CENTERS FOR	OF HEALTH AND HU MEDICARE & MEDIC T OF DEFICIENCIES		(X2) MU	ULTIPLE CO	DNSTRUCTION		RM APP	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDING B. WING			COMPLETED 07/07/2022		
			R	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMP	(X5) PLETION ATE	
E 0000 Bldg		7/22	E 00	000	The submission of this Plan of Correction, for survey event IE NPFE21, does not indicate an admission by Bloomington Ca Center that the findings and allegations contained herein a an accurate and true depiction	D n nre		

Bldg. 01

A Life Safety Code Recertification and State

K 0000

The submission of this Plan of

Correction, for survey event ID NPFE21, does not indicate an admission by Bloomington Care Center that the findings and

the quality of care and services

Facility recognizes its obligation

to provide legally and medically

residents in an economic and

efficient manner. The Facility

requirements of participation for

Comprehensive Health Care Facilities. To this end, this 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 requesting paper compliance for this survey.

hereby maintains it is in substantial compliance with the

necessary care and services to its

provided to the residents of Bloomington Care Center. The

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

Licensure Survey was conducted by the Indiana

Department of Health in accordance with 42 CFR

Provider Number: 155278

AIM Number: 100289860

the survey, the census was 124.

Quality Review completed on 07/13/22

CFR 483.73.

483.90(a).

At this Emergency Preparedness survey,

was found in compliance with Emergency

Preparedness Requirements for Medicare and

Brickyard HealthCare - Bloomington Care Center

Medicaid Participating Providers and Suppliers, 42

The facility has 153 certified beds. At the time of

TITLE

(X6) DATE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155278	B. WI	ING		07/07/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				SURKS DR		
BRICKY	ARD HEALTHCARE	- BLOOMINGTON CARE CENTE	R		IINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Survey Date: 07/07	1/22			allegations contained herein a		
					an accurate and true depiction		
	Facility Number: 0				the quality of care and service	s	
	Provider Number:				provided to the residents of		
	AIM Number: 1002	289860			Bloomington Care Center. The		
					Facility recognizes its obligation		
	At this Life Safety Code survey, Brickyard				to provide legally and medical	-	
	HealthCare -Bloomington Care Center was found				necessary care and services t	o its	
	_	vith Requirements for			residents in an economic and		
	-	dicare/Medicaid, 42 CFR			efficient manner. The Facility		
		Life Safety from Fire, and the			hereby maintains it is in		
		National Fire Protection			substantial compliance with th		
	Association (NFPA) 101, Life Safety Code (LSC),				requirements of participation for	or	
		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		
		ity with a partial basement was			credible allegation of complian	ice	
		Type II (000) construction and			with all state and federal		
		d. The facility has a fire alarm			requirements governing the		
	-	detection in the corridor and in			management of this Facility. It	IS	
	-	corridor. The facility has			thus submitted as a matter of		
		oke detectors installed in all			statute only. We are requestin	-	
		oms. The facility has a			paper compliance for this surv	ey.	
		had a census of 124 at the					
	time of this survey.						
	The Horizon Comid	or containing resident rooms					
		eyed because of a COVID 19					
		on within the quarantined					
	Horizon Wing.	on within the quarantineu					
	TIOTIZON WING.						
	All areas where the	residents have customary					
		ered. All areas providing					
	facility services wer						
		•					
Quality Review completed on 07/13/22							
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/07/2022	
	PROVIDER OR SUPPLIER	L R E - BLOOMINGTON CARE CENTE	155 E B	ADDRESS, CITY, STATE, ZIP COD BURKS DR IINGTON, IN 47401		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	Doors in a require be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and clinical security not used, only one lock permitted on each be made for the raby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special locks afety needs of the Clinical or Section are being met. In electrical locks that release upon loss building is protect automatic sprinkles space is protected detection system at an attended lock space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRET ARRANGEMENT Approved, listed of	and means of egress shall not a latch or a lock that of a tool or key from the susing one of the following rangements: SOR SECURITY THREAT Sking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ited by staff at all times; or emeans available to the example of the epatient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked of by a complete smoke (or is constantly monitored example of the sprinkler and detection aged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING SING THE TOWN THE AT T				

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7.2.1.6.1 shall be permitted on door

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPL	ETED
		155278	B. WING	G		07/07/	2022
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			URKS DR		
BRICKY	ARD HEALTHCARE	E - BLOOMINGTON CARE CENTE			IINGTON, IN 47401		
	1			-			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		ig low and ordinary hazard					
		ngs protected throughout by					
	an approved, supervised automatic fire detection system or an approved, supervised						
	automatic sprinkle						
	18.2.2.2.4, 19.2.2	-					
		OLLED EGRESS					
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
	ELEVATOR LOB	BY EXIT ACCESS					
	LOCKING ARRAN	NGEMENTS					
	Elevator lobby exi	t access door locking in					
		7.2.1.6.3 shall be permitted					
		es in buildings protected					
		approved, supervised					
		ection system and an					
		ised automatic sprinkler					
	system.	0.4					
	18.2.2.2.4, 19.2.2	.2.4 on and interview, the facility	IZ 022	,,	K 222 – E		07/25/2022
		means of egress through the	K 022	22	K 222 = E What corrective action(s) wil	1	07/25/2022
		eadily accessible for residents			be accomplished for those	•	
		iagnosis requiring specialized			residents found to have been	n	
		Doors within a required means			affected by the deficient	•	
	· ·	be equipped with a latch or			practice;		
	_	ne use of a tool or key from the			pruotioo,		
	•	otherwise permitted by LSC			No residents or visitors were		
	_	ocking arrangements shall be			affected by the alleged deficie	nt	
		ance with 19.2.2.2.5.2. This			practice. The exit code was pl		
	deficient practice co	ould affect over 25 staff and			at the cited corridor exit door.		
	visitors if needing t	o exit the facility.					
					How other residents having t	the	
	Findings include:				potential to be affected by th		
					same deficient practice will be		
		ons and interview during a			identified and what correctiv	е	
		with the Maintenance Director			action(s) will be taken;		
	on 07/07/22 betwee	en 11:30 a.m. and 2:00 p.m., the					

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CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		1 ′	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 07/07/	ETED		
	PROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR facility corridor exi- marked as a facility and could be opened but the code was no Maintenance Direct was likely painted of This finding was ac Maintenance Direct	knowledged by the or at the time of discovery and afterence with the Maintenance		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CR	athe other d to ficient s odes s of no nto ated ans ts" the	(X5) COMPLETION DATE	

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reviewed in QAPI for 6 months and at the end of 6 months of 90%

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		(X2) MULTII A. BUILDII B. WING	PLE CONSTRUCTION NG <u>01</u>	(X3) DATE SURVEY COMPLETED 07/07/2022	
	PROVIDER OR SUPPLIER	RE - BLOOMINGTON CARE CENTE	15	REET ADDRESS, CITY, STATE, ZIP COD 55 E BURKS DR LOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION DATE	
				compliance is achieved the a will be complete. If compliant not achieved in 6 months, the QAPI Committee will continumonitor monthly until 90% compliance is achieved.	ce is en the	
				By what date the systemic changes for each deficience will be completed. After submitting an acceptable p of correction, it is determine that the correction will not completed by the date previously submitted, The Division need to be contact as soon as possible. The fawill need to submit an amended plan of correction with the updated plan of correction date;	lan ed be ed cility	
K 0293 SS=E Bldg. 01	accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in occupancies with where the line of e	al signs are displayed in 7.10 with continuous erved by the emergency ne-story existing less than 30 occupants exit travel is obvious.)	V 0202	K 202 – E	07/25/2022	
	failed to ensure 1 o outside of the facili	f 3 courtyard doors to the ty were not mistaken as a 7.10.8.3.1 states any door,	K 0293	K 293 = E What corrective action(s) w be accomplished for those residents found to have been		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155278	B. W	ING		07/07/	2022
N. N. T. O. T. T.	ADOLUBED OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>			BURKS DR		
BRICKYA	ARD HEALTHCARE	E - BLOOMINGTON CARE CENTE	R	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		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		that is neither an exit nor a			affected by the deficient		
		and that is located or arranged			practice;		
		be mistaken for an exit shall			No Docidonto mano effected by	. 41	
		gn that reads as follows: NO			No Residents were affected by	-	
		IT sign shall have the word NO igh, with a stroke width of			alleged deficient practice. A ne		
		word EXIT below the word			"NO EXIT" sign was placed up	on	
		n is an approved existing			the courtyard door cited.		
	-	practice could affect 25			How other residents having	tho	
	residents.	, praetice could affect 23			How other residents having to potential to be affected by the		
	restuents.				same deficient practice will be		
	Findings include:				identified and what correctiv		
	i manigs metade.				action(s) will be taken;	C	
	Based on observation	ons and interview during a			action(3) will be taken,		
		with the Maintenance Director			All residents have the potentia	al to	
		n 11:30 a.m. and 2:00 p.m., (1) in			be affected by the alleged defi		
		ling area the door to the			practice. No other residents w		
		nd (2) the Therapy Exit sliding			affected by the alleged deficie		
		loors and the doors were not			practice. No other doors were		
		EXIT" sign. Based on			found to be out of compliance.		
	-	e of the observations, the			policy titled "Means of		
	Director of Mainten	ance stated the courtyard and			Egress—Corridors and Exits"		
	the therapy sliding of	doors are not exits to the			(Exhibit A) was reviewed with	no	
	public way and ack	nowledged the aforementioned			changes.		
	doors did not have a	a "NO EXIT" sign posted.					
					What measures will be put in	ito	
	This finding was ac				place and what systemic		
		or at the time of discovery and			changes will be made to		
	-	ference with the Maintenance			ensure that the deficient		
	Director and Admir	nistrator present.			practice does not recur:		
	3.1-19(b)				Maintenance Staff were educa	ated	
	J.1-17(0)				on the policy title "Mean of	at o u	
					Egress—Corridors and Exits"		
					(Exhibit A).		
					(=/(
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
			1		1		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		A. BUILDING B. WING	01	COMPLETED 07/07/2022		
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENT	155 E	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	
				assurance will be put into place; and An audit tool titled "2022 Life		
				Safety Audits" (Exhibit F) will I utilized to determine complian The Maintenance Director or designee will complete the au weekly for two months, bimon for two months, and monthly f two months. This audit will be reviewed in QAPI for 6 months at the end of 6 months of 90% compliance is achieved the au will be complete. If compliance not achieved in 6 months, the QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable pla of correction, it is determine that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of	dit tthly for s and didits e is n the e to	
K 0344	NEDA 404			correction date;		
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings Vertical Openings					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/07/2022		
	ROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENTE	:R	155 E B	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 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
	openings between construction having at least 1 hour. An accordance with 8 19.3.1.1 through 1 lf all vertical opening with construction price resistance ratio box. Based on observation failed to maintain proceeding accordance of 19.3. protection of vertical operation of vertical provided in accordance 8.6.1 requires every a building shall be of LSC 19.3.1.1 requires provided, the construction as 1-hour fire repractice could affect Findings include: Based on observation of the facility work of 19.3.1 the facility of 19.3 th	chutes, and other vertical infloors are enclosed withing a fire resistance rating of in atrium may be used in 3.6. 19.3.1.6 ings are properly enclosed providing at least a 2-houring, also check this in and interview, the facility rotection of 1 of 2 stairways in 1. LSC 19.3.1 requires all opening 39.3.1. LSC 19.3.1 ening shall be enclosed or ance with Section 8.6. LSC of floor that separates stories in constructed as a smoke barrier. The swhere an enclosure is ruction shall have not less esistance rating. This deficient in the 28 residents. The man and interview during a with the Maintenance Director in 11:30 a.m. and 2:00 p.m., the floom 143 had a 10" by 10" hole who will be the contact that the maintenance with the Maintenance	K 0	311	K 311 = E 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. The area noted was repaired. How other residents having a 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 deficient practice. No other residents we affected by the alleged deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:	the eeee ee al to eere ent	07/25/2022

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l f '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155278	B. WI	ING		07/07/	/2022
	PROVIDER OR SUPPLIEF	R - BLOOMINGTON CARE CENTE	R	155 E B	ADDRESS, CITY, STATE, ZIP COD BURKS 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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Maintenance staff were educa on vertical openings (Exhibit E and the need to repair them or noted. No other areas were not upon audit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will utilized to determine compliant The Maintenance Director or he designee will complete the audit weekly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months at the end of 6 months of 90% compliance is achieved the audit will be complete. If compliance not achieved in 6 months, ther QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plate of correction, it is determined that the correction will not be considered.	ted 3) nce oted the be ce. nis dit thly or e sand ditse is n the to	DATE
					completed by the date previously submitted, The Division need to be contacte	d	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/07/2022
	ROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	155 E I	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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
				as soon as possible. The f will need to submit an amended plan of correctio with the updated plan of correction date; 7/25/2022	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardour of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or complements of the door closed with a control of the door closed with applied. There is closing of the door release when the compartment of the door release when the control of the door release when the control of the door solid flammable and the door solid flammable and the door solid flammable and the door release when the control of the door release when the control of the door solid flammable and the door solid fla	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain bustible material. In bottom of door and floor speeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping men a force of 5 lbf is no impediment to the res. Hold open devices that door is pushed or pulled are ad protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155278		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/07/2022			
		ROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 155 E BURKS DR BLOOMINGTON, IN 47401				
) ID EFIX AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
		allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ration devices, etc. Based on observation failed to ensure 2 or impediment to closs frame and would restrained and would restrained to the facility of t	Laundry Fire Door Central Supply Room knowledged by the tor at the time of discovery and afterence with the Maintenance	K 0.	363	K 363 = E 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. Both door latches were immediately replaced. 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 deficient practice. No residents were affected by the alleged deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:	the the e e l to cient	07/25/2022

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AND FLAN OF CORRECTION IDENTIFICATION NUMBER A BULIDING 15278 COMPLETED O7/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIF COD 155 E BURKS DR BLOOMINGTON, IN 47401 IX4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER STAN IFF COMPLETION COMPLETION DATT: TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualify assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, informathly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction, it is determined that the correction, it is determined that the correction submit an of correction, it is determined that the correction but mit an expension of the proviously submitted, The Division needs to be contacted as soon as possible. The facility will need to be ubmit an expension of the proviously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an expension of the proviously submitted. The Division need to be contacted as soon as possible. The facility will need to submit an expension of the proviously submitted. The Division need to be contacted as soon as possible. The facility will need to submit an expension of the proviously submitted. The Division need to be contacted as soon as possible. The facility will need to submit an expension of the proviously submitted.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER INTEGER CONTROL OF THE CONTROL OF	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER (X4) ID PREFIX TAG SUMMAY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LISC IDENTIFYING INFORMATION Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compilance. The Maintenance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compilance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compilance is achieved the audits will be be complete. If compliance is not achieved in 6 months, then the QAPI Committee will condinue to monitor monthly until 30% compilance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the data previously submitted, The Division need to be contacted as soon as possible. The facility			155278	B. WI	NG		07/07/	2022
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER (X4) ID REPERLY PREFIX TAG SUMMARY STATEMENT OF DEPICTINCE! GEACH DEFICENCY MUST BE REFECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months, and months and at the end of 6 months of 90% compliance is achieved the audits will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If complete is complete in the QAPI committee will continue to monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility	NAME OF F	PROVIDER OR SUPPLIEF	- {					
SUMMARY STATEMENT OF DEFICIENCIE (PACH DEFICERCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility	BDICKV/	ADD HEALTHCADE	E BLOOMINGTON CARE CENTE	D				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will confine to monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility		1		<u> </u>		111101011, IN 47401		
Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is anchieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
Maintenance staff were educated on door latching properly (Exhibit B). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compiliance. The Maintenance Director or designee will complete the audit weekly for two months, birnorthly for two months, and monthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months and at the end of 6 months of 90% compiliance is achieved the audits will be complete. If compliance is not achieved the form the QAPI Committee will place to monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility		`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Maintenance staff were education on door latching properly (Exhibit). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliant. The Maintenance Director or designee will complete the audit weekly for two months, bimonifor two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months at the end of 6 months of 90% compliance is achieved the audit will be complete. If compliance not achieved in 6 months, ther QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable platof correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The factorized.	che ce. dit thly or sand addits e is a the to	DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES							B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		_
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED	
		155278	B. W	ING		07/07/	/2022	
NAME OF	PROVIDER OR SUPPLIEI		•	STREET	ADDRESS, CITY, STATE, ZIP COD			_
NAME OF	FROVIDER OR SUFFLIEI				BURKS DR			
BRICKY	ARD HEALTHCARE	E - BLOOMINGTON CARE CENT	ER	BLOOM	MINGTON, IN 47401			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓΕ	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	_
					amended plan of correction			
					with the updated plan of correction date;			
					correction date,			
					7/25/2022			
K 0372	NFPA 101							
SS=D		ilding Spaces - Smoke						
Bldg. 01	Barrie	maing opacits official						
-	Subdivision of Bu	ilding Spaces - Smoke						
	Barrier Constructi	on						
2012 EXISTING								
		nall be constructed to a						
		tance rating per 8.5. Smoke						
		permitted to terminate at an						
		te dampers are not required						
	•	ns in fully ducted HVAC						
		n approved sprinkler system						
	to the smoke barr	oke compartments adjacent						
	19.3.7.3, 8.6.7.1(°							
		chanical smoke control						
	system in REMAR							
	1 -	on and interview, the facility	KO	372	K 372 = E		07/25/2022	
	failed to ensure the	penetrations caused by the			What corrective action(s) will	i		
	passage of wire and	l/or conduit through 1 of 2			be accomplished for those			
	smoke barriers wal	ls were protected to maintain			residents found to have been	i		
		ee of each smoke barrier. LSC			affected by the deficient			
		quires smoke barriers to be			practice;			
		rdance with LSC Section 8.5						
		nimum ½ hour fire resistive			No residents were affected by			
		n 8.5.2.1 requires smoke barriers			alleged deficient practice. The			
		om an outside wall to an			ceiling tile was replaced.			
		a floor to a floor, or from a			Ham alban madda ()	de a		
		smoke barrier, or by use of a f. 8.5.6.2 requires penetrations			How other residents having to potential to be affected by the			
		ys, conduits, pipes, tubes,			same deficient practice will be			
	101 caoics, caoic ila	ijo, conduno, pipes, tuoes,	1		Janie Generali Practice Mill D	/ C	I	

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vents, wires, and similar items to accommodate

communications systems that pass through a wall,

electrical, mechanical, plumbing, and

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identified and what corrective

action(s) will be taken;

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION (X3) DAT		URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ETED
		155278	B. W	ING		07/07/2	2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
DDICKY			·D		BURKS DR		
BRICKY	ARD HEALTHCARE	E - BLOOMINGTON CARE CENTE	:K	BLOOM	MINGTON, IN 47401		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	floor, or floor/ceilir	ng assembly constructed as a			All residents have the potentia	al to	
	smoke barrier, or th	rough the ceiling membrane of			be affected by the alleged def		
	the roof/ceiling of a	a smoke barrier assembly, shall			practice. No residents were		
	be protected by a sy	ystem or material capable of			affected by the alleged deficie	nt	
	restricting the move	ement of smoke. This deficient			practice. No other removed ce		
	practice could affect	et 2 staff in the Chart Room.			tiles were noted.		
	Findings include:				What measures will be put in	nto	
					place and what systemic		
	Based on observation	ons and interview during a			changes will be made to		
	tour of the facility v	with the Maintenance Director			ensure that the deficient		
	on 07/07/22 betwee	en 11:30 a.m. and 2:00 p.m., an			practice does not recur:		
	unsealed penetratio	n was discovered in the smoke					
	barrier drop ceiling	in the Chart Room where			Maintenance staff were educa	ited	
	approximately a 18	'X24' of ceiling tile had been			on smoke barriers (Exhibit B)	and	
	removed.				ensuring ceiling tiles are in pla	ace.	
	This finding was ac	cknowledged by the			How the corrective action(s)		
	Maintenance Direct	tor at the time of discovery and			will be monitored to ensure t	the	
	again at the exit con	nference with the Maintenance			deficient practice will not		
	Director and Admir	nistrator present.			recur, i.e., what quality		
					assurance will be put into		
	3.1-19(b)				place; and		
			1				
			1		An audit tool titled "2022 Life		
			1		Safety Audits" (Exhibit F) will I	be	
					utilized to determine complian	ce.	
					The Maintenance Director or		
					designee will completed the a	udit	
			1		weekly for two months, bimon	thly	
					for two months, and monthly f	or	
					two months. This audit will be		
					reviewed in QAPI for 6 months	s and	
					at the end of 6 months of 90%		
					compliance is achieved the au	ıdits	
					will be complete. If compliance	e is	
					not achieved in 6 months, the	n the	
					QAPI Committee will continue		
					monitor monthly until 90%		
					compliance is achieved.		

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	OF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDING B. WING	01	COMPLETED 07/07/2022
	ROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	155 E I	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 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using goomplies with NFF Code, electrical with the complies with the complies with the complies with the complies with the code. Existing instruction in the complex of the complex with ground (GFCI) protection and 19.5.1.1 requires utilities of the complex with the complex with the complex with the complex with the complex of t	Electric Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.	K 0511	By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plate of correction, it is determine that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date; 7/25/2022 K 511 = E What corrective action(s) with the updated plan of correction date; 7/25/2022 No Residents or staff were affected by the deficient practice; No Residents or staff were affected by the alleged deficient practice. All 3 cited receptable	an de e e e e e e e e e e e e e e e e e e

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	ì í	UILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/07/2022	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
BRICKY	ARD HEALTHCARI	E - BLOOMINGTON CARE CENT	155 E BURKS DR BLOOMINGTON, IN 47401				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		C). The ground-fault			receptacles.		
	_	shall be installed in a readily			l		
	accessible location				How other residents having		
		velling Units. All 125-volt, nd 20-ampere receptacles			potential to be affected by the	I	
		ations specified in 210.8(B)(1)			same deficient practice will identified and what corrective		
					action(s) will be taken;	/e	
	through (8) shall have ground-fault circuit-interrupter protection for personnel.				action(s) will be taken,		
	(1) Bathrooms	reconstruction of the second			All residents and staff have th	ne	
	(2) Kitchens				potential to be affected by the		
	(3) Rooftops				alleged deficient practice. No		
	(4) Outdoors				residents or staff were affecte		
	Exception No. 1 to (3) and (4): Receptacles that are				the alleged deficient practice.	The	
not readily accessible and are supplied by a					policy titled "Electrical Safety"	,	
		cated to electric snow-melting,			(Exhibit C) was reviewed with	no	
		and vessel heating equipment			changes made.		
	_	to be installed in accordance					
	with 426.28 or 427				What measures will be put in	nto	
	_	(4): In industrial establishments			place and what systemic		
		nditions of maintenance and			changes will be made to		
	_	that only qualified personnel			ensure that the deficient		
		sured equipment grounding			practice does not recur:		
		as specified in 590.6(B)(2) for only those receptacle			The Maintenance Staff were		
		bly equipment that would					
		ard if power is interrupted or			educated on the policy titled "Electrical Safety" (Exhibit C).		
	_	at is not compatible with GFCI			Listing Carety (Exhibit 6).		
	protection.				How the corrective action(s)	,	
	•	eceptacles are installed within			will be monitored to ensure		
	` '	outside edge of the sink.			deficient practice will not		
		(5): In industrial laboratories,			recur, i.e., what quality		
	receptacles used to	supply equipment where			assurance will be put into		
	_	would introduce a greater			place; and		
	_	mitted to be installed without					
	GFCI protection.				An audit tool titled "2022 Life		
	_	(5): For receptacles located in			Safety Audits" (Exhibit F) will		
	_	ns of general care or critical			utilized to determine compliar	nce.	
		care facilities other than those			The Maintenance Director of		
	covered under				designee will utilize the tool		
	210.8(B)(1), GFCI	protection shall not be required.			weekly for two months, bimon	nthly I	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CO	ONSTRUCTION 01	(X3) DATE COMPL	
		155278	B. WI	NG		07/07/	/2022
BRICK	T	- BLOOMINGTON CARE CENTI	ER	155 E E BLOON	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 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
	facilities (8) Garages, service electrical diagnostic tools. NFPA 70, 517-20 V receptacles and fixe the wet location to linterrupter (GFCI) preduce the contact relectrical insulation. This deficient pract 18 residents in the v. Findings include: Based on observation to be discovered tour of the facility who not 17/07/22 between water machines near Nurses Stations were receptacle which we freestanding water a supply. The water 3 feet of the electric with ground fault of Maintenance Direct stated he did not be GFCI circuit. Further pumps were submer a receptacle which when the maintenance Direct stated he did not be GFCI circuit. This finding was ac Maintenance Direct.	with associated showering bays, and similar areas where equipment, electrical hand Vet Locations, requires all dequipment within the area of have ground-fault circuit protection. Note: Moisture can esistance of the body, and is more subject to failure. ice could affect staff and up to pricinity of the water machines ons and interview during a with the Maintenance Director on 11:30 a.m. and 2:00 p.m., the or (1) Station 1 and (2) Station 2 or connected to an electric as being used to power the machines, with their own water machines were located within or receptacle, and not provided recuit interruption (GFCI). The or at the time of observation lieve the receptacles were on a termore, (3) the basement sump orged in water and connected to was not GFCI protected. The or at the time of observation lieve the receptacle was on a			for two months, and monthly fitwo months. This audit will be reviewed in QAPI for 6 month at the end of 6 months of 90% compliance is achieved the auwill be complete. If compliance not achieved in 6 months, the QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plate of correction, it is determine that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date; 7/25/2022	s and dudits e is n the e to	
	again at the exit cor	ference with the Maintenance	1		I		I

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Director and Administrator present.

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/07/2022	
	PROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENT	155 E	FADDRESS, 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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION	
K 0741 SS=F Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the int smoking. (2) In health care a smoking is prohibi prominently placed secondary signs with smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the passupervision. (5) Ashtrays of not safe design shall be where smoking is (6) Metal contained devices into which	ns shall be adopted and ass than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are d at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Intent of 18.7.4(3) shall not attent is under direct incombustible material and be provided in all areas permitted. In swith self-closing cover a ashtrays can be emptied ailable to all areas where				
	failed to ensure 2 of maintained by dispo	on and interview; the facility 2 smoking areas were using cigarette butts in a metal container with self-closing	K 0741	K 741 = E What corrective action(s) v be accomplished for those residents found to have be affected by the deficient		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155278	B. WI	ING		07/07/	/2022
				STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			BURKS DR		
BRICKY	ARD HEALTHCARE	- BLOOMINGTON CARE CENTE	R		IINGTON, IN 47401		
	Г		· 		,		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		deficient practice could affect		TAG			DATE
	all staff and residen	•			practice;		
	an sam and residen				No Residents were affected b	v the	
	Findings include:				alleged deficient practice.	,	
					amagaa aanalant piaatioo.		
	Based on observation	ons and interview during a			How other residents having	the	
	tour of the facility v	vith the Maintenance Director			potential to be affected by th		
		n 11:30 a.m. and 2:00 p.m., the			same deficient practice will b	ре	
		d that the facility had two			identified and what correctiv	е	
		g areas, one supervised for			action(s) will be taken;		
		eparate for staff. During a tour			<u> </u>		
		ette butts were observed in			All Residents have the potenti		
	_	round the building including			be affected by the alleged def	icient	
		e exit doors, in the mulch, and			practice. No residents were	4	
		Next to the Station 2 Exit building and the immediate			affected by the alleged deficie	nı	
		with 300 plus cigarette butts.			practice. The policy titled "Employee Smoking" (Exhibit	D)	
		xit door had over 100 cigarette			was reviewed and no changes		
		immediately outside the exit			was reviewed and no changes were made	•	
	_	ffee can was full of cigarette			word made		
		ing. The Maintenance Director			What measures will be put in	nto	
		igarette butts on the ground in			place and what systemic		
	the aforementioned	locations around the facility			changes will be made to		
	and that smoking w	as a problem at the facility.			ensure that the deficient		
					practice does not recur:		
	This finding was ac						
		for at the time of discovery and			All Employees were educated	on	
		iference with the Maintenance			the policy titled "Employee		
	Director and Admir	nistrator present.			Smoking" (Exhibit D), and,		
	3.1-19(b)				educated on the designated a		
	J.1-19(U)				for smoking. Staff were educa on placing cigarette butts in th		
					proper receptacles located in		
					designated smoking area.	Caon	
					assignated smoking area.		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance will be put into		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r /		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED 07/07/2022	
		155278	B. W	_		07/07/	/2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BRICKYA	ARD HEALTHCARE	E - BLOOMINGTON CARE CENTE	:R		BURKS DR MINGTON, IN 47401		
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID			(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)	IE.	DATE
					place; and		
					The Maintenance Director or designee will utilize the audit t	ool	
					titled "2022 Life Safety Audits"		
					(Exhibit F) to determine		
					compliance. The audit will be		
					completed weekly for two mor	nths,	
					Bimonthly for two months, and		
					monthly for two months. This	audit	
					will be reviewed in QAPI for 6 months and at the end of 6		
					months of 90% compliance is		
					achieved the audits will be		
					complete. If compliance is not		
					achieved in 6 months, then the		
					QAPI Committee will continue	to	
					monitor monthly until 90%		
					compliance is achieved.		
					By what date the systemic		
					changes for each deficiency		
					will be completed. After		
					submitting an acceptable pla		
					of correction, it is determine		
					that the correction will not be completed by the date	ŧ	
					previously submitted, The		
					Division need to be contacte	d	
					as soon as possible. The fac	ility	
					will need to submit an		
					amended plan of correction		
					with the updated plan of		
					correction date;		
					7/25/2022		
14 0000							
K 0920 SS=E	NFPA 101	ont Dower Carda and					
SS=⊑ Bldg. 01	Electrical Equipme Extens	ent - Power Cords and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	01	COMPLETED	
		155278	B. WING			07/07/	2022
				TDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			URKS DR		
BDICKV	ADD HEVI THOVDE	- BLOOMINGTON CARE CENTE			IINGTON, IN 47401		
BICICITA	AND FILAL ITICANL	- BEOOMINGTON CARE CENTE		DECON			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	Electrical Equipme	ent - Power Cords and					
	Extension Cords						
Power strips in a patient care vicinity are only							
	used for compone						
	•	ed electrical equipment					
	, ,	les that have been					
		alified personnel and meet					
		0.2.3.6. Power strips in					
	-	cinity may not be used for					
	, -	personal electronics),					
		m care resident rooms that					
		E. Power strips for PCREE					
		r UL 60601-1. Power strips					
		the patient care rooms					
	,	meet UL 1363. In					
		ooms, power strips meet					
		ls. All power strips are					
	-	precautions. Extension					
		d as a substitute for fixed					
	-	re. Extension cords used					
		moved immediately upon purpose for which it was					
		ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	· ·	(D) (NFPA 70), TIA 12-5					
	` '	ation and interview, the facility	K 0920	n	K 920 = E		07/25/2022
		ver strips in 5 locations met UL	K 0920		What corrective action(s) wil	ı	0772372022
	-	60601-1. Patient care vicinity is			be accomplished for those	•	
	-	within a location intended for			residents found to have beer	1	
		I treatment of patients,			affected by the deficient	•	
		yond the normal location of the			practice;		
		eadmill, or other device that			,		
		during examination and			No residents were affected by	the	
		at care vicinity extends			alleged deficient practice. All		
	-	inches above the floor. This			power strips identified during t	he	
	•	ffects 12 resident who reside in			survey were immediately remo		
	resident rooms.				•		
					How other residents having t	the	
	Findings include:				potential to be affected by th		
					same deficient practice will b		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 07/07/2022				
	PROVIDER OR SUPPLIER	E - BLOOMINGTON CARE CENT	ER	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
TAG	Based on observation tour of the facility won 07/07/22 betwee following locations outside the patient of personal electrical erating of 1363A or estrip. A) Resident Room B) Resident Room C) Resident Room D) Resident Room E) Resident Room E) Resident Room This finding was ac Maintenance Direct again at the exit cor Director and Admir 2. Based on observation facility of the breakroom. Findings include: Based on observation to be used for (1) are the breakroom. Findings include:	ons and interview during a with the Maintenance Director in 11:30 a.m. and 2:00 p.m., the were using power strips are vicinity for resident's equipment that lacked a UL 50601-1 label on each power in # 3 in # 4 in # 2 in # 101 in # 111 in # 11 in # 111 in # 111 in # 11 in # 11 in # 11 in # 11 in # 1		TAG	identified and what corrective action(s) will be taken; All residents have the potential be affected by the alleged defipractice. No residents were affected by the alleged deficie practice. A building sweep was conducted and all power strips patient care areas and for power strips being used for high drawequipment. No other power streated with the policy titled "Electrical Safety" (Exhibit C) reviewed with no changes made with the deficient practice does not recur: Maintenance staff will be educed on the policy titled "Electrical Safety" (Exhibit C). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and The audit titled "2022 Life Safe Audits" (Exhibit F) will be utilize to determine compliance. The	e al to icient nt s in ver v rips was de. ated	DATE		
	used to power a cof	fee machine (high power draw aintenance Director removed			Maintenance Director of his designee will complete the au weekly for two weeks, bimontl	dit			

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for two months, and monthly for

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	OF CORRECTION	IDENTIFICATION NUMBER 155278	A. BUILDING B. WING	01	COMPLETED 07/07/2022
	ROVIDER OR SUPPLIER	- BLOOMINGTON CARE CENTE	155 E E	ADDRESS, CITY, STATE, ZIP COD BURKS DR MINGTON, IN 47401	
(X4) ID PREFIX TAG	(EACH DEFICIENC 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
		or at the time of discovery and ference with the Maintenance		two months. This audit will be reviewed in QAPI for 6 months at the end of 6 months of 90% compliance is achieved the auwill be complete. If compliance not achieved in 6 months, there QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plate of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date; 7/25/2022	adits e is n the to
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in accor Transfilling of High Oxygen Used for Fany gas from one prohibited in patiento liquid oxygen containers over 50 under 11.5.2.3.1 (I	Fransfilling Cylinders Fransfilling Cylinders Gen from one cylinder to dance with CGA P-2.5, In Pressure Gaseous Respiration. Transfilling of cylinder to another is Int care rooms. Transfilling Intainers or to portable In psi comply with conditions INFPA 99). Transfilling to aniners or to portable			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTIO		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPLETED			
155		155278	B. WING			07/07/2022			
				STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIEF	₹			BURKS DR				
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTE									
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE ID PROV		PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE		
		50 psi comply with							
		11.5.2.3.2 (NFPA 99).							
	11.5.2.2 (NFPA 9				K 007 - F		05/05/0000		
	Based on observation and interview, the facility		K 0927		K 927 = E		07/25/2022		
	failed to ensure 1 of 2 oxygen storage room where				What corrective action(s) will be accomplished for those				
	oxygen transferring takes place, was provided with properly working mechanical ventilation.								
		2			residents found to have been				
	NFPA 99 2012 edition, 11.5.2.3.1 (2) requires				affected by the deficient practice;				
	oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical				practice,				
	exhaust to maintain a negative pressure in the				No Residents were affected b	v the			
	space continuously. This deficient practice could				alleged deficient practice. The				
	affect up to 21 residents in one smoke				inoperable fan was replaced with				
	compartment.				an operable fan.				
	compartment.								
	Findings include:				How other residents having	the			
					potential to be affected by the				
	Based on observations and interview during a				same deficient practice will be				
	tour of the facility with the Maintenance Director				identified and what corrective				
	on 07/07/22 between 11:30 a.m. and 2:00 p.m., the				action(s) will be taken;				
	oxygen storage/transfer room near Station 1								
	contained large liquid oxygen tanks. There were				All residents have the potential to				
	two vents in the room, but the vents did not				be affected by the deficient				
	contain a mechanically ventilated exhaust fan and				practice. No residents were				
	it was unclear if either vent terminated to the				affected by the alleged deficient				
	outside air. Based on interview at the time of				practice.				
	observation, the Maintenance Director								
	acknowledged the vents in the oxygen room were				What measures will be put into place and what systemic changes will be made to				
	not power ventilated stated that he was sure								
	neither vent went to the outside.								
	This finding was acknowledged by the				ensure that the deficient				
	Maintenance Director at the time of discovery and				practice does not recur:				
	again at the exit conference with the Maintenance				Maintenance staff were educated				
	Director and Administrator present.				on Oxygen Storage with an				
	Director and Administrator present.				inservice titled "Oxygen				
	3.1-19(b)				Safety—Storage, Handling, and				
	(-)				Use" (Exhibit E).				
					How the corrective action(s)				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155278	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/07/2022			
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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION	TAG	will be monitored to ensure deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled "2022 Life Safety Audits" (Exhibit F) will utilized to determine complia The Maintenance Director or designee will complete the a weekly for two weeks, bimon for two months, and monthly two months. This audit will be reviewed in QAPI for 6 month at the end of 6 months of 90° compliance is achieved the a will be complete. If compliance not achieved in 6 months, the QAPI Committee will continue monitor monthly until 90% compliance is achieved. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable pof correction, it is determine that the correction will not completed by the date previously submitted, The Division need to be contact as soon as possible. The fawill need to submit an amended plan of correction with the updated plan of correction date;	the I be noce. udit athly for e hs and % audits ce is en the e to y lan ed be ted acility			
				7/25/2022				

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