquid, 1 unlabeled and undated pitcher of a pink liquid, 5 opened 1 quart containers of half and half with an expiration date of 12/16/23, and 7 unopened 1 quart containers of half and half with an expiration date of 12/16/23. During an interview on 12/20/23 at 10:10 a.m., the Dietary Manager indicated the pitchers of liquid should have been labeled and dated to ensure freshness of the beverages, and the containers of half and half should have been discarded on or before the expiration date. On 12/20/23 at 11:25 a.m., the facility Administrator provided the Storage of Perishable Food policy, revised 5/2010 and indicated it was the policy currently used by the facility. A review		by deficit practice. Dietary Manager discarded items found that were not labeled and dated on 12/19/23. All residents have the potential to be affected by the deficiency. Dietary Manager or designee will conduct and log a daily audit for one month of all food items stored to verify items are dated, labeled and discarded upon necessary expiration date or use by date. Administrator or designee will conduct and log a weekly audit and log for one month to ensure compliance. The monthly audit will be completed on 2/5/23. The Administrator and/or designee will complete weekly audits for 3 months to verify all food items are labeled, dated and expired items are discarded. Any issues identified during the audit will be addressed immediately by the Administrator and discussed in the Daily Stand Up Meeting Monday through Friday.	

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	of the policy indicated, "...refrigerated items shall be covered, labeled indicating product name, and dated (month/day/year) product was received or prepared...all pre-dished items must be covered, labeled,and dated..."			