STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING 00 B. WING	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00370814 and a COVID-19 Focused Infection Control Survey. Complaint IN00370814 - Unsubstantiated due to lack of evidence. Survey dates: January 18, 19, and 20, 2022 Facility number: 000177 Provider number: 155278 AIM number: 100289860 Census Bed Type: SNF/NF: 119 Total: 119 Census Payor Type: Medicare: 10 Medicaid: 98 Other: 11 Total: 119 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 27, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by Golden Living of Bloomington that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Golden Living Bloomington. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economical and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of the participation for Comprehensive Health Care Facilities (for title 16/17 programs). To this end, the Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We are respectfully requesting paper compliance for this survey (event number ID BEK211).	
F 9999 Bldg. 00	410 IAC 16.2-3.1-18 Infection control program Authority: IC 16-28-1-7 Affected: IC 16-28-5-1	F 9999	What corrective action(s) will be accomplished for those residents found to have been affected by	02/07/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	Sec. 18. (a) The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. (b) The facility must establish an infection control program under which it does the following: (7) Reports communicable disease to public health authorities. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to report confirmed COVID-19 infections among 3 of 4 residents and 27 of 35 staff reviewed for infection control reporting. (Residents J, K, L, and 27 staff members) Findings include: On 1/19/22 at 11:20 A.M., the Director of Nursing Services provided a list of residents and facility staff who had tested positive for COVID 19 since 11/30/21. A review of the list indicated 4 residents and 35 staff members had tested positive for COVID 19 since 11/30/21. On 1/19/22 at 11:44 A.M., a review of the Redcap reporting history indicated 3 of the 4 residents (Residents J, K, and L) who had tested positive for COVID 19 since 11/30/21 were not reported to the Redcap reporting system. Only 8 of the 35 facility staff members who had tested positive for COVID 19 since 11/30/21 had been reported to the Redcap reporting		the deficient It is the policy of Golden Living Bloomington to report all covid positive residents and staff members to the Redcap reporting system (see exhibit A). The missing notifications were reviewed. All future covid positive residents and staff will be reported to the Redcap reporting system and will be monitored for completion. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be All covid positive residents and staff have the potential to be affected. Once reporting is completed on Redcap, a screen shot of the Residents/Staff information will be printed and kept for future reviews and verifications. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not Nursing administration have been educated on printing a screen shot of each person entered and retaining a copy for future see exhibit B). The audit tool “Redcap	

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	system. During and interview, on 1/20/22 at 10:10 A.M., the Director of Nursing Services indicated the facility reported the number of COVID positive residents and staff to the Redcap reporting system. There was no documentation to indicate 3 residents and 27 staff who had tested positive for COVID 19 since 11/30/21 had been reported to the Redcap reporting system.		Reporting" will be utilized, by the Director of Nursing or a designee, to ensure all covid positive residents and staff have been reported by indicating the screen shot for has been printed and reviewed (see exhibit c). 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 The "Redcap Reporting" audit will be conducted weekly x 4 weeks, bi-monthly for 2 months, and monthly for 3 see exhibit D). All audits will be reviewed in QA for compliance. If compliance has been established the audit will be discontinued. If compliance is not achieved, then the audit will continue monthly until compliance is achieved. By what date be February 7, 2022	