STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLE				
		155278	B. WI			08/08/	
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD BURKS DR		
BRICKYA	ARD HEALTHCARE	- BLOOMINGTON CARE CENT	ER	BLOOM	INGTON, IN 47401		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 00	000	The submission of this Plan of	f	
	_	diana Department of Health in			Correction, for survey event IE)	
	accordance with 42	CFR 483.73.			1C4421 does not indicate an		
	Survey Date: 09/09	2/22			admission by Bloomington Ca	re	
	Survey Date: 08/08	0/23			Center that the findings and allegations contained herein a	re	
	Facility Number: 0	00177			an accurate and true depiction		
	Provider Number:				the quality of care and service		
	AIM Number: 100	289860			provided to the residents of		
					Bloomington Care Center. The	Э	
	At this Emergency	Preparedness survey,			Facility recognizes its obligation	on	
	Brickyard HealthCa	are - Bloomington Care Center			to provide legally and medical	ly	
	was found in compl	iance with Emergency			necessary care and services t	o its	
	Preparedness Requi	rements for Medicare and			residents in an economic and		
	Medicaid Participat	ing Providers and Suppliers, 42			efficient manner. The Facility		
	CFR 483.73.				hereby maintains it is in		
					substantial compliance with th	е	
	-	certified beds. At the time of			requirements of participation f	or	
	the survey, the cens	sus was 116.			Comprehensive Health Care		
	Ouality Review cor	mpleted on 08/10/23			Facilities. To this end, this Pla Correction shall serve as a	n of	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				credible allegation of compliar	nce	
					with all state and federal		
					requirements governing the		
					management of this Facility. It	is	
					thus submitted as a matter of	=	
					statute only. We are requesting	g	
					paper compliance for this surv	_	
K 0000							
Bldg. 01							
	-	Recertification and State	K 0	000	The submission of this Plan of		
		vas conducted by the Indiana			Correction, for survey event II)	
	-	th in accordance with 42 CFR			1C4421 does not indicate an		
	483.90(a).				admission by Bloomington Ca	re	
					Center that the findings and		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	TITLE		(X6) DATE

(X6) DATE

Scott Swaby **Executive Director** 08/25/2023 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.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155278	B. WI	ING		08/08/2023	
N	DOLUBER OF CO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			URKS DR		
BRICKYA	ARD HEALTHCARE	E - BLOOMINGTON CARE CENTER	R	BLOOM	IINGTON, IN 47401		
(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 APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Survey Date: 08/08	3/23			allegations contained herein a		
	E::::N	00177			an accurate and true depiction		
	Facility Number: 0 Provider Number:				the quality of care and service	S	
	AIM Number: 1002				provided to the residents of		
	Alivi Number: 100.	289800			Bloomington Care Center. The		
	At this Life Sofety	Code survey, Brickyard			Facility recognizes its obligation		
	•	ington Care Center was found			to provide legally and medicall necessary care and services to	-	
					residents in an economic and	บ แอ	
	not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR				efficient manner. The Facility		
	Subpart 483.90(a), Life Safety from Fire, and the				hereby maintains it is in		
		National Fire Protection			substantial compliance with the	e	
) 101, Life Safety Code (LSC),			requirements of participation for		
		g Health Care Occupancies and			Comprehensive Health Care		
	410 IAC 16.2.				Facilities. To this end, this Pla	n of	
					Correction shall serve as a		
	This one-story facil	ity with a partial basement was			credible allegation of complian	ice	
	determined to be of	Type II (000) construction and			with all state and federal		
	was fully sprinklere	ed. The facility has a fire alarm			requirements governing the		
	system with smoke	detection in the corridor and in			management of this Facility. It	is	
	all areas open to the	e corridor. The facility has			thus submitted as a matter of		
		oke detectors installed in all			statute only. We are requestin	g	
		oms. The facility has a			paper compliance for this surv	ey.	
		had a census of 116 at the					
	time of this survey.						
	All areas where the	residents have customary					
		ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 08/10/23					
K 0291	NFPA 101						
SS=F	Emergency Lightir	ng					
Bldg. 01	Emergency Lightin	-					
		g of at least 1-1/2-hour					
	duration is provide	_					
	accordance with 7						
	18.2.9.1, 19.2.9.1						
	Based on record rev	view, observation, and	K 02	291	What corrective action(s) wil	I	08/25/2023

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Facility ID: 000177

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	· ′	ILDING	onstruction 01	(X3) DATE SI COMPLE 08/08/2	TED
	PROVIDER OR SUPPLIER	: - BLOOMINGTON CARE CENTE	ER_	155 E B	ADDRESS, CITY, STATE, ZIP COD BURKS DR IINGTON, 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)	ATE	(X5) COMPLETION DATE
	complete document battery backup light 30 seconds during to the light would prove power outages. LSG lighting shall be prosection 7.9. Section functional testing shall be prosected with a minimum of weeks between tests seconds, (3) Function				be accomplished for those residents found to have been affected by the deficient practice. The were no residents affected the alleged deficient practice, battery backup emergency lig was tested after January 2023 was documented. How other residents having	ed by All hting 3 and	
	if the emergency lig powered and (5) Wi	for a minimum of 1 1/2 hours thing system is battery ritten records of visual s shall be kept by the owner			potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken.	be	
	jurisdiction. This d	eficient practice could affect all staff and visitors in the			All residents have the potential be affected by the alleged def practice. No residents were not be affected by the alleged	icient	
	a.m. to 1:08 p.m. wi	riew on 08/08/23 from 10:30 ith the Maintenance Director did have a preventative			deficient practice. Testing will completed monthly. All battery backup emergency lighting we tested after January 2023 and were documented.	y ere	
	emergency lights we seconds and annual no documented 30 s 2023 for the battery Based on an intervio	report that battery powered ere tested monthly for 30 ly for 90 minutes. There were second testing prior to January powered emergency lights. ew at the time of record review, rector stated he started in his			What measure will be put interplace and what systemic changes will be made to ensure that the deficient practice does not recur.	to	
	position on January additional battery potesting documentati time of the survey.	2023 and there are no owered emergency light on available for review at the viewed with the Executive			The community has initiated to "Tels" program to help monito dates and documentation of required task to be completed. This system prompts when takeneeds to be completed in	r due I.	
		enance Director during the exit			accordance with the NFPA.		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/08/2023		
	PROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, 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)	ιΤΕ	(X5) COMPLETION DATE
IAU	conference. 3.1-19(b)	LISC IDENTIFITING INFORMATION		IAU	Reminders are sent to the Maintenance Director, Execut Director, and the Regional Maintenance Director. The TE assignment sheet is attached (Exhibit A). The Life Safety Co CMS form 2786R was reviewed and is attached (Exhibit B). The policy "Emergency Lighting" were viewed with no changes man (Exhibit C). Testing has been consistent since January 2023. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; The audit tool titled "Maintenan Life Safety Survey Audits" (Exp.) will be utilized to determine compliance. The audit tool will completed by the Maintenan Director or designee Monthly months. Audited records will be reviewed by the Quality Assur Committee until such time that consistent compliance has be achieved as determined by the Quality Assurance Committee. By what date the systemic changes for each deficiency will be completed. Systemichanges will be completed by 8/25/2023.	ode ed ne vas de 3. the ut nce chibit e for 6 pe cance t en e e.	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			(X3) DATE SURVEY COMPLETED				
THILD I LIMIT	or conduction	155278	B. WI		01	08/08/	
		.552.5				00,00,	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD BURKS DR		
BRICKYA	ARD HEALTHCARE	- BLOOMINGTON CARE CENTER	R		MINGTON, IN 47401		
(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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0300 SS=C	NFPA 101						
Bldg. 01	Protection - Other						
Blug. UT	Protection - Other						
	Section 18.3 and	RKS section any LSC					
		are not addressed by the					
		out are deficient. This					
		with the applicable Life					
		FPA standard citation,					
	•	d on Form CMS-2567.					
	Based on record rev		K 03	300	What corrective action(s) wil	ı	08/25/2023
		ility failed to ensure	b		be accomplished for those	-	00/23/2023
		the preventative maintenance			residents found to have been	1	
		smoke alarms in resident			affected by the deficient		
	rooms was complete	e. NFPA 101 in 4.6.12.3 states			practice.		
	existing life safety f	features obvious to the public,					
	if not required by th	ne Code, shall be maintained.			There were no residents ident	ified	
	NFPA 72, 29.10 Ma	aintenance and Tests.			as being affected by the allege	∍d	
	Fire-warning equips	ment shall be maintained and			deficient practice. Testing has		
		e with the manufacturer's			been completed consistently		
	_	ons and per the requirements			since January 2023.		
	_	A 72, 14.2.1.1.1 Inspection,					
	_	nance programs shall satisfy			How other residents having t		
	•	this Code and conform to the			potential to be affected by th		
		eturer's published instructions.			same deficient practice will be		
	-	ice could affect all residents,			identified and what correctiv	е	
	staff, and visitors.				action(s) will be taken.		
	Findings include:				All residents have the potentia	ıl to	
	Č				be affected by the alleged defi		
	Based on review of	the Monthly Battery Operated			practice. There were no reside		
		sting documentation on			identified as being affected by		
	08/08/23 at 11:23 a.	.m. with the Maintenance			alleged deficient practice. Batt		
	Director present, the	e itemized list of resident room			Operated Smoke Detector Tes	sting	
	battery operated sm	oke alarms tested for			has been completed consister	nt	
		nonthly basis was not complete			since January 2023.		
		hs. Monthly documentation of					
	. –	oke alarm testing prior to			What measure will be put int	0	
	<u>-</u>	ot available for review. Based			place and what systemic		1
	on interview at the t	time of record review the	ı		changes will be made to		1

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155278	B. WING		08/08/2023	
		1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R		BURKS DR		
BRICKY	ARD HEALTHCARE	- BLOOMINGTON CARE CENTE		MINGTON, IN 47401		
(X4) ID	SHMMAPV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	Maintenance Direct	tor confirmed that		ensure that the deficient		
	documentation for l	pattery operated smoke		practice does not recur.		
	detector testing price	or to January 2023 was not				
		at the time of the survey.		The community has initiated the	he	
		ons during a tour of the facility		"Tels" program to help monito	r due	
		e Maintenance Director,		dates and documentation of		
		oke alarms were observed in		required task to be completed		
	all resident sleeping	g rooms.		This system prompts when ta	sk	
	יייי מיי	e de valadores de		needs to be completed in		
	_	viewed with the Executive		accordance with the NFPA.		
	Director and Mainte conference.	enance Director at the exit		Reminders are sent to the	ivo	
	conference.			Maintenance Director, Execut	ive	
	3.1-19(b)			Director, and the Regional Maintenance Director, TELS v	was	
	3.1-17(0)			reviewed and the monthly	was	
				assignment was reviewed (Ex	thibit	
				E). The Life Safety Code CMS		
				form 2786R was reviewed (Ex		
				F).		
				How the corrective action(s)		
				will be monitored to ensure	the	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will be p	ut	
				into place;		
				The audit tool titled "Maintena	nce	
				Life Safety Survey Audits" (IIIO C	
				Exhibit D) will be utilized to		
				determine compliance. The au	ıdit	
				tool will be completed by the	441.	
				Maintenance Director or design	nee	
				Monthly for 6 months. Audited		
				records will be reviewed by th		
				Quality Assurance Committee		
				until such time that consistent		
				compliance has been achieve	d as	
				determined by the Quality		

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Assurance Committee.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155278	B. WI	NG		08/08/	2023
BRICKYA		- BLOOMINGTON CARE CENTER	₹	155 E B BLOOM	ADDRESS, CITY, STATE, ZIP COD BURKS DR IINGTON, IN 47401		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 8/25/2023.		
K 0355	NFPA 101						
SS=D	Portable Fire Extin	•					
Bldg. 01	installed, inspected accordance with N Portable Fire Extin 18.3.5.12, 19.3.5.1	guishers are selected, d, and maintained in IFPA 10, Standard for guishers.	K 03	0.5.5	What corrective action(s) will		08/25/2023
	failed to inspect 1 or in the Activity Cente Standard for Portabl 7.2.1.2 states fire ex	f 1 portable fire extinguishers er each month. NFPA 10, le Fire Extinguishers, Section tinguishers shall be inspected by means of an electronic	K U.	533	be accomplished for those residents found to have been affected by the deficient practice.		08/23/2023
	Section 7.2.2 states electronic monitorin include a check of a (1) Location in design				No residents were affected by alleged deficient practice. A chwas completed on the fire extinguisher.		
	* *	o access or visibility			How other residents having t		
		reading or indicator in the			potential to be affected by the		
	operable range or po				same deficient practice will b		
	self expelling-type	ned by weighing or hefting for			identified and what corrective action(s) will be taken.	ŧ	
		extinguishers, and pump tanks			action(s) will be taken.		
		es, wheels, carriage, hose, and			All residents have the potentia	l to	
	nozzle for wheeled	-			be affected by the alleged defi		
		nrechargeable extinguishers			practice. No residents were		
	using push to-test pr				affected by the alleged deficien		
		es personnel making manual			practice. A check was complet	ed	
	inspections shall kee	-			on the fire extinguisher (See		
	extinguishers inspec	eted, including those found to			Exhibit G).		

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STREET ADDRESS, CITY, STATE, ZIP COD (XS) ID SUMMARY STATEMENT OF DETICIENCE (RECHED ENCYMENT BET PRECEDED BY PULL TAG REGULATORY OR LSC IDESTIFYING INFORMATION require corrective action. Section 7,2.4.3 requires where at least monthly manual inspections are conducted, records for manual inspections shall be key to a fag or label attached to the fire extinguisher, on an inspection checking maintained on file, or by an electronic method. Section 7,2.4.5 requires records shall be key to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 5 residents and staff in the area of Activity Center. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director and Maintenance Director on face of demonstrate in the Activity Center lacked documentation of a monthly inspection since January 2023. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Activity Center as missing the February 2023 - August 2023 monthly visual inspection. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) The activity Center was missing the February 2023 - August 2023 monthly visual inspection. The activity Center and Maintenance Director at the exit conference. 3.1-19(b)		T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDIN B. WING	G 01	· · · · · · · · · · · · · · · · · · ·	COMPLETED 08/08/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION AND COMPLETION COMPLETION COMPLETION TAG What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The "TELS Masters" "NFPA 10 (2010)—Inspecting Fire Extinguishers was reviewed by the Maintenance Director and List and the last 12 monthly inspections have been performed. This deficient practice could affect 5 residents and staff in the area of Activity Center. Based on observation during a tour of the facility with the Executive Director and Maintenance Director on Singulation of a monthly inspections since January 2023. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Activity Center lacked documentation of a monthly inspections since January 2023. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Activity Center was missing the February 2023 - August 2023 monthly visual inspection. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3,1-19(b) The audit tool titled "Maintenance Life Safety Survey Audits" (Exhibit D) will be utilized to determine compilance. The audit tool will be				155	E BURKS DR		
where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 5 residents and staff in the area of Activity Center. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director and Maintenance Director on 80/80/23 at 1:40 p.m., the monthly inspection tag on the fire extinguisher located in the Activity Center was missing the February 2023 - Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Activity Center was missing the February 2023 - August 2023 monthly visual inspection. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) What measure will be made to ensure that the deficient practice does not recur. changes will be made to ensure that the deficient practice does not recur. The "TELS Masters" "NFPA 10 (2010)—Inspecting Fire Extinguishers was reviewed by the Maintenance Director and Maintenance Director and Executive Director on 08/08/23 at 1:40 p.m., the monthly inspection as a fire extinguisher will have monthly checks were completed. The policy and procedure for inspecting Fire extinguishers was reviewed (Exhibit H). The TELS assignments sheet was eviewed (Exhibit H). The CMS form 2876-R was reviewed (Exhibit H) was reviewed (Exhibit H). The TELS a	PREFIX	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFI	X (EACH CORRECTI CROSS-REFERENC	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	COMPLETION
Director or designee Monthly for 6	TAG	require corrective ac where at least month conducted, the date performed and the in performing the inspection 7.2.4.4 required are conducted, reconshall be kept on a talextinguisher, on an imaintained on file, of Section 7.2.4.5 required demonstrate that at a linspections have been practice could affect area of Activity Central Englisher on 08/08/22 inspection tag on the the Activity Center monthly inspections interview at the time Maintenance Director extinguisher located missing the Februar visual inspection. This finding was revenue.	etion. Section 7.2.4.3 requires ally manual inspections are the manual inspection was nitials of the person ection shall be recorded. ires where manual inspections and so or label attached to the fire inspection checklist for by an electronic method. ires records shall be kept to least the last 12 monthly en performed. This deficient at 5 residents and staff in the atter. In during a tour of the facility Director and Maintenance at 1:40 p.m., the monthly en fire extinguisher located in lacked documentation of a since January 2023. Based on the of observation, the or confirmed the fire in the Activity Center was by 2023 - August 2023 monthly wiewed with the Executive	TAC	What measur place and who changes will ensure that the practice does. The "TELS Material (2010)—Inspection of the second of the	re will be put into at systemic be made to he deficient a not recur. asters" "NFPA 10 ecting Fire was reviewed by Director and ector. The "new" Director was not was a fire extinguistle was educated conthly checks we all other. The identified will have monthly eted. The policy a inspecting Fire was reviewed he TELS sheet was reviewed he TELS sheet was reviewed e CMS form 2876 (Exhibit J) rective action(s) ored to ensure the citice will not not at quality ogram will be putitled "Maintenaniarvey Audits" (Exhibit determine The audit tool will be the Maintenance	the sher on re and ed -R t ce ibit one

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	OF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDING B. WING	01	COMPLETED 08/08/2023
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTER	155 E B	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401	į.
(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
				months. Audited records will b reviewed by the Quality Assurace Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 8/25/2023.	ance : en
K 0363 SS=E Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible or combustible mater hardware is not except to a combustible or combustible or combustible mater hardware. The combustible mater hardware is not except to auxiliary sflammable or combustible o	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or rials have positive latching atches are prohibited by hese requirements do not			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	
		155278	B. WI	NG		08/08/	2023
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	DDEELY (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	unlimited height at meeting 19.3.6.3.6 frames shall be lat other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratir devices, etc. Based on observation failed to ensure 2 of impediment to closi frame and would restrict tour of the facility with Maintenance Direct p.m. and 2:25 p.m., room 136 and 102 fitheir respective door.	fire window assemblies are a sprinklered compartments of tions in area or fire as or frames in window. Parts 403, 418, 460, 482, 483 Setails of doors such as angs, automatics closing and interview, the facility fover 50 corridor doors had no ang and latching into the door sist the passage of smoke. See could affect 6 staff and 30 sons and interview during a with the Executive Director and for on 08/08/23 between 1:08 the corridor doors of resident ailed to latch positively into a frames. Infirmed by the Maintenance of discovery and again at the anthe Maintenance Director and	K 03	363	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents who reside in room and 102 had their doors adjust so that they would close with a positive latch. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential be affected by the alleged defi practice. No other room/reside were identified as being affected.	136 ted a the e be e lito cient	08/25/2023

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NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What measure will be put into	(X5) COMPLETION DATE
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION BLOOMINGTON, IN 47401 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION CORRECTION (EACH CORRECTION CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	
What magazine will be not into	
What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. Door checks will be completed according to the TELS schedule and will be documented (Exhibit K). The Life Safety Code CMS for 2768-R was reviewed (Exhibit L). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The audit tool titled "Maintenance	
Life Safety Survey Audits" (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance	
Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been	

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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 01	COMPLETED
155278 B. WING	08/08/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL)
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER 155 E BURKS DR BLOOMINGTON, IN 47401	
BRIGHT AND TIEALT INCARE - BLOOWINGTON CARE CENTER BLOOWINGTON, IN 47401	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECT	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP	ROPRIATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
achieved as determined	-
Quality Assurance Comm	nittee.
By what date the system	
changes for each defici	=
will be completed. Syst	
changes will be complete	ed by
8/25/2023.	
K 0500 NFPA 101	
SS=C Building Services - Other	
Bldg. 01 Building Services - Other	
List in the REMARKS section any LSC	
Section 18.5 and 19.5 Building Services	
requirements that are not addressed by the	
provided K-tags, but are deficient. This	
information, along with the applicable Life	
Safety Code or NFPA standard citation,	
should be included on Form CMS-2567.	
Based on observations and interview, the facility K 0500 What corrective action(s	s) will $08/25/2023$
failed to ensure 2 of 2 fuel-fired boilers had current be accomplished for the	ose
inspection certificates to ensure the boilers were residents found to have	been
in safe operating condition. NFPA 101, Section affected by the deficien	t
19.1.1.3.1 requires all health facilities to be practice.	
designed, constructed, maintained, and operated	
to minimize the possibility of a fire emergency No Residents were affect	-
requiring the evacuation of occupants. This alleged deficient practice).
deficient practice could affect all residents, staff	
and visitors in the facility. How other residents ha	
potential to be affected	- 1
Findings include: same deficient practice	
Based on observations on 08/08/23 during a tour identified and what corruption action(s) will be taken.	ecuve
Based on observations on 08/08/23 during a tour action(s) will be taken. of the facility from 1:08 p.m. to 2:25 p.m. with the	
Executive Director and Maintenance Director, the All residents have the po	tential to
two fuel-fired boilers in the facility had certificates be affected by the allege	
with expiration dates of 02/01/22. Based on practice. All boilers had be affected by the affec	
interview at the time of observations, the inspected and had an ex	
Maintenance Director confirmed the expiration date of 2/1/2024 or 2/2/2	·

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULT A. BUILI B. WING	DING	nstruction 01	(X3) DATE : COMPL 08/08/	ETED
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OR dates of the two fue This finding was re-	LSC IDENTIFYING INFORMATION			What measure will be put interplace and what systemic changes will be made to ensure that the deficient practice does not recur. The community has initiated the "Tels" program to help monito dates and documentation of required task to be completed. This system prompts when taken needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Execut Director, and the Regional Maintenance Director. All "Boil Fired Pressure Vessel Report Inspections" (Exhibit M) are offor review. The Life Safety Co CMS form 2786-R was review (Exhibit N) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; The audit tool titled "Maintena Life Safety Survey Audits" (Expo) will be utilized to determine compliance. The audit tool will completed by the Maintenance Director or designee Monthly in the control of the signer of the	o ne r due . sk ler – of n file de ved the ut nce hibit	
					months. Audited records will be reviewed by the Quality Assur Committee until such time that	e ance	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING 01 B. WING			COMPL	x3) date survey Completed 08/08/2023	
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					consistent compliance has been achieved as determined by the Quality Assurance Committee.)	
					By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 8/25/2023.	:	
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills at routine. Where dr 9:00 PM and 6:00	ay be used instead of					
	Based on record rev failed to provide do conducted on the th	view and interview, the facility cumentation of a fire drill ird shift for 2 of 4 quarters. ice affects all residents, staff	K 0'	712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.		08/25/2023
		view with the Executive			No residents were identified as being affected by the deficient practice.		
	a.m. to 1:08 p.m. or documentation for a second quarter (Apr	aintenance Director from 10:30 in 08/08/23, there was no a third shift fire drill in the ril, May, June) 2023.			How other residents having t potential to be affected by the same deficient practice will be identified and what corrective	e e	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIP A. BUILDIN B. WING		nstruction 01	(X3) DATE COMPL 08/08/	ETED
	ROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENTE	15	5 E B	DDRESS, CITY, STATE, ZIP COD URKS DR IINGTON, IN 47401		
	SUMMARY: (EACH DEFICIEN REGULATORY OR third shift fire drill: August, September) interview at the tim Maintenance Direct additional fire drill for review at the tim	E - BLOOMINGTON CARE CENTE STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION in the third quarter (July, 2022/2023. Based on e of record review, the or confirmed that no documentation was available	15	5 E B OOM	URKS DR	al to icient ere the o ne r due . sk ive	(X5) COMPLETION DATE
					shift per the Tels Assignment sheet (Exhibit Q). How the corrective action(s) will be monitored to ensure t deficient practice will not recur, i.e., what quality	he	

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	OF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDING B. WING	01	COMPLETED 08/08/2023
	ROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS 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
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the e switches are perfor NFPA 110. Generator sets are exercised under lo	- Essential Electric Syste - Essential Electric ace and Testing other alternate power ated equipment is capable ace within 10 seconds. If the acid is not met during the acess shall be provided to acid capability for the life branches. Maintenance generator and transfer acid in accordance with acid inspected weekly, and 30 minutes 12 times a		assurance program will be p into place; The audit tool titled "Maintena Life Safety Survey Audits" (Ex D) will be utilized to determine compliance. The audit tool will completed by the Maintenance Director or designee Monthly months. Audited records will be reviewed by the Quality Assur Committee until such time that consistent compliance has be achieved as determined by the Quality Assurance Committee By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 8/25/2023.	nce chibit e I be e for 6 be erance t en e

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/08/2023		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, 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		
	Scheduled test una a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Nocircuit breakers are program for period components is est manufacturer requof maintenance are and readily availal and circuits are mand separate from Minimizing the postemergency power consideration for reference of the standard facility failed to do the emergency generated generators in according facility failed to do the emergency generated generators in according to the Standard for Emergency generators of the Standard for Emergency gener	ual transfer of all EES inducted by competent nance and testing of stored rces (Type 3 EES) are in IFPA 111. Main and feeder is inspected annually, and a dically exercising the rablished according to uirements. Written records and testing are maintained tole. EES electrical panels arked, readily identifiable, a normal power circuits. The sibility of damage of the source is a design new installations. (NFPA 99), NFPA 110,	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by alleged deficient practice. How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action(s) will be taken. All residents have the potential be affected by the alleged definition. All residents have the potential be affected by the alleged definition.	the the the te pe te al to icient		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/08/2023
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER			155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	REGULATORY OR 8.4.9.5.1, 8.4.9.5.2, states for spark-igni available EPSS load affect all residents, facility. Findings include: Based on record rev Director and the Ma a.m. to 1:08 p.m. on period emergency g documentation for f diesel fired emerger was conducted on 0 at the time of record Director stated the f generator and agree supplemental load to the most recent thre available for review This finding was rev	LSC IDENTIFYING INFORMATION or 8.4.9.5.3. Section 8.4.9.5.3 ted EPS's, loading shall be the deficient practice could staff, and visitors in the liew with the Executive intenance Director from 10:30 o8/08/23, thirty-six-month generator testing four continuous hours for the facility 3/06/2020. Based on interview dereview, the Maintenance facility has one 420kW diesely discourant design for four hours within ge-year period was not	TAG	alleged deficient practice. What measure will be put int place and what systemic changes will be made to ensure that the deficient practice does not recur. The community has initiated the "Tels" program to help monito dates and documentation of required task to be completed. This system prompts when taken needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Execut Director, and the Regional Maintenance Director. The Maintenance Director and Executive Director reviewed the K-918 "Health Care Facilities Requirements Electrical System - Essential Electrical System	DATE O ne r due . sk ive ne Code ems
	2. Based on record of facility failed to man of monthly generated months and weekly Chapter 6.4.4.1.1.4(monthly testing of the emergency electrical with NFPA 110, the Standby Powers System 8.4.2 requires dieselected at least on 30 minutes. Section Power Supply System	review and interview, the intain a complete written record or load testing for 1 of 12 inspection for 4 of 52 weeks. a) of 2012 NFPA 99 requires the generator serving the 1 system to be in accordance Standard for Emergency and stems, Chapter 8. NFPA 110 generator sets in service to be ce monthly, for a minimum of 8.4.1 requires an Emergency of (EPSS) including all tents, shall be inspected		Maintenance and Testing" (ExR). Also the Tels Masters "NF 110 (2010) – Operational Test of Emergency Power Generat (Exhibit S) was reviewed. The TELS assignment sheet of "Te Generator under load, perform routine checks, create entry in logbook—Diesel" (Exhibit T) a "Conduct a 4 hours Load test" (Exhibit U) were reviewed. A hour test was conducted and weekly and monthly documentation will continue a has since January 2023.	FPA ting or" est n ind four

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED (A. B. WING STREET ADDRESS, CITY, STATE, ZIP COD STREET ADDRESS, CITY, STATE, ZIP COD	ETED
155278 B. WING 08/08/2 STREET ADDRESS, CITY, STATE, ZIP COD	
STREET ADDRESS, CITY, STATE, ZIP COD	2023
STREET ADDRESS, CITY, STATE, ZIP COD	
■ STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 155 E BURKS DR	
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER BLOOMINGTON, IN 47401	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
weekly and exercised monthly. Chapter 6.4.4.2 of How the corrective action(s)	
NFPA 99 requires a written record of inspection, will be monitored to ensure the	
performance, exercising period, and repairs for the deficient practice will not	
generator to be regularly maintained and available recur, i.e., what quality	
for inspection by the authority having assurance program will be put	
jurisdiction. This deficient practice could affect all into place;	
occupants.	
The audit tool titled "Maintenance	
Findings include: Life Safety Survey Audits" (Exhibit	
D) will be utilized to determine	
Based on records review with the Maintenance compliance. The audit tool will be	
Director on 08/08/23 from 10:30 a.m. to 1:08 p.m.,	
documentation for the 12/03/22 monthly generator Director or designee Monthly for 6	
load testing was incomplete. The documentation months. Audited records will be	
had 'na' marked on all items except the start, stop reviewed by the Quality Assurance	
time and fuel level. Also, the generator weekly Committee until such time that	
inspection log showed the weekly inspections consistent compliance has been	
were not conducted between November 14 and achieved as determined by the	
December 19, 2022. Based on an interview at the Quality Assurance Committee.	
time of record review, the Maintenance Director	
stated he started the position in January 2023 and By what date the systemic	
has no additional generator inspection changes for each deficiency	
documentation available for review. will be completed. Systemic	
changes will be completed by	
These findings were reviewed with the Executive 8/25/2023.	
Director and Maintenance Director during the exit	
conference.	
Controller.	
3.1-19(b)	

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