STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Bloomington Care Center	155 E Burks Dr Bloomington, IN 47401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. A. Based on observation, interview and record review, the facility failed to provide supervision to prevent a cognitively impaired resident with a history of exit seeking behavior from leaving the facility property without staff knowledge for 1 of 3 residents reviewed. (Resident B)B. Based on observation, interview, and record review, the facility failed to ensure the secured unit courtyard gate was locked for 2 of 3 observations. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 5/8/26 at approximately 9:30 a.m. when the facility failed to provide supervision to prevent a cognitively impaired resident with a history of exit seeking behavior from leaving the facility property for an unknown amount of time without staff knowledge. The Administrator, the Director of Nursing, the Regional Nurse were notified of the Immediate Jeopardy on 5/13/23 at 3:45 p.m. The Immediate Jeopardy was removed on 5/14/26 at 1:30 p.m., but noncompliance remained at a lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: A. During an interview on 5/13/26 at 8:50 a.m., Licensed Practical Nurse (LPN) 1 indicated on 5/8/26 at approximately 10:00 a.m., Resident B left the facility property without staff knowledge and was found almost a mile away.During an interview on 5/13/26 at 10:12 a.m., CNA 1 indicated on 5/8/26 during day shift, she was the nursing aide that worked with Resident B. CNA 1 had last seen Resident B at approximately 9:00 a.m. when Resident B told CNA 1 he was going to smoke. During an interview on 5/13/26 at 12:46 p.m., the Administrator indicated on 5/8/26 at approximately 9:30 a.m., he saw Resident B's walker outside in a grassy area across from the main entrance. The Administrator did not see Resident B, so he searched around the area and then went inside and notified the staff to begin looking inside and outside the facility. After approximately thirty minutes, staff located Resident B at a carwash approximately 0.7 miles from the facility. Resident B returned to the facility with the Administrator in the facility van. Resident B told the Administrator he was trying to go to the store to buy more cigarettes and was going to return to the facility.On 5/13/26 from 1:30 p.m. until 1:40 p.m., the path Resident B walked when he left the facility without staff knowledge on 5/8/26 at approximately 9:30 a.m. was observed. From the main entrance Resident B walked approximately 0.1 miles down the facility parking lot and driveway to the sidewalk and street. Resident B crossed over a side street and turned to the right and walked approximately 0.1 miles on an uneven sidewalk. At the intersection of the side street and the main road Resident B turned to the left and walked approximately 0.5 miles on an uneven sidewalk of a busy main road with a speed limit of 40 miles per hour to a business at a busy intersection where Resident B was located by staff.The clinical record for Resident B was reviewed on 5/13/26 at 2:01 p.m. The diagnoses included, but were not limited to, dementia, seizure disorder, and psychotic disorder.An Elopement Risk Evaluation, dated 10/29/25, indicated Resident B was an elopement risk due to verbally expressing the desire to go home.An Elopement Risk Evaluation, dated 2/26/26, indicated Resident B was not at risk for elopement.A Quarterly Minimum Data Set (MDS) assessment, dated 4/30/26, indicated Resident B was moderately cognitively impaired.A physician's order started on 1/10/25, indicated the resident may go on a leave of absence with supervision. There was no stop date noted.A physician's order started on 2/26/26 and discontinued on 5/8/26 (after Resident B (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	returned to the secured unit), indicated to check wanderguard for placement and function every shift.A care plan, dated 4/4/25, and resolved on 4/24/26, indicated Resident B was at risk for wandering and elopement related to a history of attempt to leave the facility and impaired safety awareness. Interventions included, but were not limited to, distract Resident B by offering pleasant diversions and identify patterns of wandering. A nurse's progress note, dated 4/20/26 at 7:30 p.m., indicated Resident B was outside on supervised smoke time and was making inappropriate gestures with his tongue toward another resident. Another resident told Resident B to stop then all of the residents started yelling at each other. Resident B threw his walker and unintentionally hit another resident in the right leg.A nurse's progress note, dated 4/21/26 at 9:15 a.m., indicated Resident B became upset when going to smoke break and started walking in the parking lot. Staff immediately redirected Resident B back inside the facility. A Nurse Practitioner progress note, dated 4/28/26 at 7:37 p.m., indicated Resident B had behavioral episodes on 4/20/26 and 4/21/26, that included becoming upset and walking into the parking lot during a smoke break, making inappropriate gestures toward other residents, and yelling and throwing his walker.The Medication Administration Record, dated 5/1/26 at 12:00 a.m. through 5/13/26 at 2:00 p.m., indicated Resident B's wanderguard was in place and functioning properly every shift from 5/1/26 at 12:00 a.m. until 5/8/26 on evening shift.During an interview on 5/13/26 at 2:17 p.m., the Activity Assistant indicated on 5/8/26 at 9:00 a.m., she provided supervision for the residents who wanted to go smoke. She knew Resident B smoked cigarettes, but Resident B was not with the smokers the Activity Assistant supervised. The Activity Assistant had not seen Resident B outside during smoke time on 5/8/26 at 9:00 a.m. She had been made aware of Resident B's past exit seeking behavior that occurred on 4/21/26.B. During an interview on 5/13/26 at 8:41 a.m., Resident B indicated, a few days ago, he left the facility to walk to the store. Resident B thought he walked through the gate on the secured unit's courtyard to leave the facility.On 5/13/26 from 8:52 a.m. until 9:10 a.m., observed the enclosed courtyard outside the secured memory care unit. The courtyard was located past the secure unit dining room and required a passcode to unlock the exit door. Once outside in the courtyard, there was a concrete walkway that encircled the courtyard and a privacy fence approximately seven feet tall. At the end of the courtyard the sidewalk led to a privacy gate that had a latch to close the door. The gate was latched but not locked and easily opened. The gate led to another sidewalk that led left or right with another privacy fence approximately seven feet tall on the other side of the sidewalk. Going left, the sidewalk led to another courtyard to a separate secured memory care unit. Going right, the sidewalk led to another gate that was open. Outside that gate was a grassy area that led up a hill to a chain-link fence approximately six feet tall. The gate ran along the facility property and an apartment complex parking lot. Going left at the top of the hill led to a narrow grassy pathway approximately 20 feet long that led around the facility to overgrown brush that was not passable. Going right at the top of the hill led to a narrow grassy pathway approximately twenty feet long with weeds. The facility roof was easily accessible. Just past the narrow path a larger grassy area that eventually led to the facility parking lot and driveway.During an interview on 5/13/26 at 9:12 a.m., the Maintenance Manager indicated the gate should have been locked. He believed the lawn crew left the gate unlocked a couple days ago but would make sure the gate was locked.On 5/14/26 from 8:10 a.m. until 8:17 a.m., observed the enclosed courtyard outside the secured memory care unit. The courtyard was located past the secure unit dining room and required a passcode to unlock the exit door. Once outside in the courtyard, there was a concrete walkway that encircled the courtyard and a privacy fence approximately seven feet tall. At the end of the courtyard the sidewalk led to a privacy gate that had a latch to close the door. The gate was latched but not locked and easily opened. The gate led to another sidewalk that led left or right with another privacy fence approximately seven feet tall on the other side of the sidewalk. Going left, the sidewalk led to another courtyard to a separate secured memory care unit. Going right, the sidewalk led to another gate that was open. At that time, the Maintenance Manager indicated, the gate would be locked immediately.On 5/13/26 at 8:50 a.m., the Director of Nursing provided a copy of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	an undated facility policy, titled Elopements and Wandering Residents. A review of the policy indicated residents who exhibit wandering behavior and or are at risk for elopement receive adequate supervision to prevent accidents. The Immediate Jeopardy, that began on 5/8/26, was removed on 5/14/26 when the facility inserviced the facility staff on elopements policies and behaviors, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence.This citation relates to Intake 3009486.410 IAC (Indiana Administrative Code) 16.2-3.1- 3.1-45(a)